# SIMULATION EXAM 17

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

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

1. A surgeon excises a 1.8 cm malignant squamous cell carcinoma from the patient's right cheek with 0.6 cm margins. What is the excised diameter for code selection?

A. 3.0 cm

B. 2.4 cm

C. 1.8 cm

D. 4.2 cm

2. A patient has three lacerations: a 4.0 cm simple repair on the right forearm, a 5.0 cm intermediate repair on the left forearm, and a 3.0 cm intermediate repair on the right hand. The left forearm and right hand are in the same intermediate repair grouping. How should these be reported?

A. Three separate repair codes

B. One intermediate repair code for 12.0 cm combining all wounds

C. One simple repair code for 4.0 cm and one intermediate repair code for 8.0 cm

D. One complex repair code for 12.0 cm

3. A dermatologist performs destruction of 14 actinic keratoses and separately destroys 2 benign acrochordons (skin tags) on the same patient during the same encounter. How should the actinic keratosis destruction be coded?

A. 17004

B. 17000 × 1, 17003 × 13

C. 17000 × 14

D. 17000 × 1, 17003 × 11

4. A surgeon performs a wound revision (scar revision) involving excision of a hypertrophic scar from a patient's forearm and complex layered closure with Z-plasty technique. The resulting defect after scar excision is 6 sq cm. How should the Z-plasty be coded?

A. With a wound repair code for complex closure

B. With a scar excision code only

C. With a skin graft code

D. With an adjacent tissue transfer code — Z-plasty is a tissue rearrangement technique classified under adjacent tissue transfer

5. A physician performs a shave removal of a 0.6 cm raised pedunculated benign skin tag from the patient's left axilla and separately performs a punch biopsy of a 0.4 cm suspicious pigmented lesion from the patient's right shoulder during the same encounter. How should these be coded?

A. Both the shave removal code and the punch biopsy code — they are distinct procedures on different lesions at different sites

B. Only the punch biopsy code; the shave removal is bundled

C. Only the shave removal code; the biopsy is bundled

D. One excision code combining both

6. A surgeon performs debridement of a pressure ulcer on the patient's sacrum. The debridement extends through the skin and subcutaneous tissue to exposed muscle, but does not reach bone. The wound also has necrotic tissue and fibrin. Which depth determines the debridement code?

A. Skin only

B. Subcutaneous tissue

C. Muscle — the deepest tissue level debrided determines the code

D. Bone

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

7. A surgeon performs arthroscopic removal of a loose body from the right elbow and a diagnostic arthroscopy during the same session. 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 treats a non-displaced distal fibula fracture (lateral malleolus) with a short leg walking boot. No manipulation is performed. The surgeon provides all follow-up care. What type of fracture treatment is this?

A. Open reduction with internal fixation

B. Closed treatment with manipulation

C. Percutaneous fixation

D. Closed treatment without manipulation

9. A patient undergoes a two-level posterior lumbar interbody fusion (PLIF) at L4-L5 and L5-S1 with bilateral pedicle screw instrumentation and interbody cages at each level. How should the second-level fusion be coded?

A. With an add-on code for the additional interspace fusion

B. With a second primary fusion code and modifier 51

C. With the first code and modifier 76

D. With a second primary fusion code and modifier 59

10. A patient undergoes excision of a ganglion cyst from the dorsal aspect of the right wrist. The cyst arises from the scapholunate ligament. Which CPT section contains ganglion cyst excision codes?

A. Integumentary system

B. Medicine section

C. Musculoskeletal system (20,000 series)

D. Nervous system

11. A surgeon performs an open Bankart repair (labral repair) of the left shoulder for recurrent anterior instability. No arthroscopy is performed. What type of approach is this?

A. Arthroscopic approach

B. Open surgical approach

C. Percutaneous approach

D. Endoscopic approach

12. A patient undergoes removal of a broken intramedullary nail from the right femur. The nail was placed during a previous fracture treatment, and the fracture has healed. Which type of code should be reported?

A. The original fracture treatment code with modifier 76

B. An E/M code only

C. A new fracture treatment code

D. A hardware removal code (20680 for deep implant removal)

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

13. A patient undergoes bronchoscopy with therapeutic aspiration of a mucus plug causing atelectasis and separately with bronchial washing during the same session. How should the diagnostic bronchoscopy be coded?

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

B. As a separate code with modifier 59

C. As a separate code with modifier 51

D. As a separate code with modifier 25

14. A cardiologist replaces the pulse generator of an existing dual-chamber pacemaker. The existing leads are tested and left in place. Only the battery-depleted generator is replaced with a new one. How should this be coded?

A. With a complete system replacement code

B. With separate codes for lead removal and generator insertion

C. With the pulse generator replacement code only — the leads were not manipulated

D. With the lead insertion code and modifier 52

15. A patient undergoes an open repair of a ruptured abdominal aortic aneurysm (AAA) using a tube graft. The procedure is performed emergently through a midline laparotomy. Which vascular subsection contains this code?

A. The peripheral vascular subsection

B. The aorta and great vessel subsection

C. The venous system subsection

D. The coronary artery subsection

16. A patient undergoes bilateral sentinel lymph node biopsy of the axillae for staging of breast cancer. The sentinel nodes are identified using radioisotope injection and blue dye mapping. How should the bilateral nature be reported?

A. With a single code and no modifier

B. With the code and modifier 22

C. With two separate codes and modifier 51

D. With the sentinel lymph node biopsy code and modifier 50 or RT/LT modifiers

17. A surgeon performs a thoracentesis (pleural tap) on the right side to drain a large pleural effusion. The procedure is performed percutaneously under ultrasound guidance. The thoracentesis code includes ultrasound guidance. How should the ultrasound be coded?

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

B. With a separate ultrasound guidance code

C. With a separate ultrasound code and modifier 26

D. With a separate ultrasound code and modifier 59

18. A cardiologist performs a right heart catheterization with measurement of intracardiac pressures and cardiac output. No left heart catheterization is performed. How should this be coded?

A. With the combined left and right heart catheterization code

B. With only the cardiac output measurement code

C. With the right heart catheterization code

D. With a venous access code only

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

19. A patient undergoes a colonoscopy with removal of three polyps from the ascending colon — all three are removed using the same technique (snare polypectomy with electrocautery). How should the polypectomy be coded?

A. Three separate snare polypectomy codes

B. Three separate snare polypectomy codes with modifier 59 on the second and third

C. The diagnostic colonoscopy code plus one polypectomy code

D. One snare polypectomy code — multiple polyps removed using the same technique from the same segment are reported with one code

20. A surgeon performs a laparoscopic adjustable gastric band placement for morbid obesity. What does an adjustable gastric band accomplish?

A. It bypasses a segment of small intestine

B. It places an inflatable silicone band around the upper stomach to create a small pouch that limits food intake

C. It removes a large portion of the stomach

D. It creates a gastrojejunostomy

21. A patient undergoes an EGD with esophageal stent placement for palliation of an obstructing esophageal malignancy. How should the diagnostic EGD be coded?

A. It is not reported separately; it is included in the surgical EGD stent placement 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

22. A surgeon performs a right hemicolectomy with primary ileocolonic anastomosis for a cecal mass. What does a right hemicolectomy remove?

A. The left colon, sigmoid, and rectum

B. Only the appendix

C. The cecum, ascending colon, hepatic flexure, and a portion of the transverse colon with their associated mesentery and blood supply

D. Only the transverse colon

23. A patient undergoes flexible sigmoidoscopy with biopsy of a rectal mass. The scope is advanced to the descending colon. 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 biopsy code

24. A surgeon performs an ERCP with placement of a biliary stent and dilation of a biliary stricture using a balloon dilator during the same session. The diagnostic ERCP is bundled. How should the two surgical procedures be coded?

A. Only the stent placement code; the dilation is bundled

B. Both the stent placement code and the balloon dilation code — they are separate surgical ERCP procedures

C. Only the dilation code; the stent is bundled

D. One combined code for both procedures

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

25. A urologist performs a cystoscopy with fulguration of trigonitis. The diagnostic cystoscopy is bundled. What does fulguration accomplish in this context?

A. It uses electrocautery to destroy inflamed or abnormal tissue on the bladder trigone

B. It removes a bladder stone

C. It places a ureteral stent

D. It biopsies the bladder wall

26. A patient undergoes a percutaneous nephrostolithotomy (PCNL) for a large staghorn renal calculus. The surgeon creates a percutaneous tract through the flank into the kidney and uses a nephroscope to fragment and remove the stone. What distinguishes PCNL from ESWL?

A. PCNL uses shock waves from outside the body

B. PCNL is a noninvasive procedure

C. PCNL uses only medication to dissolve the stone

D. PCNL involves creating a surgical tract through the skin into the kidney for direct stone visualization, fragmentation, and extraction; ESWL uses external shock waves without a surgical tract

27. A physician provides all antepartum care (13 visits), performs a cesarean delivery after failed trial of labor, and provides all postpartum care. CPT provides a specific global code for cesarean delivery after attempted vaginal delivery. Which code should be used?

A. The global vaginal delivery code with modifier 22

B. The global routine cesarean delivery code

C. The global cesarean delivery after attempted vaginal delivery code

D. Separate codes for antepartum care, delivery-only, and postpartum care

28. A surgeon performs a laparoscopic myomectomy — excision of 3 intramural uterine fibroids. The uterus is preserved. How does a myomectomy differ from a hysterectomy?

A. A myomectomy removes the uterus; a hysterectomy removes only the fibroids

B. A myomectomy removes only the fibroids while preserving the uterus; a hysterectomy removes the uterus

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

D. A myomectomy is always performed through an open approach

29. A urologist performs a urodynamic complex cystometrography (CMG) with voiding pressure study on a patient with urinary incontinence. Where are urodynamic study codes located in CPT?

A. In the Surgery section — urinary system subsection

B. In the Radiology section

C. In the Medicine section

D. In the Pathology and Laboratory section

30. A surgeon performs a total thyroidectomy with central neck dissection (level VI lymph node dissection) for papillary thyroid carcinoma. The central neck dissection is a separate procedure from the thyroidectomy. How should the lymph node dissection be coded?

A. It is included in the total thyroidectomy code

B. With the thyroidectomy code and modifier 22

C. With an E/M code

D. With a separate central neck dissection code in addition to the thyroidectomy code

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

31. A neurosurgeon performs a craniectomy for evacuation of a posterior fossa epidural hematoma. The bone is removed and NOT replaced. How does a craniectomy differ from a craniotomy?

A. A craniectomy replaces the bone; a craniotomy does not

B. Both are identical procedures

C. A craniectomy removes the bone without replacing it; a craniotomy temporarily removes and then replaces the bone flap

D. A craniectomy is less invasive than a craniotomy

32. An ophthalmologist performs a vitrectomy with membrane peeling (epiretinal membrane removal) on the right eye for visual distortion caused by a macular pucker. What does membrane peeling accomplish?

A. It removes the crystalline lens

B. It removes a thin fibrous membrane from the surface of the retina (macula) to reduce distortion and improve vision

C. It creates a drainage pathway for glaucoma

D. It repairs a retinal detachment with a scleral buckle

33. A pain management physician performs a cervical epidural steroid injection at C7-T1 via an interlaminar approach under fluoroscopic guidance. The injection code includes imaging guidance. How should the fluoroscopy be coded?

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

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

34. A neurosurgeon performs an anterior cervical discectomy without fusion at C5-C6 for a herniated disc causing radiculopathy. No interbody cage or bone graft is placed. How does this differ from an ACDF?

A. There is no difference; both are identical

B. An ACDF always includes fusion (interbody graft/cage and possible plate); a discectomy alone removes only the disc without fusion

C. An ACDF removes only the disc; a discectomy includes fusion

D. An anterior discectomy is performed posteriorly; an ACDF is performed anteriorly

35. An otolaryngologist performs functional endoscopic sinus surgery (FESS) — bilateral total ethmoidectomy, bilateral maxillary antrostomy, and bilateral frontal sinusotomy during the same session. Each procedure has its own CPT code. How should the bilateral nature of each procedure be reported?

A. Each procedure is reported once with no modifier

B. Only the most complex procedure is reported bilaterally

C. Each procedure code is reported bilaterally with modifier 50 or RT/LT modifiers

D. Only one procedure is reported for all sinuses combined

36. An ophthalmologist performs an evisceration of the right eye for endophthalmitis unresponsive to intravitreal antibiotics. How does evisceration differ from enucleation?

A. Evisceration removes the entire globe; enucleation removes only the contents

B. Evisceration removes the intraocular contents while preserving the scleral shell; enucleation removes the entire globe

C. Both procedures are identical

D. Evisceration is only performed for trauma; enucleation is for infection

**Evaluation and Management (Questions 37–42)**

37. An established patient presents to the office with one acute, uncomplicated illness (urinary tract infection). The physician performs a focused evaluation, orders a urinalysis, and prescribes an antibiotic. No additional data review or complex management is involved. What level of MDM does this support?

A. Low

B. Straightforward

C. High

D. Moderate

38. A physician provides care to a patient in the emergency department. The patient is not admitted to the hospital. The physician provides a level 4 ED visit. Which E/M code set should be used?

A. Office visit codes (99211–99215)

B. Hospital discharge codes (99238–99239)

C. Observation care codes (99218–99220)

D. Emergency department visit codes (99281–99285)

39. A physician provides initial inpatient care and discharges the patient on the same calendar date. The patient was admitted in the morning, treated, and discharged by the afternoon. Which code set covers this same-day admission and discharge?

A. Initial hospital care plus discharge day management codes (both on the same date)

B. Only the initial hospital care code; the discharge is bundled

C. Observation or inpatient care services including admission and discharge on the same date (99234–99236)

D. Only the discharge day management code

40. A physician provides a level 3 established patient office visit (99213). During the same visit, the physician removes three skin tags using cryotherapy (17110/17111, 0-day global period). 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 51

41. Under the current E/M guidelines, a physician sees a new patient in the office. The total time on the date of service is 55 minutes. Using the time-based pathway, which code is supported?

A. 99204 (new patient, 45 minutes)

B. 99203 (new patient, 30 minutes)

C. 99205 (new patient, 60 minutes)

D. 99202 (new patient, 15 minutes)

42. Under the current E/M guidelines, which of the following correctly describes the concept of "shared visit" in hospital E/M services?

A. A shared visit occurs when both a physician and a qualified healthcare practitioner (APP) provide services to the same patient on the same date

B. A shared visit means two patients share the same E/M encounter

C. A shared visit applies only to critical care services

D. A shared visit allows both the physician and APP to bill separately for the same encounter — the substantive portion determines who bills under CMS guidelines

**Anesthesia (Questions 43–46)**

43. An anesthesiologist provides general anesthesia for a bilateral inguinal hernia repair on a 55-year-old patient with obesity and sleep apnea (P3). Total anesthesia time is 120 minutes. The payer uses 15-minute time units and assigns 1 modifying unit for P3. Base units are 6. What is the total unit calculation?

A. 14 units

B. 13 units

C. 15 units

D. 16 units

44. An anesthesiologist provides monitored anesthesia care (MAC) for a patient undergoing a colonoscopy. How is MAC distinguished from general anesthesia?

A. MAC and general anesthesia are identical

B. MAC involves the anesthesiologist monitoring the patient and providing sedation/analgesia while the patient maintains some level of consciousness; general anesthesia renders the patient completely unconscious

C. MAC requires endotracheal intubation; general anesthesia does not

D. MAC is only provided by CRNAs; general anesthesia is only provided by anesthesiologists

45. An anesthesiologist provides anesthesia for an emergency cesarean delivery on a 25-year-old healthy patient (P1 — no systemic disease) with fetal distress. No extreme age or other qualifying circumstances conditions exist. Which qualifying circumstances code applies?

A. 99140 (emergency conditions)

B. 99100 (extreme age)

C. 99116 (total body hypothermia)

D. 99135 (controlled hypotension)

46. In anesthesia coding, anesthesia start time and stop time must be documented. When does anesthesia time officially begin?

A. When the surgeon makes the first incision

B. When the patient arrives in the preoperative holding area

C. When the patient enters the operating room

D. When the anesthesiologist begins preparing the patient for anesthesia in the operating room or equivalent area

**Radiology (Questions 47–52)**

47. A patient undergoes a CT of the abdomen without contrast to evaluate kidney stones. No IV contrast is administered. How should this be coded?

A. CT abdomen with contrast

B. CT abdomen without contrast followed by with contrast

C. CT abdomen without contrast

D. CT angiography of the abdomen

48. A radiologist in a private practice performs and interprets an abdominal ultrasound in the practice's own office using practice-owned equipment. The radiologist employs the sonographer. Which modifier should be appended?

A. Modifier 26

B. No modifier; the global service is reported

C. Modifier TC

D. Modifier 59

49. A patient undergoes a nuclear medicine hepatobiliary scan (HIDA scan) to evaluate for acute cholecystitis. After injection of the radiotracer, sequential images are obtained over 60 minutes. What does a HIDA scan evaluate?

A. The blood supply to the liver

B. The size of liver tumors

C. The density of gallstones

D. The patency and function of the biliary system — uptake by the liver, excretion into the bile ducts, filling of the gallbladder, and drainage into the duodenum

50. In radiation oncology, what does the code for clinical treatment planning (77261–77263) cover?

A. The physician's design of the treatment approach — including evaluation of the patient's condition, tumor location, selection of treatment modalities, and determination of the overall treatment strategy

B. The actual delivery of radiation to the patient

C. The weekly management during the radiation course

D. The mathematical calculation of dose distribution

51. A patient undergoes a diagnostic mammogram of the right breast (unilateral) for evaluation of a palpable mass. Which mammography code should be used?

A. 77067 (screening mammography, bilateral)

B. 77066 (diagnostic mammography, bilateral)

C. 77065 (diagnostic mammography, unilateral)

D. 77067 with modifier RT

52. A patient undergoes a fluoroscopy-guided lumbar myelogram — injection of intrathecal contrast followed by fluoroscopic imaging of the spinal canal. How should the contrast injection be coded?

A. It is included in the fluoroscopy code

B. With a separate intrathecal injection code (62284) for the contrast injection, reported in addition to the fluoroscopy/CT code

C. With the fluoroscopy code and modifier 22

D. With an epidural injection code

**Pathology and Laboratory (Questions 53–58)**

53. A physician orders a lipid panel (80061) and a fasting glucose (82947) on the same specimen. Glucose IS a component of both the CMP and the BMP but is NOT a component of the lipid panel. How should these be reported?

A. Only the lipid panel; the glucose is bundled

B. The lipid panel with modifier 22

C. Individual codes for all tests

D. The lipid panel code plus the individual glucose code

54. A pathologist examines a gallbladder specimen removed during a cholecystectomy for cholelithiasis with chronic cholecystitis. At which level of surgical pathology is a gallbladder classified?

A. Level IV (88305)

B. Level III (88304)

C. Level V (88307)

D. Level II (88302)

55. A laboratory performs a prothrombin time (PT/INR) and a partial thromboplastin time (PTT) on the same specimen. These are two separate coagulation tests. How should they be coded?

A. One coagulation panel code

B. With only the PT code; the PTT is bundled

C. With separate codes for the PT (85610) and the PTT (85730) — they are distinct tests

D. With one code and modifier 91

56. A patient undergoes a liquid-based Pap smear (ThinPrep) with HPV co-testing. The Pap smear and the HPV test are performed on the same specimen using different methodologies. How should these be coded?

A. One combined Pap/HPV code

B. With separate codes for the cytopathology (Pap) and the HPV molecular testing — they are distinct tests

C. Only the Pap code; the HPV is bundled

D. Only the HPV code; the Pap is bundled

57. A pathologist performs immunohistochemistry on a melanoma specimen: S-100, HMB-45, and Melan-A — three antibody stains. How should the IHC be coded?

A. 88342 × 3

B. One IHC panel code

C. 88341 × 3

D. 88342 × 1 for the first antibody plus 88341 × 2 for each additional antibody

58. A laboratory performs a comprehensive stool analysis including occult blood testing (guaiac-based), fecal calprotectin, and stool culture. These are three separate tests from different laboratory sections. How should these be coded?

A. Each test is coded separately with its own CPT code — occult blood (82270), fecal calprotectin (83993), and stool culture (87045 or 87046)

B. One comprehensive stool panel code

C. Only the stool culture code; the other tests are bundled

D. Only the occult blood code

**Medicine (Questions 59–64)**

59. A patient receives a 1-hour IV infusion of a chemotherapy agent (doxorubicin) followed by an IV push of a different chemotherapy agent (cyclophosphamide) during the same outpatient encounter. No hydration is given. How should the cyclophosphamide IV push be coded?

A. With a second initial chemotherapy infusion code (96413)

B. With a therapeutic drug push code (96374)

C. With the chemotherapy IV push code (96409 for the first substance or 96411 for an additional substance push)

D. With a hydration code

60. An adult patient receives a single subcutaneous injection of the shingles vaccine (recombinant, 1 component) at a pharmacy. No physician counseling is provided. How should the administration be coded?

A. 90460 × 1 (pediatric code)

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

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

D. 90472 × 1 (additional vaccine code)

61. A patient undergoes a diagnostic cardiac catheterization. During the catheterization, an intravascular ultrasound (IVUS) of the coronary arteries is also performed. IVUS is a separate diagnostic procedure from the angiography. How should the IVUS be coded?

A. It is included in the catheterization code

B. With the catheterization code and modifier 22

C. With an echocardiography code

D. With a separate IVUS code in addition to the catheterization/angiography codes

62. A therapist provides 10 minutes of ultrasound (therapeutic, 97035 — constant attendance modality) and 25 minutes of therapeutic exercise (97110) during the same session. Using the 8-minute rule, how many total timed units are reported?

A. 2 timed units — 1 unit of 97035 (10 minutes meets the 8-minute minimum) and 1 unit of 97110 (first 15 minutes); with 10 remaining minutes of 97110 meeting the 8-minute minimum for a third unit — wait, let me recalculate. Total timed treatment: 35 minutes. 35 ÷ 15 = 2.33. Two full units plus 5 remaining minutes (does not meet 8-minute threshold). Total: 2 units.

A. 2 timed units total

B. 3 timed units

C. 1 timed unit

D. 4 timed units

63. A cardiologist performs a cardioversion (external, electrical) on a patient with atrial fibrillation that has not responded to medical therapy. The cardioversion is performed under conscious sedation. Which Medicine subsection contains the cardioversion code?

A. Neurology

B. Allergy and immunology

C. Cardiovascular therapeutic services

D. Pulmonary function testing

64. A patient undergoes a sleep study — polysomnography (PSG) with sleep staging, respiratory monitoring, ECG, pulse oximetry, and additional physiologic parameters. The PSG is performed at an accredited sleep center with a technologist in attendance. The study does NOT include CPAP titration. Which code should be reported?

A. 95800 (home sleep test)

B. 95811 (PSG with CPAP titration)

C. 93000 (ECG code)

D. 95810 (diagnostic PSG without CPAP)

**Medical Terminology (Questions 65–68)**

65. The suffix "-rrhage" or "-rrhagia" means which of the following?

A. Surgical repair

B. Excessive bleeding or hemorrhage

C. Inflammation

D. Pain

66. Which combining form refers to the liver?

A. Hepat/o

B. Ren/o

C. Cardi/o

D. Pulmon/o

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

A. Forward

B. Above

C. Behind or backward

D. Below

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

A. Rapid breathing

B. Painful breathing

C. Slow breathing

D. Absence or cessation of breathing

**Anatomy (Questions 69–72)**

69. The common peroneal (fibular) nerve wraps around the neck of which bone?

A. The femur

B. The fibula

C. The tibia

D. The humerus

70. Which structure connects the kidney to the urinary bladder?

A. The ureter

B. The urethra

C. The renal pelvis

D. The vas deferens

71. The tricuspid valve is located between which two cardiac chambers?

A. The left atrium and left ventricle

B. The left ventricle and the aorta

C. The right ventricle and the pulmonary artery

D. The right atrium and the right ventricle

72. The parathyroid glands are typically located on the posterior surface of which structure?

A. The pituitary gland

B. The adrenal gland

C. The thyroid gland

D. The pancreas

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

73. A patient presents with Type 1 diabetes mellitus with diabetic chronic kidney disease stage 3. Under ICD-10-CM, how should this be coded?

A. With separate codes for diabetes and CKD with no linkage

B. With a combination code from E10 specifying Type 1 diabetes with diabetic CKD, plus an additional code from N18 specifying the CKD stage

C. Only the CKD code

D. Only the diabetes code without specifying the complication

74. A patient undergoes outpatient evaluation for chest pain. The physician documents "possible angina, rule out MI." In the outpatient setting, how should this be coded?

A. With the symptom code for chest pain — suspected conditions are not coded in the outpatient setting

B. With the angina code

C. With the MI code

D. With both the angina and MI codes

75. In ICD-10-CM, a patient has documented sickle cell disease with crisis (vaso-occlusive crisis). How should this be coded?

A. Only the crisis code without specifying the underlying disease

B. With separate codes for sickle cell disease and the crisis

C. Only the sickle cell disease code without specifying crisis

D. With a combination code from D57 that specifies sickle cell disease with crisis

76. A patient is treated for a displaced pathological fracture of the right femoral neck due to metastatic breast cancer. Which codes are needed?

A. Only the fracture code

B. Only the metastatic cancer code

C. The pathological fracture code with the 7th character for initial encounter, plus the code for the secondary malignant neoplasm of bone, plus the code for the primary breast cancer (if still active)

D. Only the breast cancer code

77. A coder is assigning diagnosis codes for a patient with documented chronic pain syndrome. Which ICD-10-CM code category covers chronic pain?

A. G89 (Pain, not elsewhere classified) — but only the acute pain codes

B. G89.29 (Other chronic pain) or the appropriate chronic pain code from the G89 category

C. R10 (Abdominal pain)

D. Z87 (Personal history)

**HCPCS Level II (Questions 78–80)**

78. A patient receives an infusion of zoledronic acid (Reclast) 5 mg IV for treatment of osteoporosis. The HCPCS J-code for zoledronic acid specifies 1 mg per unit. How many units of the J-code should be reported?

A. 5 units

B. 1 unit

C. 50 units

D. 10 units

79. A Medicare patient receives a customized diabetic shoe with inserts as part of the Medicare Therapeutic Shoe Program. Which HCPCS Level II code range covers therapeutic shoes and inserts?

A. E0100–E9999

B. J0000–J9999

C. L0000–L4999

D. A5500–A5514 (within the A-code range for diabetic shoes)

80. A provider performs a screening test on a Medicare patient and appends modifier PT. What does modifier PT indicate?

A. The service was performed by a physical therapist

B. The service is a statutory exclusion

C. The screening test was performed as a colorectal cancer screening — modifier PT is specific to screening services

D. The service requires prior authorization

**Coding Guidelines (Questions 81–87)**

81. A surgeon performs a diagnostic thoracoscopy. During the procedure, the surgeon identifies a suspicious pleural lesion and performs a thoracoscopic biopsy. How should the diagnostic thoracoscopy be coded?

A. As a separate code with modifier 59

B. It is not reported separately; it is bundled into the surgical thoracoscopy code

C. As a separate code with modifier 51

D. As a separate code with modifier 25

82. A patient undergoes a planned second-stage breast reconstruction (tissue expander exchange for permanent implant) during the 90-day global period of the first-stage tissue expander insertion. Which modifier should be appended to the second-stage procedure?

A. Modifier 58 (staged or related procedure during the postoperative period)

B. Modifier 78

C. Modifier 79

D. Modifier 76

83. Under the NCCI, which X modifier indicates that the two procedures were performed during separate encounters on the same date?

A. Modifier XS (Separate Structure)

B. Modifier XP (Separate Practitioner)

C. Modifier XU (Unusual Non-Overlapping Service)

D. Modifier XE (Separate Encounter)

84. A CPT code has a global period of "000." What does this indicate?

A. The code has a 90-day global period

B. The global period does not apply

C. The code has a 0-day global period — routine postoperative care on the same day is included, but visits on subsequent days are not bundled

D. The code has a 10-day global period

85. Which of the following correctly describes the purpose of modifier 26 (professional component)?

A. It indicates the service was reduced in scope

B. It indicates only the professional component (interpretation and report) was provided, without the technical component

C. It indicates a bilateral procedure

D. It indicates a distinct procedural service

86. In CPT, when a surgeon performs a planned staged procedure, the first stage is coded as the primary procedure. How should the second stage performed during the global period be coded?

A. With the appropriate procedure code and modifier 58

B. With the first-stage code and modifier 76

C. With the first-stage code and modifier 22

D. With an E/M code only

87. A laboratory performs the same test twice on the same patient on the same date — the first specimen was drawn at 8:00 AM, and the second specimen was drawn at 2:00 PM to monitor a clinical value. Which modifier should be appended to the repeat test?

A. Modifier 76

B. Modifier 59

C. Modifier 77

D. Modifier 91

**Compliance and Regulatory (Questions 88–90)**

88. Under HIPAA, the Privacy Rule governs the use and disclosure of which type of information?

A. Financial records only

B. Employment records only

C. Protected health information (PHI)

D. Marketing data only

89. A medical practice discovers an overpayment from Medicare during an internal audit. Under the 60-Day Rule, what is the practice required to do?

A. Ignore the overpayment if it is less than $100

B. Report and return the overpayment to Medicare within 60 days of identification

C. Wait for Medicare to identify the overpayment through their own audit

D. Apply the overpayment as a credit to future claims

90. Under Medicare, which entity is responsible for developing and publishing the Physician Fee Schedule, including the annual conversion factor and RVU values?

A. The Centers for Medicare & Medicaid Services (CMS)

B. The American Medical Association (AMA)

C. The Office of Inspector General (OIG)

D. The Medicare Administrative Contractors (MACs)

**Cases — Integrated Coding Scenarios (Questions 91–100)**

**Case 1 (Questions 91–92):**

**A 62-year-old patient undergoes excision of a 2.2 cm malignant basal cell carcinoma from the dorsal nose with 0.4 cm margins. The wound is repaired with a full-thickness skin graft from the preauricular area.**

91. What is the excised diameter for code selection?

A. 2.2 cm

B. 2.6 cm

C. 3.4 cm

D. 3.0 cm

92. Should the excision be coded separately from the free skin graft?

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

B. No; only the graft code is reported

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

D. Yes, but only with modifier 22

**Case 2 (Questions 93–94):**

**A 70-year-old Medicare patient presents for a screening colonoscopy. The gastroenterologist identifies and removes a 2.0 cm flat polyp from the ascending colon using endoscopic mucosal resection (EMR). No other abnormalities are found.**

93. Should the diagnostic colonoscopy be reported in addition to the EMR code?

A. Yes, with modifier 59

B. No; the diagnostic colonoscopy is bundled into the surgical colonoscopy EMR code

C. Yes, with modifier 25

D. Yes, with modifier 33

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

D. R19.5 (Other fecal abnormalities)

**Case 3 (Questions 95–96):**

**A patient receives IV services during a single outpatient encounter: a 2-hour IV infusion of cetuximab (antineoplastic agent for colorectal cancer — chemotherapy), an IV push of diphenhydramine (non-chemotherapy pre-medication), and 30 minutes of IV hydration with normal saline.**

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

A. The IV hydration

B. The diphenhydramine IV push

C. Each is a separate initial service

D. The cetuximab chemotherapy infusion

96. How should the 30 minutes of IV hydration be coded?

A. As the initial hydration code (96360)

B. It cannot be reported when chemotherapy is given

C. As a secondary/sequential hydration service using the appropriate add-on code

D. With the hydration code and modifier 59

**Case 4 (Questions 97–98):**

**A surgeon performs a right total hip arthroplasty for severe osteoarthritis. The surgeon provides all preoperative, surgical, and postoperative care. During the 90-day global period, the patient falls and sustains a completely unrelated left distal radius fracture. The same surgeon treats the wrist fracture.**

97. How should the wrist fracture treatment be coded?

A. It is included in the hip arthroplasty global package

B. With the fracture treatment code and modifier 79 (unrelated procedure during the postoperative period)

C. With the fracture treatment code and modifier 78

D. With the fracture treatment code and modifier 58

98. The hip arthroplasty global package is intact. How should the primary arthroplasty be coded?

A. With the complete global package — no splitting modifiers

B. With modifier 54

C. With modifier 55

D. With modifier 22

**Case 5 (Questions 99–100):**

**A 55-year-old patient undergoes a diagnostic colonoscopy for evaluation of iron deficiency anemia. The gastroenterologist advances the scope to the cecum and identifies a large cecal mass. Biopsies are taken. The pathology reveals adenocarcinoma.**

99. Should the diagnostic colonoscopy be reported in addition to the biopsy code?

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 biopsy code

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

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

B. D50.9 (Iron deficiency anemia, unspecified)

C. The iron deficiency anemia code as the first-listed diagnosis — the anemia was the reason the colonoscopy was ordered; the cecal mass/adenocarcinoma is reported as a secondary diagnosis

D. K63.5 (Polyp of colon)

# SIMULATION EXAM 17 — ANSWER KEY WITH EXPLANATIONS

**10,000 Series — Integumentary System**

1. **A. 3.0 cm** The excised diameter is calculated as lesion diameter plus margins on both sides: 1.8 cm + (0.6 cm × 2) = 3.0 cm. The margin is doubled because normal tissue is removed circumferentially around the entire lesion. This 3.0 cm excised diameter determines the correct code within the malignant excision range for the cheek/face anatomical grouping.

2. **C. One simple repair code for 4.0 cm and one intermediate repair code for 8.0 cm** Wounds of different classifications cannot be combined. The simple repair on the right forearm (4.0 cm) is a different classification from the intermediate repairs. The two intermediate repairs on the left forearm and right hand (5.0 + 3.0 = 8.0 cm) are in the same grouping and same classification, so they are combined. Two codes are reported — one simple and one intermediate.

3. **B. 17000 × 1, 17003 × 13** For 14 actinic keratoses, the individual counting method applies: 17000 × 1 (first lesion) plus 17003 × 13 (lesions 2 through 14). The flat code 17004 is only used when 15 or more premalignant lesions are destroyed. At exactly 14 lesions, the threshold for 17004 is not met. The benign skin tags are coded separately with 17110/17111.

4. **D. With an adjacent tissue transfer code — Z-plasty is a tissue rearrangement technique classified under adjacent tissue transfer** Z-plasty is a tissue rearrangement technique classified under the adjacent tissue transfer codes (14000–14350). The procedure involves transposing two triangular flaps to change the direction of a scar, release a contracture, or close a defect. Adjacent tissue transfer codes are based on the defect size in square centimeters and the anatomical location. The excision of the scar is included in the adjacent tissue transfer code.

5. **A. Both the shave removal code and the punch biopsy code — they are distinct procedures on different lesions at different sites** The shave removal and the punch biopsy are different procedures performed on different lesions at different anatomical sites. Both are separately reportable. The shave removal captures the tangential removal of the skin tag, and the biopsy captures the diagnostic tissue sampling. Modifier 59 or XS may be appended to the second procedure.

6. **C. Muscle — the deepest tissue level debrided determines the code** Wound debridement codes are based on the deepest tissue level debrided. When the debridement extends through skin and subcutaneous tissue to exposed muscle, the muscle-depth debridement code is selected. CPT

provides separate codes for debridement to skin, subcutaneous tissue, muscle, and bone. The deepest level reached determines the 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 loose body removal is a surgical arthroscopic procedure — the diagnostic examination is included and is not separately reportable.

8. **D. Closed treatment without manipulation** A non-displaced fracture treated with a walking boot without manipulation constitutes closed treatment without manipulation. No attempt is made to realign the fracture fragments because the fracture is not displaced. The walking boot provides external support during healing. This is the least invasive type of fracture treatment.

9. **A. With an add-on code for the additional interspace fusion** Spinal fusion codes use a primary code for the first interspace and an add-on code for each additional interspace. Two levels (L4-L5 and L5-S1) require one primary fusion code plus one add-on code. The instrumentation and interbody devices are coded separately as additional components.

10. **C. Musculoskeletal system (20,000 series)** Ganglion cyst excision codes are located in the musculoskeletal system section of CPT. Ganglion cysts arise from joint capsules or tendon sheaths — they are musculoskeletal structures. The codes are specific to the anatomical location (wrist, foot, etc.) and differentiate between simple and recurrent cyst excision.

11. **B. Open surgical approach** An open Bankart repair involves a surgical incision to directly access and repair the torn labrum. No arthroscope is used. Open shoulder stabilization has its own CPT codes distinct from arthroscopic shoulder stabilization codes. The approach determines the code selection.

12. **D. A hardware removal code (20680 for deep implant removal)** Removal of a deep implant (intramedullary nail) has its own CPT code (20680). When hardware is removed after fracture healing as a separate procedure, the hardware removal code is reported. This is not a repeat of the original fracture treatment and does not use the original ORIF code.

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

13. **A. 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 therapeutic aspiration and bronchial washing are separate surgical procedures, each with their own code. The diagnostic examination is included in the surgical codes.

14. **C. With the pulse generator replacement code only — the leads were not manipulated** When only the battery-depleted pulse generator is replaced while the existing leads are tested and left in place, only the generator replacement code is reported. No lead codes are needed because the leads

were not inserted, repositioned, or removed. Component-based coding means each component is coded only when directly involved in the procedure.

15. **B. The aorta and great vessel subsection** Open repair of an abdominal aortic aneurysm is coded in the aorta and great vessel subsection of the cardiovascular surgery section. This subsection covers procedures on the thoracic and abdominal aorta, including both open repair and endovascular repair (EVAR) of aneurysms.

16. **D. With the sentinel lymph node biopsy code and modifier 50 or RT/LT modifiers** Sentinel lymph node biopsy codes are unilateral. When performed bilaterally, the procedure is reported with modifier 50 or on separate lines with RT and LT modifiers. Bilateral axillary sentinel node biopsy for breast cancer staging requires laterality modifiers.

17. **A. It is not reported separately; it is included in the thoracentesis code** When the thoracentesis code includes ultrasound guidance in its description, the guidance is bundled. The coder must verify the current code description. For thoracentesis codes that include imaging guidance, a separate ultrasound code should not be reported.

18. **C. With the right heart catheterization code** When only a right heart catheterization is performed (without left heart catheterization), the standalone right heart catheterization code is reported. This code covers the catheter placement and hemodynamic measurements (pressures, cardiac output). The combined left/right code would only be used when both are performed.

**40,000 Series — Digestive System**

19. **D. One snare polypectomy code — multiple polyps removed using the same technique from the same segment are reported with one code** When multiple polyps are removed from the same anatomical segment of the colon using the same technique during the same colonoscopy, one polypectomy code is reported. CPT colonoscopy polypectomy codes are reported per technique per anatomical segment — not per polyp. Three polyps removed by snare from the ascending colon = one snare polypectomy code.

20. **B. It places an inflatable silicone band around the upper stomach to create a small pouch that limits food intake** An adjustable gastric band (Lap-Band) is an inflatable silicone ring placed around the upper portion of the stomach, creating a small pouch above the band. The band restricts food intake by slowing the passage of food from the pouch to the rest of the stomach. The band can be adjusted by adding or removing saline through a subcutaneous port.

21. **A. It is not reported separately; it is included in the surgical EGD stent placement code** When a surgical procedure (esophageal stent placement) is performed during an EGD, the diagnostic examination is bundled into the surgical code. Only the surgical EGD stent placement code is reported. The endoscopic hierarchy applies consistently.

22. **C. The cecum, ascending colon, hepatic flexure, and a portion of the transverse colon with their associated mesentery and blood supply** A right hemicolectomy removes the cecum,

ascending colon, hepatic flexure, and a portion of the transverse colon along with their associated mesentery, lymph nodes, and blood supply (ileocolic and right colic arteries). A primary ileocolonic anastomosis reconnects the terminal ileum to the remaining transverse colon.

23. **D. It is not reported separately; it is included in the surgical sigmoidoscopy biopsy code** When a surgical procedure (biopsy) is performed during a sigmoidoscopy, the diagnostic examination is bundled into the surgical code. Only the surgical sigmoidoscopy biopsy code is reported. The endoscopic hierarchy applies consistently.

24. **B. Both the stent placement code and the balloon dilation code — they are separate surgical ERCP procedures** The biliary stent placement and the biliary balloon dilation are two distinct surgical ERCP procedures, each with their own CPT code. Both are reported when performed during the same session. The diagnostic ERCP is bundled into the surgical codes. Appropriate modifiers may be needed per NCCI guidelines.

**50,000 Series — Urinary, Reproductive, and Endocrine**

25. **A. It uses electrocautery to destroy inflamed or abnormal tissue on the bladder trigone** Fulguration uses electrocautery energy to destroy (burn) inflamed or abnormal tissue on the bladder trigone. The trigone is the triangular area on the floor of the bladder between the two ureteral orifices and the internal urethral orifice. Trigonitis causes irritative voiding symptoms, and fulguration may provide symptomatic relief.

26. **D. PCNL involves creating a surgical tract through the skin into the kidney for direct stone visualization, fragmentation, and extraction; ESWL uses external shock waves without a surgical tract** PCNL is a minimally invasive surgical procedure that creates a percutaneous tract from the skin through the flank into the renal collecting system. A nephroscope is inserted through this tract to directly visualize and fragment the stone using laser, ultrasonic, or pneumatic lithotripsy, and the fragments are extracted. ESWL uses externally generated shock waves without any surgical access.

27. **C. The global cesarean delivery after attempted vaginal delivery code** CPT provides a specific global code for cesarean delivery performed after a failed trial of labor (attempted vaginal delivery). This code reflects the additional work and complexity of managing a labor that did not progress to vaginal delivery and required conversion to cesarean. The physician provided all three components, so the global code is appropriate.

28. **B. A myomectomy removes only the fibroids while preserving the uterus; a hysterectomy removes the uterus** A myomectomy is a uterus-preserving procedure that removes only the fibroids (leiomyomas) while leaving the uterus intact. This is the preferred approach for patients who desire future pregnancy. A hysterectomy removes the entire uterus. CPT provides specific codes for myomectomy by approach (open, laparoscopic) and by the number of fibroids removed.

29. **A. In the Surgery section — urinary system subsection** Urodynamic study codes (51725–51798) are located in the Surgery section under the urinary system subsection. Complex cystometrography and voiding pressure studies evaluate bladder function, detrusor pressure, and voiding dynamics. These are diagnostic procedures coded in the urinary system section.

30. **D. With a separate central neck dissection code in addition to the thyroidectomy code** Central neck dissection (level VI lymph node dissection) is a separate surgical procedure from the total thyroidectomy. It addresses a different objective (lymph node staging/treatment) and has its own CPT code. Both the thyroidectomy and the neck dissection codes are reported.

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

31. **C. A craniectomy removes the bone without replacing it; a craniotomy temporarily removes and then replaces the bone flap** A craniectomy removes a portion of the skull bone without replacing it — the bone is intentionally left out, often to allow for brain swelling. A craniotomy creates a bone flap that is temporarily removed for surgical access and then replaced at the conclusion of the procedure. The distinction between these two procedures affects CPT code selection.

32. **B. It removes a thin fibrous membrane from the surface of the retina (macula) to reduce distortion and improve vision** Membrane peeling (epiretinal membrane removal) involves using microsurgical instruments to carefully peel a thin fibrous membrane from the surface of the macula. This membrane causes wrinkling of the retinal surface (macular pucker), leading to visual distortion and decreased acuity. Removing the membrane allows the macula to flatten and vision to improve.

33. **A. It is not reported separately; it is included in the injection code** When the cervical epidural injection code includes fluoroscopic guidance in its description, the guidance is bundled. A separate fluoroscopy code should not be reported. The coder must verify the current code description to confirm whether imaging guidance is included.

34. **D. An ACDF always includes fusion (interbody graft/cage and possible plate); a discectomy alone removes only the disc without fusion** An anterior cervical discectomy without fusion (ACDF without the "F") removes the herniated disc material but does not include placement of an interbody graft, cage, or plate. ACDF includes both the discectomy and the fusion with structural support. The decision to fuse depends on clinical factors including stability and the number of levels involved.

35. **C. Each procedure code is reported bilaterally with modifier 50 or RT/LT modifiers** Endoscopic sinus surgery codes for ethmoidectomy, antrostomy, and frontal sinusotomy are unilateral. When performed bilaterally, each procedure code is reported with modifier 50 or RT/LT modifiers. All three bilateral procedures are reported separately — they involve different sinuses.

36. **B. Evisceration removes the intraocular contents while preserving the scleral shell; enucleation removes the entire globe** Evisceration involves removing the intraocular contents (cornea, uvea, lens, vitreous, retina) while preserving the scleral shell and extraocular muscle attachments. Enucleation removes the entire globe. Evisceration is sometimes preferred for endophthalmitis because it preserves the orbital anatomy for a better cosmetic result with a prosthesis.

**Evaluation and Management**

37. **A. Low** Two stable chronic conditions plus one acute uncomplicated illness (UTI) constitutes low-level problem complexity. Ordering a urinalysis constitutes limited data. Prescribing an antibiotic is low-risk management. The MDM elements support low complexity, coding at 99213 for an established patient.

38. **D. Emergency department visit codes (99281–99285)** When a physician provides care in the emergency department, the ED visit codes are used regardless of the complexity of the encounter. ED codes do not distinguish between new and established patients. A level 4 ED visit is coded with 99284.

39. **C. Observation or inpatient care services including admission and discharge on the same date (99234–99236)** When a patient is admitted and discharged on the same calendar date, the same-day admission and discharge codes (99234–99236) are used. These codes capture the complete service — admission evaluation, treatment, and discharge — in a single code. Separate admission and discharge codes are not both reported.

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 procedure with a 0-day or 10-day global period. Cryotherapy destruction of skin tags (17110/17111) has a 0-day global period.

41. **A. 99204 (new patient, 45 minutes)** Under the time-based pathway, 99204 requires 45 minutes for a new patient. The physician spent 55 minutes, which meets and exceeds the 45-minute threshold for 99204 but does not reach the 60-minute threshold for 99205. The code reflects the highest level for which the time threshold is met.

42. **D. A shared visit allows both the physician and APP to bill separately for the same encounter — the substantive portion determines who bills under CMS guidelines** Under CMS guidelines, a shared visit occurs when both a physician and an APP provide face-to-face services to the same patient on the same date. The practitioner who provides the substantive portion of the encounter bills for the service. Both practitioners cannot bill separately for the same encounter.

**Anesthesia**

43. **C. 15 units** Base units (6) + Time units (120 minutes ÷ 15 minutes/unit = 8.0) + Modifying units (P3 = 1) = 15.0 total units. The calculation: 6 + 8 + 1 = 15. P3 (obesity and sleep apnea representing severe systemic disease) adds 1 modifying unit.

44. **B. MAC involves the anesthesiologist monitoring the patient and providing sedation/analgesia while the patient maintains some level of consciousness; general anesthesia renders the patient completely unconscious** Monitored anesthesia care involves the anesthesiologist's presence, monitoring, and administration of sedation and analgesia while the patient maintains varying levels of consciousness. The anesthesiologist is prepared to convert to general anesthesia if needed. General anesthesia renders the patient completely unconscious with loss of protective reflexes, typically requiring airway management.

45. **A. 99140 (emergency conditions)** The emergency cesarean section for fetal distress qualifies for qualifying circumstances code 99140 (emergency conditions). The patient is 25 years old — not meeting the extreme age threshold (under 1 or over 70). No hypothermia or controlled hypotension conditions exist. Only 99140 applies.

46. **D. When the anesthesiologist begins preparing the patient for anesthesia in the operating room or equivalent area** Anesthesia time officially begins when the anesthesiologist begins preparing the patient for the induction of anesthesia in the operating room or equivalent area. This includes pre-induction monitoring setup, IV access, and induction of anesthesia. Time does not begin in the preoperative holding area or when the patient enters the OR — it begins when the anesthesiologist starts the anesthesia preparation.

**Radiology**

47. **C. CT abdomen without contrast** No IV contrast was administered. The study is coded as CT abdomen without contrast. Oral contrast does not qualify as "with contrast" in CPT terminology. Only IV or injected contrast changes the contrast designation.

48. **B. No modifier; the global service is reported** When the radiologist performs and interprets the study in their own office using practice-owned equipment with their own employees, both the technical and professional components are provided by the same entity. The global code is reported without any modifier.

49. **D. The patency and function of the biliary system — uptake by the liver, excretion into the bile ducts, filling of the gallbladder, and drainage into the duodenum** A HIDA scan (hepatobiliary iminodiacetic acid scan) evaluates the entire biliary system. The radiotracer is taken up by the liver, excreted into the bile ducts, concentrated in the gallbladder, and drained into the duodenum. Non-visualization of the gallbladder after the tracer appears in the bile ducts suggests cystic duct obstruction — consistent with acute cholecystitis.

50. **A. The physician's design of the treatment approach — including evaluation of the patient's condition, tumor location, selection of treatment modalities, and determination of the overall treatment strategy** Clinical treatment planning codes cover the radiation oncologist's design of the treatment strategy. This includes evaluating the patient's condition, determining the tumor location and extent, selecting the appropriate treatment modalities, and planning the overall course.

The complexity level (simple, intermediate, complex) reflects the number of treatment areas and the sophistication of the plan.

51. **C. 77065 (diagnostic mammography, unilateral)** A diagnostic mammogram performed for evaluation of a specific clinical finding (palpable mass) on one breast is coded as unilateral diagnostic mammography (77065). Bilateral diagnostic mammography (77066) would be used if both breasts were imaged diagnostically. Screening mammography (77067) is for asymptomatic patients without clinical findings.

52. **B. With a separate intrathecal injection code (62284) for the contrast injection, reported in addition to the fluoroscopy/CT code** A lumbar myelogram involves two distinct components: the intrathecal injection of contrast (62284) and the subsequent imaging (fluoroscopy or CT). The injection is coded separately from the imaging because it represents a distinct procedural service — the needle placement and contrast administration into the subarachnoid space.

**Pathology and Laboratory**

53. **D. The lipid panel code plus the individual glucose code** Glucose is NOT a component of the lipid panel (which includes total cholesterol, HDL, triglycerides, and calculated LDL). When all panel components are performed plus an additional test not in the panel, both codes are reported. The panel captures the bundled lipid components, and the glucose code captures the additional analyte.

54. **A. Level IV (88305)** A gallbladder specimen is classified at Level IV surgical pathology (88305). Level IV covers most routine surgical specimens including gallbladder, appendix (non-incidental), and most diagnostic biopsies. The pathologist evaluates the specimen for inflammation, stones, and any suspicious lesions.

55. **C. With separate codes for the PT (85610) and the PTT (85730) — they are distinct tests** PT/INR and PTT are two separate coagulation tests that measure different parts of the coagulation cascade. PT evaluates the extrinsic pathway. PTT evaluates the intrinsic pathway. Each has its own CPT code and is reported separately when both are performed.

56. **B. With separate codes for the cytopathology (Pap) and the HPV molecular testing — they are distinct tests** The liquid-based Pap smear and the HPV molecular test are different tests using different methodologies — cytopathology screening versus nucleic acid detection. Both may be performed on the same liquid-based specimen. Each has its own CPT code and is reported separately.

57. **D. 88342 × 1 for the first antibody plus 88341 × 2 for each additional antibody** IHC is coded per antibody per specimen. Code 88342 covers the first antibody, and code 88341 (add-on) covers each additional antibody. Three antibodies (S-100, HMB-45, Melan-A) require 88342 × 1 plus 88341 × 2.

58. **A. Each test is coded separately with its own CPT code — occult blood (82270), fecal calprotectin (83993), and stool culture (87045 or 87046)** These three tests are from different laboratory sections (chemistry, immunology, microbiology) with different CPT codes. Each test evaluates a different clinical parameter — occult blood detects hidden bleeding, calprotectin measures intestinal inflammation, and stool culture identifies bacterial pathogens. All three are reported separately.

**Medicine**

59. **C. With the chemotherapy IV push code (96409 for the first substance or 96411 for an additional substance push)** When a chemotherapy agent is administered by IV push as an additional substance after an IV infusion of a different chemotherapy agent, the chemotherapy IV push add-on code (96411) is used. The chemotherapy push codes (96409–96411) are distinct from the therapeutic drug push codes (96374–96376). The drug classification determines the code range.

60. **B. 90471 × 1 (adult injection-based code, first vaccine)** For an adult patient (age 22 and older) without physician counseling, the adult injection-based codes are used. A single vaccine injection = 90471 × 1. Pediatric component-based codes (90460) are only used for patients through age 18 with physician counseling. The vaccine product code is reported separately.

61. **D. With a separate IVUS code in addition to the catheterization/angiography codes** Intravascular ultrasound (IVUS) of the coronary arteries is a separate diagnostic procedure from coronary angiography. IVUS provides cross-sectional images of the vessel wall and plaque morphology. It has its own CPT code and is reported in addition to the catheterization/angiography codes.

62. **A. 2 timed units total** Total timed treatment is 35 minutes (10 minutes ultrasound + 25 minutes therapeutic exercise). At 15 minutes per unit, 35 minutes supports 2 full units (30 minutes) with 5 remaining minutes that do not meet the 8-minute minimum for a third unit. The 2 units are allocated based on actual time — 1 unit to 97110 (highest time) and 1 unit to 97035.

63. **C. Cardiovascular therapeutic services** External electrical cardioversion codes are located in the Medicine section under cardiovascular therapeutic services. Cardioversion uses electrical energy to convert an abnormal heart rhythm to a normal sinus rhythm. The moderate sedation provided during the cardioversion may be separately coded.

64. **D. 95810 (diagnostic PSG without CPAP)** A diagnostic polysomnography without CPAP titration is coded with 95810. This code covers attended PSG with sleep staging and the required additional parameters (respiratory monitoring, ECG, oximetry, etc.). Code 95811 would be used if CPAP titration were performed during the study.

**Medical Terminology**

65. **B. Excessive bleeding or hemorrhage** The suffix "-rrhage" or "-rrhagia" means excessive bleeding or hemorrhage. Common examples include hemorrhage (excessive bleeding),

menorrhagia (excessive menstrual bleeding), and metrorrhagia (irregular uterine bleeding). "-Plasty" means surgical repair, "-itis" means inflammation, and "-algia" means pain.

66. **A. Hepat/o** The combining form "hepat/o" refers to the liver. Common terms include hepatitis (inflammation of the liver), hepatomegaly (enlarged liver), hepatectomy (surgical removal of the liver), and hepatocyte (liver cell). "Ren/o" or "nephr/o" refers to the kidney, "cardi/o" refers to the heart, and "pulmon/o" refers to the lung.

67. **C. Behind or backward** The prefix "retro-" means behind or backward. Common terms include retroperitoneal (behind the peritoneum), retrograde (moving backward), retroflex (bent backward), and retrospective (looking backward). "Ante-" means forward or before, "supra-" means above, and "infra-" means below.

68. **D. Absence or cessation of breathing** Apnea means absence or cessation of breathing, from the prefix "a-" (without/absence) and the root "pnea" (breathing). Obstructive sleep apnea involves repeated episodes of airway collapse during sleep. Tachypnea means rapid breathing. Dyspnea means difficult breathing. Bradypnea means slow breathing.

**Anatomy**

69. **B. The fibula** The common peroneal (fibular) nerve wraps around the neck of the fibula — the bony prominence just below the lateral knee. This superficial location makes the nerve vulnerable to injury from direct trauma, leg crossing, or tight casts. Injury causes foot drop (inability to dorsiflex the foot).

70. **A. The ureter** The ureter is a muscular tube approximately 25–30 cm long that transports urine from the renal pelvis of the kidney to the urinary bladder via peristaltic contractions. There are two ureters — one from each kidney. The urethra transports urine from the bladder to outside the body.

71. **D. The right atrium and the right ventricle** The tricuspid valve is the atrioventricular valve located between the right atrium and the right ventricle. It has three leaflets (cusps) that open to allow blood to flow from the right atrium to the right ventricle and close to prevent backflow during ventricular contraction. The mitral (bicuspid) valve is between the left atrium and left ventricle.

72. **C. The thyroid gland** The parathyroid glands (typically four) are small endocrine glands located on the posterior surface of the thyroid gland. They produce parathyroid hormone (PTH), which regulates calcium and phosphorus metabolism. During thyroidectomy, the surgeon must carefully identify and preserve the parathyroid glands to prevent hypoparathyroidism.

**ICD-10-CM / Diagnosis Coding**

73. **B. With a combination code from E10 specifying Type 1 diabetes with diabetic CKD, plus an additional code from N18 specifying the CKD stage** ICD-10-CM uses combination codes within the E10 category for Type 1 diabetes with specific complications. A code from E10.22 specifies

diabetes with diabetic CKD. An additional code from N18.3 specifies CKD stage 3. Both codes are needed for complete coding — the combination code links the diabetes to the CKD, and the N18 code specifies the stage.

74. **A. With the symptom code for chest pain — suspected conditions are not coded in the outpatient setting** In the outpatient setting, conditions documented as "possible," "probable," "suspected," or "rule out" are not coded as confirmed diagnoses. Only the presenting signs and symptoms are coded. The chest pain is the confirmed symptom. The suspected angina and MI have not been established.

75. **D. With a combination code from D57 that specifies sickle cell disease with crisis** ICD-10-CM provides combination codes within category D57 that specify sickle cell disease type and crisis status in a single code. A combination code captures both the underlying sickle cell disease and the vaso-occlusive crisis. Separate codes for the disease and crisis are not needed when a combination code exists.

76. **C. The pathological fracture code with the 7th character for initial encounter, plus the code for the secondary malignant neoplasm of bone, plus the code for the primary breast cancer (if still active)** Pathological fractures due to metastatic disease require multiple codes: the pathological fracture code from M84.5 with the appropriate 7th character, the code for secondary malignant neoplasm of bone (C79.51), and the code for the primary malignancy (breast cancer) if still active. This captures the complete clinical picture.

77. **B. G89.29 (Other chronic pain) or the appropriate chronic pain code from the G89 category** Chronic pain syndrome and other chronic pain conditions are coded using category G89 (Pain, not elsewhere classified). G89.29 covers other chronic pain. G89.4 covers chronic pain syndrome. The G89 codes may be used as primary or secondary codes depending on the reason for the encounter.

**HCPCS Level II**

78. **A. 5 units** The HCPCS J-code for zoledronic acid specifies 1 mg per unit. The physician administered 5 mg: 5 mg ÷ 1 mg/unit = 5 units. Always verify the per-unit dosage in the specific J-code description.

79. **D. A5500–A5514 (within the A-code range for diabetic shoes)** The Medicare Therapeutic Shoe Program covers diabetic shoes and inserts coded within the A5500–A5514 range. These HCPCS codes cover different types of therapeutic shoes (depth, custom-molded) and inserts for patients with diabetes and qualifying foot conditions. E-codes cover DME. L-codes cover general orthotics.

80. **C. The screening test was performed as a colorectal cancer screening — modifier PT is specific to screening services** Modifier PT identifies colorectal cancer screening tests that are converted to diagnostic or therapeutic procedures. It is used specifically in the context of colorectal cancer screening to help the payer identify the service origin and apply appropriate coverage rules.

**Coding Guidelines**

81. **B. It is not reported separately; it is bundled into the surgical thoracoscopy code** Diagnostic thoracoscopy is bundled into surgical thoracoscopy when both are performed during the same session. The thoracoscopic biopsy is a surgical procedure — the diagnostic examination is included. The standard endoscopic hierarchy applies.

82. **A. Modifier 58 (staged or related procedure during the postoperative period)** The tissue expander exchange for a permanent implant is a planned staged procedure performed during the global period of the initial tissue expander insertion. Modifier 58 is appended because the second stage was prospectively planned. Modifier 78 is for unplanned complications. Modifier 79 is for unrelated procedures.

83. **D. Modifier XE (Separate Encounter)** Modifier XE indicates that the two procedures were performed during separate encounters on the same date. This is the most specific X modifier when two procedures are performed at different times on the same day — for example, a morning and afternoon procedure.

84. **C. The code has a 0-day global period — routine postoperative care on the same day is included, but visits on subsequent days are not bundled** A global period of "000" indicates a 0-day global period. Routine postoperative care on the same date as the procedure is included, but follow-up visits on subsequent days are separately reportable. An E/M service on the same day requires modifier 25 if significant and separately identifiable.

85. **B. It indicates only the professional component (interpretation and report) was provided, without the technical component** Modifier 26 identifies the professional component of a service — typically the physician's interpretation and report. It is used when the physician provides only the interpretation without providing the technical component (equipment, technologist, supplies). The facility bills modifier TC for the technical component.

86. **A. With the appropriate procedure code and modifier 58** When a planned staged procedure is performed during the global period of the first stage, modifier 58 is appended to the second-stage code. This tells the payer that the procedure was prospectively planned and initiates a new global period for the second stage.

87. **D. Modifier 91** Modifier 91 (repeat clinical diagnostic laboratory test) is appended when the same laboratory test is repeated on the same day for clinical monitoring purposes — such as serial glucose levels or serial troponins. The repeat test was medically necessary to track a clinical value over time. Modifier 76 is for repeat procedures (not lab tests). Modifier 77 is for repeats by a different physician.

**Compliance and Regulatory**

88. **C. Protected health information (PHI)** The HIPAA Privacy Rule governs the use and disclosure of protected health information (PHI) — individually identifiable health information that is

created, maintained, or transmitted by covered entities. PHI includes medical records, billing information, insurance claims, and any information that can identify a patient and relates to their health condition or treatment.

89. **B. Report and return the overpayment to Medicare within 60 days of identification** Under the 60-Day Rule (Section 6402 of the ACA), when a provider identifies an overpayment from Medicare, the overpayment must be reported and returned within 60 days of identification. Failure to return known overpayments can result in False Claims Act liability. The 60-day clock begins when the overpayment is identified.

90. **A. The Centers for Medicare & Medicaid Services (CMS)** CMS develops and publishes the Medicare Physician Fee Schedule, including the annual conversion factor, RVU values, GPCIs, and global period assignments. The AMA develops and publishes the CPT code set. The OIG provides compliance guidance and conducts audits. MACs process and pay claims within their jurisdictions.

**Cases — Integrated Coding Scenarios**

91. **D. 3.0 cm** The excised diameter is calculated as lesion diameter plus margins on both sides: 2.2 cm + (0.4 cm × 2) = 3.0 cm. This 3.0 cm excised diameter determines the correct code within the malignant excision range for the nose/face anatomical grouping.

92. **C. 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. **B. No; the diagnostic colonoscopy is bundled into the surgical colonoscopy EMR code** The diagnostic colonoscopy is always bundled into the surgical colonoscopy when a surgical procedure (EMR) is performed during the same session. Only the surgical colonoscopy EMR code is reported.

94. **A. 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 found and removed is reported as a secondary diagnosis. Medicare guidelines support the screening Z code as primary even when findings are treated during the screening.

95. **D. The cetuximab chemotherapy infusion** When cetuximab is used as an antineoplastic agent for colorectal cancer, it is coded using chemotherapy administration codes. The infusion hierarchy places chemotherapy at the highest level — it is always the initial service. The hydration and IV push are reported as secondary services.

96. **C. As a secondary/sequential hydration service using the appropriate add-on code** Since the chemotherapy infusion is the initial service, the hydration cannot be reported as an initial service.

The hydration is reported as a secondary service using the hydration add-on code. Only one initial infusion service per encounter is permitted.

97. **B. With the fracture treatment code and modifier 79 (unrelated procedure during the postoperative period)** The left distal radius fracture is completely unrelated to the right total hip arthroplasty. When an unrelated procedure is performed during the global period of a different surgery, modifier 79 is appended to the new procedure code. Modifier 78 would be for a complication-related return to the OR. Modifier 58 is for planned staged procedures.

98. **A. With the complete global package — no splitting modifiers** When the surgeon provides all components — preoperative evaluation, the surgical procedure, and all postoperative care — the complete global package is reported without splitting modifiers.

99. **D. No; the diagnostic colonoscopy is bundled into the surgical colonoscopy biopsy code** The diagnostic colonoscopy is bundled into the surgical colonoscopy when a biopsy is performed. Only the surgical colonoscopy biopsy code is reported.

100. **C. The iron deficiency anemia code as the first-listed diagnosis — the anemia was the reason the colonoscopy was ordered; the cecal mass/adenocarcinoma is reported as a secondary diagnosis** The patient presented for a diagnostic colonoscopy due to iron deficiency anemia — this was the clinical indication that prompted the procedure. The anemia is the first-listed diagnosis. The cecal mass and adenocarcinoma (confirmed on pathology) are reported as secondary diagnoses capturing the findings.