SIMULATION EXAM 2

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

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

1. A physician performs a shave removal of a 0.6 cm skin lesion from the neck. How is the code selected for this procedure?

A. Based on the excised diameter including margins

B. Based on the depth of the excision into the subcutaneous tissue

C. Based on the lesion diameter and anatomical location

D. Based on the wound repair classification required after removal

2. A patient has two intermediate repair lacerations on the right forearm measuring 4.0 cm and 2.5 cm, and one simple repair laceration on the left hand measuring 3.0 cm. How should these repairs be reported?

A. One intermediate repair code for 6.5 cm and one simple repair code for 3.0 cm

B. Three separate repair codes, one for each laceration

C. One intermediate repair code for 9.5 cm combining all three wounds

D. One complex repair code for the combined total of all wounds

3. A dermatologist excises a 2.0 cm malignant lesion from a patient's nose with 0.5 cm margins. What is the excised diameter?

A. 2.0 cm

B. 2.5 cm

C. 1.5 cm

D. 3.0 cm

4. Which of the following statements about skin graft coding is correct?

A. The excision of the lesion is always bundled into the skin graft code

B. For free skin grafts, the excision creating the defect may be reported separately from the graft code

C. The donor site repair is always coded separately from the graft code

D. Skin graft codes are based on the size of the donor site

5. A physician destroys 8 benign warts on a patient's hands using cryotherapy. Which code(s) should be reported?

A. 17000 × 1, 17003 × 7

B. 17110 × 8

C. 17110 × 1, 17111 × 1

D. 17111 × 8

6. Which of the following wound repair classifications involves single-layer closure of the epidermis and dermis with sutures, staples, or tissue adhesive?

A. Simple repair

B. Intermediate repair

C. Complex repair

D. Layered repair

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

7. A surgeon performs an open reduction with internal fixation (ORIF) of a tibial shaft fracture using a plate and screws. In CPT terminology, this is classified as which type of fracture treatment?

A. Closed treatment with manipulation

B. Percutaneous skeletal fixation

C. Closed treatment with internal fixation

D. Open treatment

8. A patient undergoes arthroscopic chondroplasty and meniscectomy of the left knee 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 codes

C. As a separate code with modifier 51

D. As a separate code with modifier 76

9. Which of the following correctly describes the axial skeleton?

A. It consists of 80 bones including the skull, vertebral column, and rib cage

B. It consists of 126 bones including the upper and lower extremities

C. It consists of the pelvic girdle and all limb bones

D. It consists of only the vertebral column and sacrum

10. An orthopedic surgeon performs a total hip replacement on a patient whose previous hip prosthesis has failed. Which type of arthroplasty code should be reported?

A. Primary total hip arthroplasty

B. Partial hip arthroplasty

C. Revision total hip arthroplasty

D. Hemiarthroplasty

11. A surgeon performs an anterior cervical discectomy with fusion at C5-C6 and C6-C7. How should the fusion be coded?

A. A single fusion code covering both levels

B. A primary fusion code for the first interspace plus an add-on code for the additional interspace

C. Two primary fusion codes with modifier 51 on the second

D. One fusion code with modifier 22 for the additional level

12. When casting is applied as part of initial fracture treatment by the physician who assumes the global fracture care package, how is the casting coded?

A. With a separate casting code and modifier 59

B. With a separate casting code and the appropriate supply codes

C. With a separate casting code and modifier 51

D. It is not coded separately; it is included in the fracture treatment code

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

13. A patient undergoes a right upper lobectomy via thoracotomy for non-small cell lung cancer. The left lung has two lobes. How many lobes does the right lung have?

A. Three

B. Two

C. Four

D. Five

14. A cardiologist replaces the pulse generator of an existing dual-chamber pacemaker. The leads are tested and left in place. How should this be coded?

A. A complete dual-chamber pacemaker system insertion code

B. A generator insertion code plus two lead insertion codes

C. A generator replacement code only; no lead codes are reported

D. A generator removal code plus a generator insertion code

15. Which of the following correctly describes the sentinel lymph node biopsy code (38900)?

A. It is a standalone code reported independently

B. It is an add-on code reported with the primary tumor excision code

C. It includes the complete regional lymph node dissection

D. It is reported only when the sentinel node is positive for cancer

16. A surgeon performs a coronary artery bypass graft using two saphenous vein grafts and two internal mammary artery grafts during the same operative session. How should the grafts be coded?

A. A single code for four total bypass grafts

B. Only the arterial graft code with modifier 22

C. Four separate single-graft codes

D. A venous graft code for two grafts plus an arterial graft code for two grafts

17. A patient undergoes a diagnostic bronchoscopy with bronchial washing. No other bronchoscopic procedures are performed. How should this be coded?

A. The bronchial washing code only; the diagnostic bronchoscopy is included

B. Both the diagnostic bronchoscopy code and the bronchial washing code

C. The diagnostic bronchoscopy code only; the washing is included

D. The bronchial washing code with modifier 26

18. A surgeon creates an arteriovenous fistula in the left forearm for hemodialysis access. Which type of dialysis access is this?

A. Arteriovenous graft

B. Direct arteriovenous fistula (AVF)

C. Tunneled dialysis catheter

D. Non-tunneled dialysis catheter

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

19. A patient undergoes a flexible sigmoidoscopy with removal of a polyp by hot biopsy forceps technique. Which of the following correctly describes the extent of a sigmoidoscopy?

A. Examination of the entire colon from rectum to cecum

B. Examination of the rectum and sigmoid colon only, extending to the terminal ileum

C. Examination of the entire large and small intestine

D. Examination of the rectum, sigmoid colon, and possibly the descending colon, not extending beyond the splenic flexure

20. A surgeon performs a laparoscopic Roux-en-Y gastric bypass for a patient with morbid obesity. Which ICD-10-CM code is required to support the medical necessity of this procedure?

A. Z68.41 (BMI 40.0–44.9, adult) only

B. E66.9 (Obesity, unspecified) only

C. E66.01 (Morbid obesity due to excess calories) with the appropriate BMI code

D. Z71.3 (Dietary counseling and surveillance)

21. During an EGD, the gastroenterologist performs a biopsy of an esophageal lesion and dilates a pyloric stricture. How should the diagnostic EGD be reported?

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

22. An inguinal hernia repair is performed on a 45-year-old patient. The hernia is recurrent and strangulated. Which factors determine the correct CPT code?

A. Only the hernia type and the patient's age

B. The hernia type, initial vs. recurrent status, and whether incarcerated or strangulated

C. Only the approach (open vs. laparoscopic) and the hernia type

D. Only the hernia type and whether mesh was used

23. A patient undergoes an ERCP with sphincterotomy and bile duct stone removal during the same session. How should the diagnostic ERCP be coded?

A. As a separate code with modifier 59

B. As a separate code with modifier 26

C. As a separate code with modifier 51

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

24. A surgeon performs an open appendectomy on a patient with a ruptured appendix and generalized peritonitis. Which appendectomy code should be reported?

A. The code for appendectomy for ruptured appendix with abscess or peritonitis

B. The code for laparoscopic appendectomy

C. The code for incidental appendectomy

D. The standard open appendectomy code with modifier 22

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

25. A urologist performs a cystoscopy with insertion of a ureteral stent and separately performs a biopsy from the bladder wall during the same session. How should the diagnostic cystoscopy be reported?

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 cystoscopy codes

D. As a separate code with modifier 25

26. A patient undergoes percutaneous nephrolithotomy (PCNL) for a large staghorn renal calculus. How does PCNL differ from ESWL?

A. PCNL uses shock waves from outside the body; ESWL uses a nephroscope

B. PCNL involves inserting a nephroscope through the back into the kidney; ESWL uses shock waves from outside the body

C. PCNL is performed through the urethra; ESWL is performed through the back

D. There is no difference; the terms are interchangeable

27. A physician provides complete antepartum care (8 visits), performs a cesarean delivery, and provides all postpartum care for the same patient. Which code should be reported?

A. Antepartum care only code plus delivery only code plus postpartum care only code

B. Delivery only code with modifier 22

C. Antepartum care only code plus the global cesarean delivery code

D. The global obstetric code for cesarean delivery

28. A surgeon performs a laparoscopic supracervical hysterectomy. What structure is preserved in a supracervical hysterectomy?

A. The cervix

B. The uterine fundus

C. The ovaries

D. The fallopian tubes

29. A patient undergoes a radical prostatectomy with bilateral pelvic lymph node dissection using a robotic-assisted laparoscopic approach. Which CPT code range covers the robotic-assisted technique?

A. Open retropubic radical prostatectomy codes

B. Open perineal radical prostatectomy codes

C. Laparoscopic radical prostatectomy code (55866)

D. TURP codes with modifier 22

30. A surgeon performs a parathyroidectomy for primary hyperparathyroidism caused by a parathyroid adenoma. During the procedure, one parathyroid gland is inadvertently devascularized and requires reimplantation into the forearm muscle. How is the reimplantation coded?

A. It is included in the parathyroidectomy code

B. With a separate parathyroid autotransplantation code (60512)

C. With a tissue transfer code from the integumentary section

D. With a muscle flap code from the musculoskeletal section

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

31. A neurosurgeon performs a decompressive craniectomy following a massive stroke. The bone flap is removed and not replaced. How does this differ from a craniotomy?

A. A craniectomy uses a smaller incision than a craniotomy

B. A craniectomy is performed under local anesthesia; a craniotomy requires general anesthesia

C. A craniectomy involves removing the bone without replacement; a craniotomy replaces the bone flap

D. A craniectomy removes the bone flap and replaces it; a craniotomy does not replace the bone

32. A pain management physician performs bilateral paravertebral facet joint injections at L3-L4, L4-L5, and L5-S1 under fluoroscopic guidance. The injection codes include imaging guidance. How many injection codes should be reported?

A. A primary code for the first level plus add-on codes for two additional levels, reported bilaterally

B. Six separate injection codes, one for each side at each level

C. One injection code for all three levels with modifier 50

D. Three injection codes without laterality modifiers

33. A patient undergoes placement of a ventriculoperitoneal (VP) shunt for hydrocephalus. What does this device do?

A. Delivers medication to the ventricles of the brain

B. Monitors intracranial pressure continuously

C. Drains excess cerebrospinal fluid from the brain ventricles to the peritoneal cavity

D. Stimulates the production of cerebrospinal fluid

34. A spinal cord stimulator trial is performed with percutaneous placement of a temporary electrode into the epidural space connected to an external generator. The patient reports adequate pain relief and returns one week later for permanent implantation. How is the trial electrode placement coded?

A. With the permanent electrode placement code

B. With a separate trial electrode placement code (63650)

C. With an E/M code only; the trial is not a procedural service

D. With the permanent generator implantation code

35. An ophthalmologist performs a trabeculectomy to create a new drainage pathway for aqueous humor in a patient with uncontrolled glaucoma. What does the trabeculectomy accomplish?

A. It creates a new outflow pathway through the sclera to reduce intraocular pressure

B. It replaces the natural lens with an artificial intraocular lens

C. It repairs a detached retina using a scleral buckle

D. It removes the vitreous humor from the posterior chamber

36. A child undergoes bilateral tympanostomy tube placement under general anesthesia. Which modifier is required to indicate the bilateral nature of the procedure?

A. Modifier 51

B. Modifier 59

C. Modifier 76

D. Modifier 50 (or RT and LT on separate lines)

Evaluation and Management (Questions 37–42)

37. A physician provides an office visit for an established patient. The MDM involves two stable chronic conditions, review of prior external records, and prescription drug management with standard monitoring. What level of MDM does this support?

A. Low

B. High

C. Moderate

D. Straightforward

38. Which of the following is a requirement for a service to qualify as a consultation rather than a standard E/M visit?

A. The patient must be new to the consulting physician

B. The consultation must result in the transfer of care

C. The consulting physician must perform surgery

D. There must be a documented request from another physician

39. A physician sees an established patient in the office. The visit involves 45 minutes of total time on the date of service. Using the time-based pathway, which office visit code is supported?

A. 99215 (established patient, 40 minutes)

B. 99214 (established patient, 30 minutes)

C. 99213 (established patient, 20 minutes)

D. 99205 (new patient, 60 minutes)

40. A patient is admitted to observation in the morning and discharged from observation later the same day by the same physician. Which E/M code set should be used?

A. Initial observation care code plus discharge management code

B. Two subsequent observation care codes

C. An ED visit code plus an observation care code

D. Same-day admission and discharge codes (99234–99236)

41. An established patient presents for an annual wellness visit. During the visit, the physician also evaluates and adjusts the patient's hypertension medication. How should both services be reported?

A. The preventive medicine code only; the hypertension management is included

B. The preventive medicine code plus an E/M code with modifier 25

C. An E/M code only; the preventive visit is bundled

D. The preventive medicine code plus an E/M code with modifier 57

42. Under the current E/M guidelines, which element of medical decision-making evaluates the risk associated with the management decisions made during the encounter?

A. Number and complexity of problems addressed

B. Amount and complexity of data reviewed

C. Risk of complications and/or morbidity or mortality

D. Total time spent on the encounter

Anesthesia (Questions 43–46)

43. An anesthesiologist provides general anesthesia for an emergency cesarean section on a healthy 28-year-old patient (P1). Which qualifying circumstances code should be reported?

A. 99140 (emergency conditions)

B. 99100 (extreme age)

C. 99116 (total body hypothermia)

D. 99135 (controlled hypotension)

44. A patient classified as physical status P4 undergoes anesthesia for an abdominal aortic aneurysm repair. What does P4 indicate?

A. A normal healthy patient

B. A patient with mild systemic disease

C. A patient with severe systemic disease

D. A patient with severe systemic disease that is a constant threat to life

45. The anesthesia payment formula is: (Base Units + Time Units + Modifying Units) × Conversion Factor. Which component of this formula is fixed for each anesthesia CPT code regardless of case duration or patient health?

A. Time units

B. Base units

C. Modifying units

D. Conversion factor

46. An anesthesiologist provides anesthesia for a procedure that lasts 105 minutes. The payer uses 15-minute time units. How many time units should be reported?

A. 7.0

B. 6.0

C. 8.0

D. 7.5

Radiology (Questions 47–52)

47. A patient undergoes an MRI of the lumbar spine without contrast followed by MRI with gadolinium contrast. How should this study be coded?

A. MRI lumbar spine without contrast plus MRI lumbar spine with contrast

B. MRI lumbar spine with contrast only

C. MRI lumbar spine without contrast followed by with contrast (single code)

D. MRI lumbar spine without contrast plus a separate contrast injection code

48. A physician in a hospital setting performs only the interpretation and report of an abdominal ultrasound. The hospital provided the equipment, technologist, and supplies. Which modifier should the physician append?

A. Modifier TC

B. No modifier

C. Modifier 59

D. Modifier 26

49. A patient is referred for a diagnostic mammogram after a palpable breast mass was found on physical examination. Which type of mammography should be coded?

A. Screening mammography

B. Diagnostic mammography

C. Screening mammography with modifier 77

D. Diagnostic mammography with modifier 52

50. In radiation oncology, a patient receives 33 fractions of radiation therapy. Treatment management (77427) is reported per 5 fractions. How many units of 77427 should be reported?

A. 7 units (6 full units plus 1 unit with modifier 52 for the remaining 3 fractions)

B. 6 units

C. 33 units

D. 7 full units without modifier 52

51. Which of the following imaging modalities does NOT use ionizing radiation?

A. Fluoroscopy

B. CT scan

C. Plain X-ray

D. MRI

52. A CT of the abdomen is performed with both oral and intravenous contrast. How should this study be coded?

A. CT abdomen without contrast

B. CT abdomen without contrast followed by with contrast

C. CT abdomen with contrast

D. Two separate CT codes — one for oral and one for IV contrast

Pathology and Laboratory (Questions 53–58)

53. A laboratory performs a basic metabolic panel (BMP) and separately orders an additional hepatic function panel on the same specimen. Both panels share overlapping component tests including albumin. How should the overlapping albumin test be reported?

A. As a separate individual code in addition to both panels

B. It is included in each panel code; the overlapping test is not reported separately as an additional individual code

C. As a separate code with modifier 91

D. As a separate code with modifier 59

54. A pathologist examines a breast excision specimen with complete surgical margin assessment for a patient with breast cancer. At which level of surgical pathology is this specimen classified?

A. Level V (88307)

B. Level IV (88305)

C. Level III (88304)

D. Level VI (88309)

55. A physician orders definitive drug testing for opiates (3 analytes), benzodiazepines (2 analytes), and amphetamines (2 analytes). How are the definitive testing codes reported?

A. One code for all three drug classes combined

B. One code per date of service regardless of drug classes

C. Two codes — one for opiates and one for the remaining classes combined

D. Three codes, one for each drug class, based on the number of analytes within each class

56. Which CLIA modifier is appended to a laboratory code when the test is performed in a physician's office under a CLIA certificate of waiver?

A. Modifier 26

B. Modifier 91

C. Modifier QW

D. Modifier TC

57. A patient has a routine urinalysis performed by dip stick without microscopy in a physician's office. The result shows trace protein and positive leukocyte esterase. The physician orders a follow-up urinalysis with microscopy at the hospital laboratory. How many urinalysis codes should the physician's office report?

A. One code for the non-automated urinalysis without microscopy

B. Two codes — one for the office urinalysis and one for the hospital urinalysis

C. One code for the urinalysis with microscopy

D. No urinalysis code; only the hospital laboratory reports the test

58. Therapeutic drug assays measure which of the following?

A. The presence or absence of illicit drugs in the blood

B. The blood level of a prescribed medication to ensure it is within the therapeutic range

C. The concentration of allergens in the blood

D. The DNA sequence of drug-metabolizing enzymes

Medicine (Questions 59–64)

59. A patient receives a 90-minute IV infusion of rituximab (a non-antineoplastic biologic agent) for rheumatoid arthritis. Which code range should be used for the administration?

A. Chemotherapy administration codes (96413–96417)

B. Moderate sedation codes (99151–99157)

C. Hydration codes (96360–96361)

D. Therapeutic drug infusion codes (96365–96368)

60. A patient receives IV hydration for 35 minutes as the only IV service during the encounter. How should the hydration be coded?

A. 96360 × 2 (two units for 35 minutes)

B. 96360 is not reportable; the minimum time threshold was not met

C. 96360 × 1 (initial hydration, 31 minutes to 1 hour)

D. 96361 × 1 (additional hour of hydration)

61. An adult patient receives two separate vaccine injections at a routine office visit. No physician counseling about the vaccines is provided. How should the administration be coded?

A. 90471 × 1 for the first injection plus 90472 × 1 for the second injection

B. 90460 × 1 for the first injection plus 90461 × 1 for the second injection

C. 90471 × 2

D. 90460 × 2

62. A therapist provides 22 minutes of therapeutic exercise (97110) and 15 minutes of manual therapy (97140) during the same session. Using the 8-minute rule, how many total units should be reported?

A. 3 units (2 units of 97110, 1 unit of 97140)

B. 2 units (1 unit of 97110, 1 unit of 97140)

C. 4 units

D. 1 unit of 97110 only; 97140 does not meet the 8-minute minimum

63. A psychiatrist performs a psychiatric diagnostic evaluation that includes a physical examination, review of medications, and ordering of laboratory tests. Which code should be reported?

A. 90791 (psychiatric diagnostic evaluation without medical services)

B. An E/M code plus 90791

C. 90791 with modifier 25

D. 90792 (psychiatric diagnostic evaluation with medical services)

64. A patient undergoes a transthoracic echocardiogram (TTE) with Doppler and color flow imaging at a hospital. The cardiologist provides only the interpretation and report. Which modifier should the cardiologist append?

A. Modifier TC

B. No modifier

C. Modifier 26

D. Modifier 59

Medical Terminology (Questions 65–68)

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

A. Creating a new opening

B. Surgical removal

C. Incision into

D. Visual examination

66. Which combining form refers to the kidney?

A. Hepat/o

B. Nephr/o

C. Cyst/o

D. Enter/o

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

A. Below normal

B. Around

C. Within

D. Excessive or above normal

68. What is the correct plural form of "bronchus"?

A. Bronchi

B. Bronchuses

C. Bronchai

D. Bronchae

Anatomy (Questions 69–72)

69. Which of the following structures is part of the upper respiratory tract?

A. Bronchi

B. Alveoli

C. Larynx

D. Trachea

70. The tricuspid valve is located between which two chambers of the heart?

A. Left atrium and left ventricle

B. Right atrium and right ventricle

C. Right ventricle and pulmonary artery

D. Left ventricle and aorta

71. Which section of the small intestine receives bile from the common bile duct and pancreatic enzymes from the pancreatic duct?

A. Jejunum

B. Ileum

C. Cecum

D. Duodenum

72. The cervical region of the vertebral column consists of how many vertebrae?

A. Seven

B. Twelve

C. Five

D. Three

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

73. A patient is diagnosed with both acute and chronic bronchitis. ICD-10-CM provides separate codes for each. How should these be sequenced?

A. Chronic bronchitis first, acute bronchitis second

B. Acute bronchitis first, chronic bronchitis second

C. Only the chronic bronchitis code is reported

D. Only the acute bronchitis code is reported

74. In ICD-10-CM, the abbreviation "NOS" (Not Otherwise Specified) indicates which of the following?

A. The coding system does not have a specific code for the documented condition

B. The condition is not covered by insurance

C. The documentation does not provide enough information to select a more specific code

D. The condition has been ruled out

75. A patient with documented hypertension and chronic kidney disease stage 3 presents for a routine office visit. Under ICD-10-CM guidelines, what is the assumed relationship between these two conditions?

A. No relationship is assumed; both are coded independently

B. The hypertension is assumed to be secondary to the kidney disease

C. The kidney disease is assumed to be unrelated to the hypertension

D. A causal relationship is presumed; a code from I12 (hypertensive chronic kidney disease) is reported

76. Which ICD-10-CM chapter contains Z codes for factors influencing health status and contact with health services?

A. Chapter 21 (Z00–Z99)

B. Chapter 18 (R00–R99)

C. Chapter 19 (S00–T88)

D. Chapter 20 (V00–Y99)

77. A patient takes the correct dose of a prescribed antibiotic but develops a severe allergic rash as an unintended reaction. How is this classified in ICD-10-CM?

A. Poisoning

B. Adverse effect

C. Underdosing

D. Intentional self-harm

HCPCS Level II (Questions 78–80)

78. Which HCPCS Level II code range covers durable medical equipment such as wheelchairs, hospital beds, and oxygen equipment?

A. J0000–J9999

B. A4000–A8999

C. E0100–E9999

D. L0000–L9999

79. A physician provides a service that is a statutory exclusion under Medicare — a service Medicare categorically never covers. The provider issues a voluntary notice to the patient. Which modifier should be appended?

A. Modifier GA

B. Modifier GZ

C. Modifier QW

D. Modifier GX

80. When reporting a bilateral procedure, which HCPCS modifier indicates the procedure was performed on the right side?

A. Modifier RT

B. Modifier LT

C. Modifier 50

D. Modifier RC

Coding Guidelines (Questions 81–87)

81. A CPT code description includes the phrase "(separate procedure)." The procedure is performed as part of a more comprehensive surgery through the same incision. How should it be coded?

A. With a separate code and modifier 59

B. It is not reported separately; it is bundled into the comprehensive procedure

C. With a separate code and modifier 51

D. With a separate code and modifier 22

82. When multiple procedures are performed during the same operative session, Medicare's Multiple Procedure Payment Reduction (MPPR) typically reduces payment for the second and subsequent procedures to what percentage?

A. 75% of the allowed amount

B. 25% of the allowed amount

C. 50% of the allowed amount

D. 100% of the allowed amount

83. A surgeon performs an unrelated procedure during the 90-day global period of a previous major surgery. Which modifier should be appended to the new procedure?

A. Modifier 58

B. Modifier 78

C. Modifier 24

D. Modifier 79

84. In the CPT manual, the symbol "●" (filled bullet/circle) indicates which of the following?

A. A new code added in the current year's edition

B. A revised code description

C. An add-on code

D. A modifier 51 exempt code

85. Which of the following statements correctly describes modifier 59?

A. It indicates a bilateral procedure

B. It indicates a distinct procedural service that is separate and independent from other services performed on the same day

C. It indicates a reduced service

D. It indicates a repeat procedure by the same physician

86. A physician performs a procedure and also provides an E/M service on the same day as a minor procedure with a 10-day global period. The E/M is significant and separately identifiable. Which modifier is appended to the E/M code?

A. Modifier 57

B. Modifier 51

C. Modifier 25

D. Modifier 59

87. Under NCCI rules, when a Column 1/Column 2 edit has a modifier indicator of 0, what does this mean?

A. A modifier may be appended to bypass the edit

B. The edit applies only to Medicare Advantage plans

C. The edit has not been assigned a modifier indicator

D. No modifier is allowed; the edit cannot be overridden

Compliance and Regulatory (Questions 88–90)

88. The Stark Law (Physician Self-Referral Law) prohibits physicians from referring Medicare patients for designated health services to entities with which they have a financial relationship. Which of the following correctly describes the Stark Law's liability standard?

A. It is a strict liability statute; no intent to violate is required

B. It requires proof of knowing and willful conduct

C. It requires proof of criminal intent

D. It applies only to hospitals, not individual physicians

89. Which of the following is included in the OIG's recommended seven elements of an effective compliance program?

A. Eliminating all billing errors within the first year

B. Achieving 100% coding accuracy on all claims

C. Regular education and training for all employees on compliance requirements

D. Outsourcing all coding to a third-party vendor

90. A provider submits a claim for a level 5 office visit (99215) when the documentation supports only a level 3 visit (99213). This billing practice is known as which of the following?

A. Unbundling

B. Upcoding

C. Duplicate billing

D. Downcoding

Cases — Integrated Coding Scenarios (Questions 91–100)

Case 1 (Questions 91–92):

A 62-year-old patient undergoes a diagnostic colonoscopy. The gastroenterologist advances the scope to the cecum but finds no polyps, masses, or other abnormalities. No surgical procedures are performed.

91. Which colonoscopy code should be reported?

A. A surgical colonoscopy code with modifier 52

B. A sigmoidoscopy code since no findings were identified

C. No procedure code; only an E/M code is appropriate

D. The diagnostic colonoscopy code (45378)

92. The patient is a Medicare beneficiary presenting for a routine screening with no symptoms. Which diagnosis code should be reported as the first-listed diagnosis?

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

B. K63.5 (Polyp of colon)

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

D. R19.5 (Other fecal abnormalities)

Case 2 (Questions 93–94):

A 50-year-old patient with Type 2 diabetes mellitus presents to the ophthalmologist for evaluation of diabetic retinopathy. The physician performs a comprehensive eye examination and bilateral intravitreal injections of an anti-VEGF agent.

93. The patient's diabetes is Type 2 with ophthalmic complications. Which ICD-10-CM category should be used for the diabetes code?

A. E10 (Type 1 diabetes mellitus)

B. E11 (Type 2 diabetes mellitus)

C. E13 (Other specified diabetes mellitus)

D. E09 (Drug or chemical induced diabetes mellitus)

94. The intravitreal injections are performed bilaterally. How should the laterality be reported?

A. With a single code and modifier 22

B. With a single code and no modifier

C. With the procedure code reported for each eye using modifiers RT and LT (or modifier 50)

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

Case 3 (Questions 95–96):

A pain management physician performs a lumbar transforaminal epidural steroid injection at L5-S1 under fluoroscopic guidance. The CPT code for the injection includes imaging guidance. The patient also receives a separate facet joint injection at L4-L5 on the same date.

95. How should the fluoroscopic guidance for the transforaminal injection be coded?

A. With a separate fluoroscopic guidance code

B. With a separate fluoroscopic guidance code and modifier 26

C. With a separate fluoroscopic guidance code and modifier 59

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

96. The facet joint injection at L4-L5 is a separate procedure from the transforaminal injection at L5-S1. Both are performed on the same date. Can both be reported?

A. Yes, both injection codes may be reported with appropriate modifiers to indicate they are distinct services

B. No, only one spinal injection code may be reported per date of service

C. No, the facet injection is bundled into the transforaminal injection

D. Yes, but only with modifier 51 on the second injection

Case 4 (Questions 97–98):

A 7-year-old child presents for a well-child visit. The pediatrician performs a comprehensive preventive medicine examination and administers three separate vaccine injections: DTaP, IPV, and MMR. The physician provides face-to-face counseling about each vaccine.

97. How should the vaccine administration be coded for this pediatric patient with physician counseling?

A. 90471 × 1 plus 90472 × 2 (adult injection-based codes)

B. 90460 for each vaccine's first component plus 90461 for each additional antigen component (pediatric component-based codes)

C. A single administration code covering all three injections

D. 90460 × 3 only, without any 90461 codes

98. The DTaP vaccine contains three antigen components (diphtheria, tetanus, pertussis). How is the administration of DTaP specifically coded using the pediatric codes?

A. 90460 × 3

B. 90471 × 1

C. 90460 × 1 plus 90461 × 2

D. 90472 × 3

Case 5 (Questions 99–100):

A patient receives the following IV services during a single outpatient encounter: 45 minutes of IV hydration with normal saline, followed by a 1-hour IV infusion of an antibiotic, followed by an IV push of an antiemetic medication.

99. According to the infusion hierarchy, which service should be reported as the initial service?

A. The IV hydration, because it was administered first

B. The IV push antiemetic, because it was administered last

C. Either service may be reported as initial

D. The therapeutic antibiotic infusion, because it is highest in the hierarchy among the services provided

100. The IV hydration lasted 45 minutes and is reported as a secondary service because the therapeutic infusion is the initial service. Which hydration code should be used?

A. The sequential IV hydration add-on code, since it is a secondary service on the same day as a therapeutic infusion

B. The initial hydration code (96360) with modifier 59

C. The initial hydration code (96360) with modifier 51

D. Hydration is not separately reportable when a therapeutic infusion is provided

SIMULATION EXAM 2 — ANSWER KEY WITH EXPLANATIONS

10,000 Series — Integumentary System

1. **C. Based on the lesion diameter and anatomical location** Shave removal codes are based on the lesion diameter and the anatomical site — not the excised diameter. Unlike excision codes, shave removals do not include margins of normal tissue because the lesion is removed by horizontal slicing through the epidermis or dermis without full-thickness excision. No margin calculation is needed for shave removals.

2. **A. One intermediate repair code for 6.5 cm and one simple repair code for 3.0 cm** Wounds repaired with the same classification and in the same anatomical grouping are added together and reported as a single code. The two intermediate repairs on the right forearm (4.0 + 2.5 = 6.5 cm) are combined into one intermediate repair code. The simple repair on the left hand is a different classification and is reported separately with its own code.

3. **D. 3.0 cm** The excised diameter is calculated as lesion diameter plus margins on both sides: 2.0 cm + (0.5 cm × 2) = 3.0 cm. The margin is always multiplied by two because normal tissue is removed on all sides of the lesion. This total excised diameter determines the correct code within the malignant excision range for the face/nose anatomical grouping.

4. **B. For free skin grafts, the excision creating the defect may be reported separately from the graft code** Free skin graft codes do not include the excision of the lesion that created the defect — the excision may be reported separately with its own CPT code. This is a key distinction from adjacent tissue transfer, where the excision is bundled into the flap code. Graft codes are based on the size of the recipient area (defect), not the donor site.

5. **C. 17110 × 1, 17111 × 1** Benign lesion destruction uses code 17110 for the first lesion and 17111 for the second through fourteenth additional lesions. For 8 warts: 17110 × 1 (first lesion) plus 17111 × 1 (2 through 14 additional lesions — reported as a single unit covering all additional lesions in this range). Note that 17111 covers the second through fourteenth lesions as a flat code, not per lesion.

6. **A. Simple repair** Simple wound repair involves single-layer closure of the epidermis and dermis using sutures, staples, or tissue adhesive. It does not involve layered closure of deeper structures. Intermediate repair requires layered closure of subcutaneous tissue and superficial fascia in addition to the skin. Complex repair involves techniques beyond layered closure such as undermining or retention sutures.

20,000 Series — Musculoskeletal System

7. **D. Open treatment** Open reduction with internal fixation (ORIF) is classified as open treatment in CPT because the fracture site is surgically exposed and the fracture fragments are directly visualized. The internal fixation hardware (plate and screws) is applied during the open procedure. "Open treatment" refers to the treatment method — the fracture site is surgically opened — not the fracture type.

8. **B. 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 chondroplasty and meniscectomy are surgical arthroscopic procedures — the diagnostic examination is included in each. Both surgical procedures are reported with their own codes, but the diagnostic component is not reported separately.

9. **A. It consists of 80 bones including the skull, vertebral column, and rib cage** The axial skeleton forms the central axis of the body and consists of 80 bones: the skull (cranium and facial bones), vertebral column (cervical, thoracic, lumbar, sacral, and coccygeal vertebrae), rib cage (ribs and sternum), and hyoid bone. The appendicular skeleton consists of 126 bones making up the limbs and the girdles that attach them to the axial skeleton.

10. **C. Revision total hip arthroplasty** When a previously implanted hip prosthesis has failed and requires replacement, the procedure is classified as a revision arthroplasty — not a primary arthroplasty. Revision procedures are more complex than primary replacements due to scar tissue, bone loss, and altered anatomy. CPT provides separate codes for revision arthroplasty that carry higher RVU values than primary replacement codes.

11. **B. A primary fusion code for the first interspace plus an add-on code for the additional interspace** Spinal fusion codes cover a single vertebral interspace. When multiple interspaces are fused during the same session, the primary code is reported for the first interspace and the corresponding add-on code is reported for each additional interspace. Two interspaces (C5-C6 and C6-C7) require one primary anterior cervical fusion code plus one add-on code.

12. **D. It is not coded separately; it is included in the fracture treatment code** When a cast or splint is applied as part of initial fracture treatment by the physician who assumes the global fracture care package, the casting is included in the fracture treatment code and is not reported separately. Cast application, cast changes, and routine follow-up are all bundled into the global package when the treating physician provides complete fracture care.

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

13. **A. Three** The right lung has three lobes: upper (superior), middle, and lower (inferior). The left lung has only two lobes (upper and lower) because the heart occupies space on the left side of the chest. This anatomical distinction is critical for coding lung resection procedures — a right middle lobectomy can only be performed on the right lung.

14. **C. A generator replacement code only; no lead codes are reported** When only the pulse generator of an existing pacemaker is replaced and the 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. Pacemaker coding is component-based — each component is coded only when it is directly manipulated during the procedure.

15. **B. It is an add-on code reported with the primary tumor excision code** Sentinel lymph node biopsy (38900) is an add-on code that is always reported in conjunction with the primary tumor excision code — it cannot be reported as a standalone procedure. The sentinel node is the first lymph node to which cancer is likely to spread, and its biopsy is performed at the time of the primary cancer surgery. It does not include complete regional lymph node dissection.

16. **D. A venous graft code for two grafts plus an arterial graft code for two grafts** CABG codes are organized by graft type and number. When both venous and arterial grafts are performed during the same session, both code sets are reported. The venous code for two grafts captures both saphenous vein grafts, and the arterial code for two grafts captures both IMA grafts. A single combined code for all four grafts does not exist.

17. **A. The bronchial washing code only; the diagnostic bronchoscopy is included** When a surgical bronchoscopic procedure (bronchial washing) is performed during the same session as a diagnostic bronchoscopy, only the surgical procedure code is reported. The diagnostic bronchoscopy is bundled into the surgical bronchoscopy code. This follows the standard endoscopic hierarchy that applies to all endoscopic procedures in CPT.

18. **B. Direct arteriovenous fistula (AVF)** A direct arteriovenous fistula is a surgical connection between an artery and a vein created in the patient's own vessels — no synthetic graft material is used. An AVF in the forearm (radiocephalic fistula) connects the radial artery to the cephalic vein. An arteriovenous graft uses a synthetic tube to bridge the artery and vein. Dialysis catheters are temporary or semi-permanent central venous access devices.

40,000 Series — Digestive System

19. **D. Examination of the rectum, sigmoid colon, and possibly the descending colon, not extending beyond the splenic flexure** A flexible sigmoidoscopy examines the rectum, sigmoid colon, and sometimes a portion of the descending colon — but does not advance beyond the splenic flexure. A colonoscopy, by contrast, examines the entire colon from the rectum to the cecum and may include the terminal ileum. The extent of the examination determines which code range is used.

20. **C. E66.01 (Morbid obesity due to excess calories) with the appropriate BMI code** Bariatric surgery requires documentation of medical necessity, which includes an ICD-10-CM code for morbid obesity (E66.01) along with the appropriate BMI code (Z68.3x–Z68.4x) to specify the patient's BMI. An unspecified obesity code (E66.9) or a BMI code alone does not adequately establish medical necessity for bariatric surgery.

21. **A. It is not reported separately; it is included in the surgical EGD codes** When surgical procedures (biopsy and dilation) are performed during an EGD, the diagnostic examination is bundled into the surgical codes. Each surgical procedure is reported with its own code, but the diagnostic EGD is not reported separately. This is the standard endoscopic hierarchy rule that applies across all GI endoscopy.

22. **B. The hernia type, initial vs. recurrent status, and whether incarcerated or strangulated** CPT codes for inguinal hernia repair are determined by the hernia type (inguinal), the patient's age, whether the repair is initial or recurrent, and whether the hernia is incarcerated or strangulated. For adult patients, all of these factors affect code selection. Whether mesh was used does not change the CPT code — mesh is generally considered part of the repair.

23. **D. It is not reported separately; it is included in the surgical ERCP codes** Diagnostic ERCP is bundled into surgical ERCP when both are performed during the same session. The sphincterotomy and stone removal are each reported with their own surgical ERCP codes, but the diagnostic examination is included in the surgical codes. This follows the same endoscopic hierarchy as colonoscopy, EGD, and bronchoscopy.

24. **A. The code for appendectomy for ruptured appendix with abscess or peritonitis** CPT provides a specific code (44960) for appendectomy performed for a ruptured appendix with abscess or generalized peritonitis. This code carries a higher RVU than the standard open appendectomy code (44950) because the procedure is more complex — involving drainage, debridement, and management of peritoneal contamination in addition to the appendix removal.

50,000 Series — Urinary, Reproductive, and Endocrine

25. **C. It is not reported separately; it is included in the surgical cystoscopy codes** Diagnostic cystoscopy is always bundled into surgical cystoscopy when both are performed during the same session. The ureteral stent insertion and bladder biopsy are both surgical cystoscopic procedures. The diagnostic examination that necessarily precedes these surgical interventions is included in each surgical code and is not reported separately.

26. **B. PCNL involves inserting a nephroscope through the back into the kidney; ESWL uses shock waves from outside the body** Percutaneous nephrolithotomy involves making a small incision in the back, inserting a nephroscope directly into the kidney through a percutaneous tract, and fragmenting and removing the stone under direct visualization. ESWL uses shock waves generated outside the body focused on the stone — no incision or instrument insertion is required. These are fundamentally different procedures with different CPT code ranges.

27. **D. The global obstetric code for cesarean delivery** When a single physician provides all three components of obstetric care — complete antepartum care, delivery, and all postpartum care — the global obstetric code is reported. Code 59510 covers the complete package for cesarean delivery. Unbundling into individual component codes is only appropriate when different physicians provide different components of care.

28. **A. The cervix** A supracervical (subtotal) hysterectomy removes the uterine body while preserving the cervix. A total hysterectomy removes both the uterine body and the cervix. A radical hysterectomy removes the uterus, cervix, upper vagina, and parametrial tissue. The extent of removal — specifically whether the cervix is preserved — is one of the primary factors that distinguishes between hysterectomy types.

29. **C. Laparoscopic radical prostatectomy code (55866)** CPT code 55866 covers laparoscopic radical prostatectomy, which includes both standard laparoscopic and robotic-assisted laparoscopic techniques. A robotic-assisted procedure is coded as a laparoscopic procedure because the robot is a tool used to perform the laparoscopy — it is not a separate surgical approach. There is no separate "robotic" code in CPT.

30. **B. With a separate parathyroid autotransplantation code (60512)** Parathyroid autotransplantation — the reimplantation of parathyroid tissue into muscle to preserve parathyroid function — is coded separately with code 60512. This is not included in the parathyroidectomy code because autotransplantation is a distinct additional procedure performed to manage a complication or anticipated consequence of the primary surgery.

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

31. **C. A craniectomy involves removing the bone without replacement; a craniotomy replaces the bone flap** The fundamental distinction is whether the bone is replaced. A craniotomy cuts a bone flap, performs the intracranial procedure, and replaces the bone flap. A craniectomy removes the bone without replacing it — either for decompression (allowing the swollen brain to expand) or because the bone is involved in disease. The subsequent cranioplasty to repair the skull defect is a separate procedure coded at a later date.

32. **A. A primary code for the first level plus add-on codes for two additional levels, reported bilaterally** Paravertebral facet joint injection codes use a primary code for the first level and add-on codes for each additional level (up to three levels per spinal region per session). When performed bilaterally, the codes are reported with modifier 50 or with RT and LT modifiers. Three lumbar levels bilaterally require the primary code and two add-on codes, each reported bilaterally. Since imaging guidance is included in the injection codes, no separate fluoroscopy code is reported.

33. **C. Drains excess cerebrospinal fluid from the brain ventricles to the peritoneal cavity** A ventriculoperitoneal (VP) shunt diverts excess cerebrospinal fluid from the ventricles of the brain to the peritoneal cavity, where it is absorbed by the body. This treats hydrocephalus by reducing the accumulation of CSF and relieving elevated intracranial pressure. The shunt system consists of a ventricular catheter, a valve mechanism, and a distal catheter that terminates in the peritoneal cavity.

34. **B. With a separate trial electrode placement code (63650)** The trial electrode placement is coded separately from the permanent implant. Code 63650 covers the percutaneous placement of the trial

electrode into the epidural space. The trial is a distinct procedure performed to evaluate whether the patient will benefit from permanent implantation. When the patient returns for permanent implantation, separate codes are reported for the permanent electrode and the generator.

35. **A. It creates a new outflow pathway through the sclera to reduce intraocular pressure** Trabeculectomy creates a new drainage pathway for aqueous humor by removing a small piece of the trabecular meshwork and creating a flap in the sclera. This allows fluid to drain from inside the eye into a blister-like space (bleb) under the conjunctiva, reducing intraocular pressure. It is a glaucoma surgery — not a cataract, retinal, or vitreous procedure.

36. **D. Modifier 50 (or RT and LT on separate lines)** Tympanostomy tube placement codes are unilateral by definition. When the procedure is performed bilaterally, modifier 50 is appended to indicate a bilateral procedure, or the procedure is reported on two separate lines with modifier RT on one and modifier LT on the other. The payer's specific requirements determine which reporting method is used.

Evaluation and Management

37. **C. Moderate** Two stable chronic conditions constitute a moderate-level problem complexity. Review of prior external records constitutes moderate-level data. Prescription drug management with standard monitoring constitutes low-level risk. Two of three elements meet the moderate threshold (problems and data), making the overall MDM level moderate, supporting code 99214 for an established patient.

38. **D. There must be a documented request from another physician** The three requirements for a consultation are: a documented request from another physician, the rendering of an opinion by the consultant, and a report back to the requesting physician. A consultation does not require that the patient be new, does not require surgery, and does not involve a transfer of care — if the consultant assumes ongoing management, subsequent encounters are standard E/M visits, not consultations.

39. **A. 99215 (established patient, 40 minutes)** Under the time-based pathway for established patient office visits, 99215 requires a minimum of 40 minutes of total time on the date of service. The physician spent 45 minutes, which meets and exceeds the 40-minute threshold for 99215. The next lower code (99214) requires 30 minutes, and the next higher code would require prolonged services add-on 99417.

40. **D. Same-day admission and discharge codes (99234–99236)** When a patient is admitted to observation and discharged on the same calendar date by the same physician, the same-day admission and discharge codes (99234–99236) are reported. Separate initial observation and discharge codes are not reported — the same-day codes capture the complete service in a single code.

41. **B. The preventive medicine code plus an E/M code with modifier 25** When a significant, separately identifiable problem is addressed during a preventive medicine visit (such as evaluating

and adjusting hypertension medication), both the preventive code and an appropriate E/M code may be reported. Modifier 25 is appended to the E/M code to indicate it is a significant, separately identifiable service from the preventive visit.

42. **C. Risk of complications and/or morbidity or mortality** The risk element of MDM evaluates the risk inherent in the management decisions made during the encounter — including the risk of diagnostic procedures ordered, treatment options selected, and potential complications. It is one of three MDM elements, along with the number/complexity of problems and the amount/complexity of data. Two of three elements determine the overall MDM level.

Anesthesia

43. **A. 99140 (emergency conditions)** The procedure is an emergency cesarean section, qualifying for qualifying circumstances code 99140 (emergency conditions). The patient is 28 years old, which does not meet the extreme age criterion (under 1 year or over 70 years), so 99100 does not apply. Code 99140 is reported as an add-on to the primary anesthesia code.

44. **D. A patient with severe systemic disease that is a constant threat to life** Physical status P4 indicates a patient with severe systemic disease that poses a constant threat to life — even without the stress of surgery and anesthesia. Examples include recent MI, ongoing cardiac ischemia, severe valve dysfunction, and sepsis. P3 indicates severe systemic disease that does not pose a constant threat, and P5 indicates a moribund patient not expected to survive without surgery.

45. **B. Base units** Base units are fixed for each anesthesia CPT code and do not change regardless of case duration, patient health status, or qualifying circumstances. They reflect the inherent complexity and risk of providing anesthesia for that particular type of procedure. Time units vary by case duration, and modifying units vary by patient health status and qualifying circumstances.

46. **A. 7.0** Time units are calculated by dividing total anesthesia minutes by the minutes-per-unit value: 105 minutes ÷ 15 minutes/unit = 7.0 time units. This is a straightforward division with no remainder. Always verify the payer's specific minutes-per-unit definition, as some commercial payers use different unit values than Medicare's 15-minute standard.

Radiology

47. **C. MRI lumbar spine without contrast followed by with contrast (single code)** When an MRI is performed first without contrast and then repeated with contrast during the same session, a single combination code is reported — "without contrast followed by with contrast." Two separate codes (one without and one with) are not reported. The combination code captures the complete dual-phase study as a single service.

48. **D. Modifier 26** When a physician provides only the interpretation and report (professional component) of an imaging study performed at a facility that owns the equipment, modifier 26 is appended. The hospital bills the technical component with modifier TC. Modifier 26 identifies the

physician's cognitive work — reviewing the images, correlating with clinical history, and generating the written report.

49. **B. Diagnostic mammography** When a patient is referred for mammography because of a specific clinical indication — in this case, a palpable breast mass — the study is diagnostic, not screening. Diagnostic mammography (77065 for unilateral, 77066 for bilateral) involves additional views and targeted evaluation of the area of concern. Screening mammography is reserved for asymptomatic patients with no clinical findings.

50. **A. 7 units (6 full units plus 1 unit with modifier 52 for the remaining 3 fractions)** Treatment management (77427) is reported per 5 fractions. For 33 fractions: 30 fractions ÷ 5 = 6 full units of 77427. The remaining 3 fractions represent a partial management unit, reported as 77427 × 1 with modifier 52 (reduced services). Total: 7 units, with modifier 52 on the final unit.

51. **D. MRI** MRI uses strong magnetic fields and radiofrequency pulses to produce images — it does not use ionizing radiation. This makes MRI safe for repeated examinations and for pregnant patients (though gadolinium contrast is used with caution in pregnancy). Fluoroscopy, CT, and plain X-ray all use ionizing radiation to produce images.

52. **C. CT abdomen with contrast** In CPT, "with contrast" refers to intravenous or injected contrast. When IV contrast is administered — regardless of whether oral contrast is also given — the study is coded as "with contrast." Oral contrast alone does not qualify as "with contrast." Since this study includes IV contrast, the correct code is CT abdomen with contrast.

Pathology and Laboratory

53. **B. It is included in each panel code; the overlapping test is not reported separately as an additional individual code** When two panels share overlapping component tests, the overlapping tests are included in each panel code. The albumin appears in both the BMP and the hepatic function panel — it is not reported as a third, separate individual code. Reporting the overlapping test separately in addition to both panels would constitute double billing for that component.

54. **A. Level V (88307)** A breast excision specimen requiring complete examination of surgical margins is classified at Level V surgical pathology (88307). Level V specimens involve more extensive examination due to the need for margin assessment and cancer staging. A breast biopsy not requiring complete margin examination would be Level IV (88305). The distinction is whether complete margin assessment is required.

55. **D. Three codes, one for each drug class, based on the number of analytes within each class** Definitive drug testing codes are reported per drug class, with the specific code determined by the number of analytes detected within each class. Three drug classes require three separate codes — one for opiates (3 analytes), one for benzodiazepines (2 analytes), and one for amphetamines (2 analytes). Each code is selected based on the analyte count within its class.

56. **C. Modifier QW** Modifier QW (CLIA-waived test) is appended to laboratory codes when the test is performed in a facility operating under a CLIA certificate of waiver. This modifier tells the payer that the test qualifies for reimbursement under the waived-test category. Modifiers 26 and TC relate to professional/technical component splitting, not CLIA status.

57. **A. One code for the non-automated urinalysis without microscopy** The physician's office performed a dip stick urinalysis without microscopy — this is reported with the appropriate urinalysis code (81002 or 81003). The hospital laboratory that performs the follow-up urinalysis with microscopy reports its own code separately. The physician's office only bills for the test it performed in-house.

58. **B. The blood level of a prescribed medication to ensure it is within the therapeutic range** Therapeutic drug assays (80150–80299) measure the concentration of prescribed medications in the patient's blood to optimize dosing and prevent toxicity. They are different from drug testing codes (80305–80377), which detect the presence of drugs for screening or forensic purposes. Therapeutic drug assays are used for medications with narrow therapeutic windows such as digoxin, lithium, and vancomycin.

Medicine

59. **D. Therapeutic drug infusion codes (96365–96368)** Rituximab for rheumatoid arthritis is a non-antineoplastic biologic agent. Non-antineoplastic drugs are reported using the standard therapeutic infusion codes (96365–96368), not the chemotherapy administration codes. Chemotherapy codes are reserved for antineoplastic agents used in cancer treatment. The drug classification — not the administration technique — determines the code range.

60. **C. 96360 × 1 (initial hydration, 31 minutes to 1 hour)** IV hydration requires a minimum of 31 minutes to report the initial code (96360). The patient received 35 minutes of hydration, which meets the minimum threshold. Since hydration is the only IV service during this encounter, it is appropriately reported as the initial service. If a therapeutic infusion were also provided, the hydration would be reported as a secondary service instead.

61. **A. 90471 × 1 for the first injection plus 90472 × 1 for the second injection** For adult patients (or any age when no physician counseling is provided), the adult injection-based administration codes are used. Code 90471 covers the first vaccine injection, and 90472 covers each additional injection. The pediatric component-based codes (90460/90461) are only used for patients through 18 years of age when the physician provides face-to-face counseling.

62. **B. 2 units (1 unit of 97110, 1 unit of 97140)** Using the 8-minute rule, each timed service must have at least 8 minutes to report one unit. Therapeutic exercise had 22 minutes (qualifies for 1 unit at 15 minutes, with 7 remaining minutes — not enough for a second unit). Manual therapy had 15 minutes (qualifies for 1 unit). Total: 2 units. The total treatment time of 37 minutes supports 2 units of 15-minute timed codes.

63. **D. 90792 (psychiatric diagnostic evaluation with medical services)** When a psychiatric diagnostic evaluation includes medical services — physical examination, medication review, ordering laboratory tests — code 90792 is reported. Code 90791 covers psychiatric diagnostic evaluation without medical services and is used by non-prescribing providers or when no medical services are rendered. The medical component distinguishes between the two codes.

64. **C. Modifier 26** When a cardiologist provides only the interpretation and report (professional component) of an echocardiogram performed at a hospital, modifier 26 is appended. The hospital bills the technical component (modifier TC) for the equipment, sonographer, and supplies. This follows the same professional/technical component splitting rules as radiology coding.

Medical Terminology

65. **A. Creating a new opening** The suffix "-ostomy" means creating a new opening or mouth. Common examples include colostomy (creating an opening from the colon to the skin), tracheostomy (creating an opening in the trachea), and gastrostomy (creating an opening in the stomach). "-Ectomy" means surgical removal, "-otomy" means incision into, and "-scopy" means visual examination.

66. **B. Nephr/o** The combining form "nephr/o" refers to the kidney. Common terms include nephrectomy (kidney removal), nephrology (study of kidneys), and nephrolithiasis (kidney stones). "Hepat/o" refers to the liver, "cyst/o" refers to the bladder or sac, and "enter/o" refers to the intestine.

67. **D. Excessive or above normal** The prefix "hyper-" means excessive, above normal, or increased. Common terms include hypertension (elevated blood pressure), hyperglycemia (elevated blood sugar), and hyperthyroidism (overactive thyroid). The opposite prefix "hypo-" means below normal, deficient, or decreased.

68. **A. Bronchi** The correct plural form of "bronchus" is "bronchi," following the Latin plural rule where words ending in "-us" change to "-i." Other examples include thrombus/thrombi, meniscus/menisci, and fungus/fungi. This plural form is important in documentation and coding — "bilateral bronchi" indicates both main bronchi.

Anatomy

69. **C. Larynx** The larynx (voice box) is part of the upper respiratory tract, along with the nose, nasal cavity, and pharynx. The trachea marks the beginning of the lower respiratory tract. The bronchi and alveoli are also part of the lower respiratory tract. The upper tract filters, warms, and humidifies air; the lower tract conducts air to the lungs for gas exchange.

70. **B. Right atrium and right ventricle** The tricuspid valve is located between the right atrium and the right ventricle. It has three leaflets (cusps) and prevents blood from flowing backward into the right atrium when the right ventricle contracts. The mitral (bicuspid) valve is between the left

atrium and left ventricle. The aortic valve is between the left ventricle and aorta. The pulmonary valve is between the right ventricle and pulmonary artery.

71. **D. Duodenum** The duodenum is the first section of the small intestine and receives bile from the common bile duct and pancreatic enzymes from the pancreatic duct through the ampulla of Vater. The duodenum is the primary site where bile and enzymes mix with chyme from the stomach to begin the chemical digestion and absorption of nutrients. The jejunum and ileum are the second and third sections of the small intestine.

72. **A. Seven** The cervical region of the vertebral column consists of seven vertebrae (C1–C7). C1 (atlas) supports the skull, and C2 (axis) allows rotation of the head. The thoracic region has 12 vertebrae, the lumbar region has 5, the sacral region has 5 fused vertebrae forming the sacrum, and the coccygeal region has 3–5 fused vertebrae forming the coccyx.

ICD-10-CM / Diagnosis Coding

73. **B. Acute bronchitis first, chronic bronchitis second** When a condition is documented as both acute and chronic, and ICD-10-CM provides separate codes for each, both codes are reported with the acute code sequenced first. This is a general ICD-10-CM coding guideline. The acute condition takes sequencing priority because it typically represents the more immediate clinical concern and the primary reason for the encounter.

74. **C. The documentation does not provide enough information to select a more specific code** NOS (Not Otherwise Specified) indicates that the provider's documentation lacks the specificity needed to assign a more specific code. The code set has more detailed options available, but the documentation does not provide enough detail to use them. This is different from NEC (Not Elsewhere Classifiable), where the documentation is specific but the coding system lacks a matching code.

75. **D. A causal relationship is presumed; a code from I12 (hypertensive chronic kidney disease) is reported** ICD-10-CM presumes a causal relationship between hypertension and chronic kidney disease when both are documented. The coder reports a code from I12 (hypertensive chronic kidney disease) along with the appropriate CKD stage code from N18. The physician does not need to explicitly document that the hypertension caused the kidney disease — the causal link is assumed by the coding guidelines.

76. **A. Chapter 21 (Z00–Z99)** Z codes are found in ICD-10-CM Chapter 21 (Z00–Z99) and describe factors influencing health status and contact with health services. These include screening encounters, vaccination visits, aftercare, personal and family history, pregnancy supervision, long-term drug therapy, and social determinants of health. Chapter 18 (R codes) covers signs and symptoms. Chapter 19 (S/T codes) covers injuries. Chapter 20 (V/Y codes) covers external causes.

77. **B. Adverse effect** When a patient takes the correct dose of a correctly prescribed medication and develops an unintended reaction, this is classified as an adverse effect — not a poisoning. In

adverse effect coding, the manifestation (allergic rash) is sequenced first, followed by the T code with the adverse effect designation. Poisoning occurs when a drug is taken incorrectly (wrong drug, wrong dose, wrong route, or taken by the wrong person).

HCPCS Level II

78. **C. E0100–E9999** HCPCS Level II E-codes (E0100–E9999) cover durable medical equipment including wheelchairs, hospital beds, oxygen equipment, CPAP machines, and other devices that can withstand repeated use and serve a medical purpose. J-codes cover drugs, A-codes cover supplies and ambulance transport, and L-codes cover orthotics and prosthetics.

79. **D. Modifier GX** Modifier GX (notice of liability issued, voluntary under payer policy) is appended when the provider issues a voluntary notification for a service that is a statutory exclusion — a service Medicare categorically never covers. Modifier GA is used when a signed ABN is obtained for medical necessity denials. Modifier GZ is used when no ABN was obtained for expected medical necessity denials.

80. **A. Modifier RT** HCPCS modifier RT indicates that a procedure was performed on the right side of the body. Modifier LT indicates the left side. These laterality modifiers are used with CPT and HCPCS codes for procedures that can be performed on either or both sides. Modifier 50 indicates a bilateral procedure performed on both sides during the same session.

Coding Guidelines

81. **B. It is not reported separately; it is bundled into the comprehensive procedure** When a code designated as a "separate procedure" is performed as part of a more comprehensive surgery through the same incision, it is bundled into the comprehensive code and is not reported separately. The separate procedure designation means the procedure is commonly an integral component of a larger procedure. It may only be coded independently when performed as the sole procedure or for a distinct purpose at a different site.

82. **C. 50% of the allowed amount** Under Medicare's Multiple Procedure Payment Reduction (MPPR), the primary (highest RVU) procedure is reimbursed at 100% of the allowed amount, and the second and subsequent procedures are typically reimbursed at 50%. Add-on codes and modifier 51 exempt codes are not subject to this reduction and are paid at 100%.

83. **D. Modifier 79** Modifier 79 (unrelated procedure or service by the same physician during the postoperative period) is appended when a procedure unrelated to the original surgery is performed during the global period. Modifier 58 is for planned staged procedures. Modifier 78 is for an unplanned return to the OR for a complication. Modifier 24 is for unrelated E/M services during the postoperative period.

84. **A. A new code added in the current year's edition** The filled bullet (●) symbol in CPT indicates a new code added in the current year's edition. The triangle (▲) indicates a revised code description. The plus sign (+) indicates an add-on code. The circle with a line (Ø) indicates a

modifier 51 exempt code. These symbols help coders quickly identify changes and special code characteristics.

85. **B. It indicates a distinct procedural service that is separate and independent from other services performed on the same day** Modifier 59 identifies a procedure or service as distinct and independent from other services performed on the same day. It is used to bypass NCCI edits when the procedures involve different anatomical sites, different encounters, or different patient conditions. CMS encourages the use of more specific X modifiers (XE, XS, XP, XU) when applicable.

86. **C. 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 with a 0-day or 10-day global period. Modifier 57 would be used if the E/M resulted in the decision for a major surgery with a 90-day global period. The global period of the procedure determines whether modifier 25 or 57 is appropriate.

87. **D. No modifier is allowed; the edit cannot be overridden** NCCI modifier indicator 0 means that no modifier is permitted to bypass the edit. The two codes can never be reported together under any circumstances. Indicator 1 means a modifier may be appended when clinically justified. Indicator 9 means the edit has not yet been assigned a modifier indicator. Understanding modifier indicators is essential for determining whether an NCCI edit can be legitimately bypassed.

Compliance and Regulatory

88. **A. It is a strict liability statute; no intent to violate is required** The Stark Law is a strict liability statute, meaning that if a prohibited referral is made and no exception applies, the law is violated regardless of the physician's intent or knowledge. This differs from the Anti-Kickback Statute, which requires "knowing and willful" conduct, and the False Claims Act, which requires "knowing" conduct (including reckless disregard). The Stark Law's strict liability standard makes it particularly important for compliance programs to monitor referral patterns.

89. **C. Regular education and training for all employees on compliance requirements** Regular education and training is one of the OIG's seven recommended elements of an effective compliance program. The seven elements are: written policies and procedures, designated compliance officer, education and training, effective communication (including anonymous reporting), internal monitoring and auditing, enforcement of disciplinary standards, and prompt response to detected offenses. Achieving 100% accuracy or outsourcing coding are not OIG requirements.

90. **B. Upcoding** Upcoding is the practice of reporting a higher-level code than the documentation supports in order to increase reimbursement. Reporting a level 5 visit when only a level 3 is documented is a textbook example of upcoding. Unbundling is the separate reporting of bundled components. Downcoding is reporting a lower code than is supported. Duplicate billing is submitting the same claim twice.

Cases — Integrated Coding Scenarios

91. **D. The diagnostic colonoscopy code (45378)** When a colonoscopy is performed and no surgical procedures are needed — no biopsies, no polypectomies, no ablation — only the diagnostic colonoscopy code (45378) is reported. The scope was advanced to the cecum (complete colonoscopy), and the examination was thorough but revealed no abnormalities requiring intervention. A sigmoidoscopy code would be incorrect because the scope reached the cecum.

92. **A. Z12.11 (Encounter for screening for malignant neoplasm of colon)** The patient is a Medicare beneficiary presenting for a routine screening colonoscopy with no symptoms or history of colon disease. The first-listed diagnosis is Z12.11 (encounter for screening for malignant neoplasm of colon). Since no abnormalities were found, no additional diagnosis codes are needed. If a polyp had been found, the polyp code would be added as a secondary diagnosis.

93. **B. E11 (Type 2 diabetes mellitus)** The patient has Type 2 diabetes mellitus, which is coded in the E11 category regardless of the treatment used. The specific code would be from E11.3x to capture the ophthalmic complications (diabetic retinopathy). The retinopathy code from the H35 category would be reported as an additional code to specify the type and severity of the retinal disease.

94. **C. With the procedure code reported for each eye using modifiers RT and LT (or modifier 50)** Intravitreal injection codes are unilateral. When performed bilaterally, the procedure is reported for each eye using laterality modifiers — either modifier RT on one line and modifier LT on a second line, or a single line with modifier 50, depending on the payer's requirements. A single code without a modifier would indicate only one eye was treated.

95. **D. It is not reported separately; it is included in the injection code** The transforaminal epidural injection code includes fluoroscopic guidance in its code description. When imaging guidance is bundled into the procedure code, a separate fluoroscopy code should not be reported. Reporting both the injection and a separate guidance code constitutes double billing.

96. **A. Yes, both injection codes may be reported with appropriate modifiers to indicate they are distinct services** The transforaminal epidural injection at L5-S1 and the facet joint injection at L4-L5 are distinct procedures performed at different anatomical sites using different techniques. Both may be reported on the same date with appropriate modifiers (such as modifier 59 or XS) to indicate they are separate and independent services. There is no rule limiting spinal injections to one code per date when distinct procedures are performed.

97. **B. 90460 for each vaccine's first component plus 90461 for each additional antigen component (pediatric component-based codes)** For patients through 18 years of age with physician counseling, the pediatric component-based codes are used. Each vaccine's first antigen component is reported with 90460, and each additional component within that vaccine is reported with 90461. DTaP has 3 components (90460 × 1, 90461 × 2), IPV has 1 component (90460 × 1), and MMR has 3 components (90460 × 1, 90461 × 2).

98. **C. 90460 × 1 plus 90461 × 2** DTaP contains three antigen components: diphtheria, tetanus, and pertussis. The first component is reported with 90460 (× 1), and each additional component is reported with 90461 (× 2 for the remaining two components). The pediatric codes count individual antigen components — not injections. This is a key distinction from the adult codes, which count injections.

99. **D. The therapeutic antibiotic infusion, because it is highest in the hierarchy among the services provided** The infusion hierarchy places chemotherapy at the top, therapeutic drug infusion second, and hydration at the bottom. Since no chemotherapy was provided, the therapeutic antibiotic infusion is the highest-ranked service and is reported as the initial infusion (96365). The hydration and IV push are reported as secondary services using add-on or sequential codes, regardless of the chronological order.

100. **A. The sequential IV hydration add-on code, since it is a secondary service on the same day as a therapeutic infusion** Since the therapeutic infusion is the initial service, the hydration cannot be reported as an initial service (96360). Instead, it is reported as a sequential hydration service using the appropriate add-on code. The hydration lasted 45 minutes and is a secondary service because it ranks lower than the therapeutic infusion in the hierarchy. The add-on code captures hydration provided as a secondary IV service on the same day.