SIMULATION EXAM 3

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

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

1. A physician excises a 1.5 cm malignant melanoma from the patient's left cheek with 1.0 cm margins. What is the excised diameter for code selection?

A. 1.5 cm

B. 2.5 cm

C. 3.0 cm

D. 3.5 cm

2. A surgeon performs a full-thickness skin graft to a 15 sq cm defect on the dorsum of the right hand. How are full-thickness skin graft codes measured?

A. By the diameter of the graft in centimeters

B. By the square centimeter area of the recipient site (defect)

C. By the square centimeter area of the donor site

D. By the circumference of the graft

3. A patient presents with a 5.0 cm laceration of the scalp repaired with simple sutures and a 3.0 cm intermediate repair laceration of the right forearm. How should these repairs be coded?

A. A single intermediate repair code for 8.0 cm combining both wounds

B. A single simple repair code for 8.0 cm combining both wounds

C. One simple repair code for 5.0 cm and one intermediate repair code for 3.0 cm

D. One complex repair code for 8.0 cm

4. Which layer of tissue must be closed in addition to the skin to qualify a wound repair as intermediate?

A. Subcutaneous tissue and/or superficial fascia

B. Deep fascia and muscle

C. Bone and periosteum

D. Tendon and joint capsule

5. A dermatologist performs Mohs micrographic surgery on a basal cell carcinoma of the nose. The first stage requires 3 tissue blocks, and the second stage requires 2 tissue blocks. No additional stages are needed. Which codes are reported?

A. 17311 × 2

B. 17311 × 1, 17315 × 2

C. 17311 × 1, 17312 × 1, 17315 × 3

D. 17311 × 1, 17312 × 1

6. A physician treats a patient with 22 actinic keratoses using cryodestruction. Which code(s) should be reported?

A. 17000 × 1, 17003 × 21

B. 17004

C. 17000 × 22

D. 17000 × 1, 17003 × 14, plus a separate code for the remaining lesions

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

7. A patient undergoes closed treatment of a Colles fracture (distal radius) without manipulation. How does "without manipulation" affect the code selection?

A. The code reflects a lower complexity treatment because no reduction was performed

B. The code reflects the same complexity as treatment with manipulation

C. The code is supplemented with modifier 52 for reduced service

D. The code is the same as open treatment

8. An orthopedic surgeon performs arthroscopic surgery on the right shoulder including subacromial decompression and rotator cuff repair during the same session. How should the subacromial decompression be coded if it is performed through the same arthroscopic portal?

A. As a separate code with modifier 59

B. As a separate code with modifier 51

C. It depends on whether the decompression is considered integral to the rotator cuff repair or a distinct service per NCCI guidelines

D. It is always reported as a separate code

9. A surgeon applies an external fixation device to stabilize a comminuted tibial fracture. In CPT terminology, how is external fixation classified?

A. As a form of open treatment

B. As a separate category of treatment with its own code structure

C. As a form of closed treatment

D. As a form of percutaneous skeletal fixation

10. A patient undergoes a posterior spinal fusion at L3-L4, L4-L5, and L5-S1 with pedicle screw instrumentation. How many add-on codes for additional interspaces should be reported in addition to the primary fusion code?

A. One add-on code

B. Three add-on codes

C. No add-on codes; a single code covers all levels

D. Two add-on codes

11. Which of the following best describes the difference between a primary total knee arthroplasty and a revision total knee arthroplasty?

A. A primary replacement involves a first-time prosthetic implant; a revision replaces or modifies a previously implanted prosthesis

B. A primary replacement is always performed under regional anesthesia; a revision requires general anesthesia

C. A primary replacement includes the patella; a revision does not

D. There is no clinical distinction between the two

12. A surgeon performs an open treatment of a bimalleolar ankle fracture with internal fixation of both the medial and lateral malleoli. How should this be coded?

A. A single code for bimalleolar fracture treatment

B. Two open treatment codes with modifier 59 on the second

C. A code for open treatment of the bimalleolar fracture that includes fixation of both malleoli

D. Two separate open treatment codes, one for medial and one for lateral, with modifier 51

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

13. A patient undergoes bronchoscopy with endobronchial biopsy and bronchoalveolar lavage during the same session. How should the diagnostic bronchoscopy be coded?

A. As a separate code with modifier 51

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

C. As a separate code with modifier 59

D. As a separate code with modifier 76

14. A cardiologist removes a malfunctioning transvenous pacemaker lead and inserts a new lead during the same operative session. How should these services be coded?

A. A single code for lead exchange

B. Only the new lead insertion code

C. Only the lead removal code with modifier 22

D. Separate codes for the lead removal and the new lead insertion

15. A surgeon performs a right carotid endarterectomy for symptomatic carotid artery stenosis. During the same session, the surgeon places a temporary internal carotid shunt to maintain cerebral blood flow. How should the shunt be coded?

A. As a separate add-on code

B. As a separate code with modifier 59

C. It is not reported separately; temporary shunting is included in the endarterectomy code

D. As a separate vascular access code

16. Which of the following correctly describes the coding for a pacemaker system that has both atrial and ventricular leads?

A. It is a dual-chamber system

B. It is a single-chamber system

C. It is a biventricular system

D. It is a leadless system

17. A patient undergoes a VATS (video-assisted thoracoscopic surgery) wedge resection of a pulmonary nodule in the right lower lobe. The procedure is converted to an open thoracotomy due to bleeding. Which code should be reported?

A. Both the VATS and the open thoracotomy codes

B. The open thoracotomy wedge resection code only

C. The VATS code with modifier 22

D. The VATS code with modifier 52

18. A surgeon performs a complete axillary lymph node dissection following a positive sentinel lymph node biopsy during a breast cancer excision. The sentinel node biopsy (38900) is an add-on code. Which of the following correctly describes the coding?

A. Only the lymph node dissection code; the sentinel biopsy is bundled

B. Only the sentinel node biopsy code (38900)

C. The sentinel node biopsy (38900) with modifier 51

D. The breast excision code, the sentinel node biopsy add-on code (38900), and the axillary lymph node dissection code

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

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

A. Three separate polypectomy codes, one for each polyp

B. One polypectomy code for all three polyps using the most complex technique

C. One code for the hot biopsy forceps removal and one code for the snare polypectomy, since they represent different techniques

D. One diagnostic colonoscopy code plus one polypectomy code

20. A surgeon performs a laparoscopic Nissen fundoplication for gastroesophageal reflux disease (GERD). What does this procedure accomplish?

A. It wraps the gastric fundus around the lower esophagus to reinforce the lower esophageal sphincter

B. It removes the lower portion of the esophagus

C. It dilates the esophageal stricture

D. It inserts a gastric band for weight loss

21. An EGD is performed and the physician encounters a large bleeding gastric ulcer. The physician performs cauterization to control the bleeding. How should the diagnostic EGD be coded?

A. As a separate code with modifier 59

B. It is not reported separately; it is included in the surgical EGD code for hemostasis

C. As a separate code with modifier 25

D. As a separate code with modifier 51

22. A patient undergoes an incisional hernia repair using an open approach with mesh placement. Which of the following factors determines the CPT code for this repair?

A. Only the hernia type and the use of mesh

B. Only the approach (open vs. laparoscopic)

C. Only the patient's age and BMI

D. The hernia type, whether initial or recurrent, whether incarcerated or strangulated, and the approach

23. A surgeon performs a total colectomy with ileostomy creation for ulcerative colitis. The ileostomy is an integral part of the colectomy procedure. How should the ileostomy be coded?

A. It is included in the colectomy code when described as part of the same procedure

B. As a separate code with modifier 51

C. As a separate code with modifier 59

D. As a separate add-on code

24. A patient undergoes ERCP with placement of a biliary stent and separate sphincterotomy during the same session. How should the diagnostic ERCP and the two surgical procedures be coded?

A. Three separate codes: diagnostic ERCP, stent placement, and sphincterotomy

B. Two codes: stent placement and sphincterotomy only, with modifier 51 on the second

C. Two codes: stent placement and sphincterotomy only; the diagnostic ERCP is bundled into the surgical codes

D. One code for the most complex procedure only

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

25. A urologist performs a cystourethroscopy with dilation of a urethral stricture and a separate biopsy of a suspicious bladder lesion during the same session. How should the diagnostic cystourethroscopy be coded?

A. As a separate code with modifier 51

B. It is not reported separately; it is included in the surgical cystourethroscopy codes

C. As a separate code with modifier 59

D. As a separate code with modifier 25

26. A patient undergoes bilateral ureteroscopy with laser lithotripsy for ureteral calculi. How should the bilateral nature of the procedure be reported?

A. With the procedure code reported bilaterally using modifier 50 or RT/LT modifiers

B. With a single code and no modifier since ureteroscopy codes are inherently bilateral

C. With two separate E/M codes, one for each side

D. With the procedure code and modifier 22

27. A physician provides antepartum care only for a patient who transfers care to another physician before delivery. How should the antepartum care be reported?

A. With the global obstetric delivery code and modifier 52

B. Using individual E/M visit codes for each antepartum visit

C. With the delivery-only code

D. With the antepartum care-only code

28. A surgeon performs a laparoscopic bilateral salpingectomy for sterilization. In CPT, the fallopian tubes are coded using which body system section?

A. Digestive system

B. Urinary system

C. Female genital system (reproductive)

D. Endocrine system

29. A surgeon performs a total thyroidectomy and separately performs a central compartment neck dissection for metastatic papillary thyroid cancer. Are these coded as a single service or separate services?

A. Separate services — the thyroidectomy and the lymph node dissection are reported with separate codes

B. A single service — the neck dissection is included in the thyroidectomy code for malignancy

C. A single service — only the neck dissection code is reported

D. Separate services — but only if the lymph node dissection is performed through a separate incision

30. A patient undergoes transurethral resection of the prostate (TURP) for benign prostatic hyperplasia. Which anatomical approach is used for TURP?

A. Open incision through the lower abdomen

B. A resectoscope is passed through the urethra to access the prostate

C. Percutaneous needle insertion through the perineum

D. Laparoscopic approach through small abdominal incisions

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

31. A neurosurgeon performs a lumbar laminectomy at L4-L5 for decompression of spinal stenosis. No fusion is performed. How is the laminectomy coded?

A. With a fusion code plus a decompression code

B. With a discectomy code

C. With an injection code for the epidural space

D. With a laminectomy/decompression code based on the spinal level

32. An ophthalmologist performs a pars plana vitrectomy for a retinal detachment. What does a vitrectomy involve?

A. Removal of the crystalline lens

B. Destruction of the trabecular meshwork

C. Surgical removal of the vitreous humor from the posterior chamber of the eye

D. Repair of the extraocular muscles

33. A patient with trigeminal neuralgia undergoes a percutaneous radiofrequency ablation of the trigeminal nerve. In CPT, this procedure is classified as which type of nerve procedure?

A. Neurolysis (nerve destruction)

B. Nerve repair

C. Nerve block

D. Nerve graft

34. A neurosurgeon performs a VP shunt revision, replacing the ventricular catheter but leaving the valve and peritoneal catheter in place. How should this be coded?

A. With the complete shunt creation code

B. With the shunt revision code for replacement of the ventricular catheter component

C. With the shunt removal code plus a new shunt insertion code

D. With the complete shunt creation code and modifier 22

35. An ophthalmologist performs strabismus surgery on two horizontal muscles of the right eye. Which factor determines the CPT code for strabismus surgery?

A. The specific diagnosis (esotropia vs. exotropia)

B. The patient's age

C. The specific muscles operated on by name

D. The number of muscles operated on and whether they are horizontal or vertical

36. A patient undergoes cochlear implant surgery. The CPT code for cochlear device implantation (69930) covers which components?

A. The surgical placement of the internal receiver-stimulator and electrode array insertion into the cochlea

B. Both the internal surgical implant and the external speech processor fitting

C. Only the external speech processor programming

D. Only the electrode array insertion without the receiver-stimulator

Evaluation and Management (Questions 37–42)

37. A physician sees a new patient in the office. The encounter involves a problem-focused evaluation of a single uncomplicated problem with no data review and minimal risk. What level of MDM is supported?

A. Low

B. Moderate

C. Straightforward

D. High

38. A patient is admitted to the hospital on March 1st by Dr. Adams. Dr. Baker, a specialist, sees the patient on March 2nd for a consultation requested by Dr. Adams. Dr. Baker evaluates the patient, documents recommendations, and sends a report back to Dr. Adams. Which E/M code set should Dr. Baker use?

A. Subsequent hospital care codes (99231–99233)

B. Initial inpatient consultation codes (99252–99255)

C. Initial hospital care codes (99221–99223)

D. Critical care codes (99291–99292)

39. Under the current E/M documentation guidelines for office visits, which of the following is true regarding the history and physical examination?

A. A comprehensive history and examination are required for level 5 visits

B. Bullet-point documentation of the ROS is required for all levels

C. The physical examination must be documented using the 1995 or 1997 guidelines

D. The history and physical examination are not the determining factors for code level selection; MDM or total time determines the level

40. A physician provides critical care services to a patient in the ICU for 95 total minutes on a single date. How should the critical care be coded?

A. 99291 × 1 (first 74 minutes) plus 99292 × 1 (additional 21 minutes)

B. 99291 × 1 only; 95 minutes does not meet the threshold for a second unit

C. 99291 × 2

D. 99291 × 1 plus 99292 × 2

41. A physician performs a level 3 established patient office visit (99213) and also removes a benign skin lesion (0-day global period) during the same encounter. The E/M is significant and separately identifiable. Which modifier is appended to the E/M code?

A. Modifier 57

B. Modifier 59

C. Modifier 25

D. Modifier 51

42. A patient is seen in the emergency department. The physician determines that a high-level MDM is warranted based on the clinical complexity. Under current ED coding guidelines, which code should be reported?

A. 99285 with documentation of a comprehensive history and exam

B. 99285 based solely on MDM complexity

C. 99215 since high-complexity MDM applies to office visit codes

D. 99291 because high MDM always qualifies for critical care

Anesthesia (Questions 43–46)

43. An anesthesiologist provides general anesthesia for an upper GI endoscopy on a healthy 35-year-old patient (P1). The total anesthesia time is 30 minutes. The payer uses 15-minute time units and assigns no modifying units for P1. Base units for the procedure are 5. What is the total unit calculation?

A. 5 units

B. 8 units

C. 6 units

D. 7 units

44. Which physical status modifier indicates a normal healthy patient with no systemic disease?

A. P1

B. P2

C. P3

D. P4

45. An anesthesiologist provides anesthesia for a procedure lasting 210 minutes on a patient with well-controlled hypertension (P2). The payer uses 15-minute time units and assigns no additional modifying units for P2. Base units are 10. What is the total unit calculation?

A. 23 units

B. 22 units

C. 24 units

D. 25 units

46. A CRNA provides anesthesia services under the medical direction of an anesthesiologist. The anesthesiologist medically directs four concurrent cases. Which modifier should the anesthesiologist append to indicate medical direction?

A. Modifier AA

B. Modifier QY

C. Modifier QX

D. Modifier QZ

Radiology (Questions 47–52)

47. A patient undergoes a CT of the chest with intravenous contrast. What does "with contrast" mean in CPT radiology coding?

A. Contrast administered intravenously or by injection — not oral contrast alone

B. Any type of contrast including oral, rectal, or intravenous

C. Contrast administered orally only

D. Contrast administered rectally only

48. A radiologist performs and interprets a screening mammogram in a private imaging center that the radiologist owns. The radiologist owns the equipment and employs the technologist. Which modifier should be appended?

A. Modifier 26

B. Modifier TC

C. Modifier 59

D. No modifier; the global service is reported

49. A patient undergoes a DEXA bone density scan of the lumbar spine and hip. What does DEXA measure?

A. Blood flow to the bone

B. The size of bone lesions

C. Bone mineral density

D. Joint space width

50. A patient undergoes a PET/CT scan for cancer staging. Which of the following correctly describes PET/CT fusion imaging?

A. PET provides anatomical detail while CT provides metabolic information

B. PET provides metabolic activity information while CT provides anatomical detail

C. Both PET and CT provide identical information

D. PET/CT is used only for cardiac evaluation

51. In radiation oncology, treatment planning code 77263 represents which level of complexity?

A. Complex planning (three or more treatment areas, custom shielding, multiple modalities)

B. Simple planning (single treatment area, single port)

C. Intermediate planning (two separate treatment areas)

D. No planning is required for this code

52. A hospital performs an abdominal ultrasound on an inpatient. The ultrasound is performed by a hospital sonographer, and a radiologist employed by a separate radiology group interprets the images. How is this billed?

A. The hospital bills the global code

B. The radiologist bills the global code

C. Only the hospital bills; the radiologist's interpretation is included

D. The hospital bills with modifier TC, and the radiologist bills with modifier 26

Pathology and Laboratory (Questions 53–58)

53. A physician orders a comprehensive metabolic panel (CMP) and a lipid panel on the same specimen for the same patient. The CMP includes albumin. The lipid panel does not include albumin. How should both panels be reported?

A. Only the CMP code; the lipid panel is included

B. Both panel codes — the CMP and the lipid panel are separate panels with no overlapping components

C. The CMP code plus individual codes for each lipid test

D. Only the lipid panel code; the CMP is bundled

54. A pathologist examines a prostate needle biopsy specimen. At which level of surgical pathology is a prostate needle biopsy classified?

A. Level III (88304)

B. Level V (88307)

C. Level IV (88305)

D. Level VI (88309)

55. A laboratory performs a definitive drug test for benzodiazepines identifying 4 specific analytes and a definitive test for opiates identifying 6 analytes. How many definitive drug testing codes should be reported?

A. Two codes — one for benzodiazepines (4 analytes) and one for opiates (6 analytes)

B. One code for both drug classes combined

C. Ten codes, one for each individual analyte

D. One code per date of service

56. A patient has blood drawn at the physician's office and the specimen is sent to an outside reference laboratory for a thyroid panel. Who bills for the laboratory test?

A. The physician's office bills for the test with modifier 90

B. Both the physician's office and the reference laboratory bill for the test

C. The physician's office bills for the blood draw; the reference laboratory bills for the test

D. The performing reference laboratory bills for the test; the physician's office does not bill for the test performance

57. A Pap smear is performed and examined using automated thin-layer preparation with manual rescreening under physician supervision. Which section of CPT contains the cytopathology codes for Pap smears?

A. Medicine section

B. Pathology and Laboratory section

C. Surgery section

D. Radiology section

58. An immunohistochemistry panel using 8 antibodies is performed on a colon cancer specimen. How should the IHC be coded?

A. One code for the complete 8-antibody panel

B. 88342 × 8

C. 88342 × 1 for the first antibody plus 88341 × 7 for each additional antibody

D. Eight separate pathology consultation codes

Medicine (Questions 59–64)

59. A patient receives a 2-hour IV infusion of a chemotherapy agent followed by a 30-minute IV push of a different chemotherapy drug on the same date. According to the infusion hierarchy, which service is reported as the initial service?

A. The IV push, because it was administered second

B. Each is reported as a separate initial service

C. Neither; both are reported as add-on codes

D. The chemotherapy infusion, because infusion outranks push in the hierarchy

60. A 10-year-old patient receives one injection of the influenza vaccine during an office visit. The physician provides face-to-face counseling about the vaccine. How should the vaccine administration be coded?

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

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

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

D. 90461 × 1 (additional component code)

61. A patient undergoes hemodialysis. During the session, the patient develops severe hypotension requiring the physician to evaluate and adjust the dialysis prescription twice. Which hemodialysis code should be reported?

A. 90935 (single physician evaluation)

B. 90937 (repeated physician evaluations with or without substantial revision of the dialysis prescription)

C. Two units of 90935

D. An E/M code instead of a hemodialysis procedure code

62. A therapist provides 30 minutes of therapeutic exercise (97110) and 8 minutes of neuromuscular reeducation (97112) during the same session. Using the 8-minute rule, how many total units are reported?

A. 3 units (2 of 97110, 1 of 97112)

B. 2 units of 97110 only; 97112 does not meet the threshold

C. 3 units — the total treatment time of 38 minutes divided by 15 equals 2.5, rounded up to 3 units, allocated based on actual time spent

D. 1 unit of 97110 and 1 unit of 97112

63. A psychiatrist provides 50 minutes of psychotherapy to an established patient. No E/M services are provided. Which standalone psychotherapy code should be reported?

A. 90832 (30 minutes)

B. 90836 (45-minute add-on)

C. 90833 (30-minute add-on)

D. 90834 (45 minutes)

64. An allergist performs intradermal allergy testing using 20 allergen extracts. How is the testing coded?

A. 20 units of the appropriate intradermal testing code, one per allergen

B. One unit of the intradermal code regardless of the number of allergens

C. With a panel code for intradermal testing

D. 10 units of the intradermal code, with two allergens per unit

Medical Terminology (Questions 65–68)

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

A. Surgical removal

B. Visual examination

C. Surgical repair or reconstruction

D. Incision into

66. Which combining form refers to the liver?

A. Nephr/o

B. Hepat/o

C. Cardi/o

D. Pneum/o

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

A. Below or under

B. Above or over

C. Around

D. Between

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

A. Difficulty breathing

B. Difficulty speaking

C. Excessive urination

D. Difficulty swallowing

Anatomy (Questions 69–72)

69. The pancreas serves both endocrine and exocrine functions. Which of the following is an endocrine function of the pancreas?

A. Secretion of digestive enzymes into the duodenum

B. Production of insulin and glucagon

C. Production of bile

D. Absorption of nutrients from the small intestine

70. Which of the following structures is the functional unit of the lung where gas exchange occurs?

A. Bronchioles

B. Trachea

C. Alveoli

D. Bronchi

71. The femur is classified as which type of bone?

A. Long bone

B. Short bone

C. Flat bone

D. Irregular bone

72. Which organ produces bile?

A. Gallbladder

B. Pancreas

C. Stomach

D. Liver

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

73. A patient presents with chest pain. After evaluation, the physician documents "chest pain, unspecified." The physician does not confirm any underlying cardiac or pulmonary condition. In the outpatient setting, which code should be reported?

A. A code for myocardial infarction

B. A code for angina pectoris

C. R07.9 (Chest pain, unspecified)

D. A code for costochondritis

74. An Excludes2 note in ICD-10-CM indicates which of the following?

A. The two conditions are mutually exclusive and cannot be coded together

B. The excluded condition is not included in the code but may coexist, and both codes may be reported together

C. The excluded condition replaces the primary code

D. The excluded condition is always sequenced first

75. A patient has both Type 2 diabetes mellitus and diabetic chronic kidney disease stage 4. How should this be coded under ICD-10-CM guidelines?

A. A code from E11 with the appropriate kidney complication code, plus an additional code from N18 for the CKD stage

B. Only the CKD stage code (N18.4)

C. Only the diabetes code without specifying the kidney complication

D. A code from I12 (hypertensive CKD) plus the diabetes code

76. In ICD-10-CM, the 7th character "S" on an injury code indicates which of the following?

A. Subsequent encounter for routine healing care

B. Initial encounter with active treatment

C. Screening encounter

D. Sequela — a residual condition resulting from the previous injury after healing

77. A patient undergoes a screening colonoscopy and is found to have a family history of colon cancer. Which Z code category is used to report the family history?

A. Z12 (Encounter for screening for malignant neoplasm)

B. Z85 (Personal history of malignant neoplasm)

C. Z80 (Family history of primary malignant neoplasm)

D. Z87 (Personal history of other diseases)

HCPCS Level II (Questions 78–80)

78. Which HCPCS Level II code range is used to report orthotics and prosthetic devices?

A. L0000–L9999

B. E0100–E9999

C. J0000–J9999

D. A4000–A8999

79. A Medicare patient receives a covered preventive service that does not require cost-sharing (no copay or deductible). Which modifier may be appended to identify the preventive service?

A. Modifier GZ

B. Modifier 33

C. Modifier GA

D. Modifier QW

80. A provider administers an injection of ketorolac (Toradol) 60 mg intramuscularly in the office. The HCPCS J-code for ketorolac covers 15 mg per unit. How many units of the J-code should be reported?

A. 1 unit

B. 2 units

C. 3 units

D. 4 units

Coding Guidelines (Questions 81–87)

81. When a CPT code is designated as "modifier 51 exempt," what does this mean?

A. The code requires modifier 51 when reported with other procedures

B. The code cannot be reported with any other procedure

C. The code is not subject to the multiple procedure payment reduction and does not require modifier 51

D. The code must always be reported alone

82. A surgeon performs a planned return to the operating room during the postoperative period for a staged procedure related to the original surgery. Which modifier should be appended?

A. Modifier 58

B. Modifier 78

C. Modifier 79

D. Modifier 76

83. Under the NCCI, which of the following best describes the purpose of Medically Unlikely Edits (MUEs)?

A. To prevent reporting of two different procedures on the same date

B. To establish the maximum number of units of a service that a provider can report for a single patient on a single date of service

C. To bundle all related procedures into one code

D. To determine which modifier is required for each procedure

84. A global surgical period of 90 days applies to which category of procedures?

A. Minor procedures

B. Endoscopic procedures only

C. E/M services only

D. Major surgical procedures

85. A patient requires a return to the operating room during the postoperative period for treatment of a complication of the original surgery. Which modifier should be appended?

A. Modifier 78

B. Modifier 58

C. Modifier 79

D. Modifier 76

86. In CPT, which appendix contains the complete list of add-on codes?

A. Appendix A (Modifiers)

B. Appendix B (Summary of Additions, Deletions, and Revisions)

C. Appendix D (Summary of CPT Add-On Codes)

D. Appendix C (Clinical Examples)

87. A physician performs two separate surgical procedures through separate incisions on separate anatomical sites during the same operative session. Both procedures have separate NCCI edits with modifier indicator 1. Which modifier should be appended to the second procedure to bypass the edit?

A. Modifier 51

B. Modifier 59 (or the appropriate X modifier)

C. Modifier 25

D. Modifier 22

Compliance and Regulatory (Questions 88–90)

88. Which federal law prohibits offering, paying, soliciting, or receiving anything of value to induce referrals of patients covered by federal healthcare programs?

A. The False Claims Act

B. The Stark Law

C. HIPAA

D. The Anti-Kickback Statute

89. The OIG publishes an annual Work Plan that identifies targeted areas for investigation. Why is the OIG Work Plan important for medical coders?

A. It identifies high-risk billing areas that are likely to be audited, allowing practices to proactively review their compliance in those areas

B. It provides a list of all approved CPT codes for the year

C. It determines the conversion factor for the Medicare Physician Fee Schedule

D. It establishes the timely filing deadlines for all payers

90. A medical practice discovers through an internal audit that it has been systematically upcoding E/M services for the past two years. Under an effective compliance program, what should the practice do?

A. Ignore the findings if the total amount is under $10,000

B. Destroy the audit records to prevent external discovery

C. Promptly investigate, quantify the overpayments, initiate refunds to affected payers, and implement corrective action to prevent recurrence

D. Continue billing at the same level until an external audit occurs

Cases — Integrated Coding Scenarios (Questions 91–100)

Case 1 (Questions 91–92):

A 58-year-old patient undergoes a laparoscopic cholecystectomy for acute cholecystitis with cholelithiasis. Intraoperative cholangiography is not performed. The procedure is completed laparoscopically without conversion to an open approach.

91. Which CPT code should be reported for this procedure?

A. Open cholecystectomy

B. Laparoscopic cholecystectomy without cholangiography

C. Laparoscopic cholecystectomy with cholangiography

D. Laparoscopic cholecystectomy with exploration of the common bile duct

92. The patient has acute cholecystitis with cholelithiasis. Under ICD-10-CM, how should this be coded?

A. Two separate codes: one for acute cholecystitis and one for cholelithiasis

B. K80.00 (Cholelithiasis with acute cholecystitis without obstruction) or the appropriate combination code

C. Only the cholelithiasis code

D. A combination code from category K80 that captures both the cholelithiasis and the acute cholecystitis in a single code

Case 2 (Questions 93–94):

A 72-year-old established patient sees her primary care physician for an annual wellness visit. During the visit, the physician also evaluates the patient's worsening knee pain and orders an X-ray of the right knee. The knee evaluation involves moderate-level MDM.

93. Which code(s) should be reported for this encounter?

A. The preventive medicine code plus an E/M code (99214) with modifier 25

B. Only the E/M code (99214); the preventive visit is included

C. Only the preventive medicine code; the knee evaluation is included

D. The E/M code (99214) with modifier 57

94. What is the appropriate first-listed diagnosis code for the preventive medicine service?

A. M17.11 (Primary osteoarthritis, right knee)

B. M25.561 (Pain in right knee)

C. The appropriate Z code for the wellness visit (e.g., Z00.00 or Z00.01)

D. R29.898 (Other symptoms involving the musculoskeletal system)

Case 3 (Questions 95–96):

A pain management physician performs a right L4-L5 transforaminal epidural steroid injection under fluoroscopic guidance. The injection code includes imaging guidance. The patient also receives a right L3-L4 paravertebral facet joint injection during the same session.

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

A. With a separate fluoroscopy code and modifier 26

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

C. With a separate fluoroscopy code and modifier 59

D. With a separate fluoroscopy code and modifier TC

96. The facet joint injection at L3-L4 is a distinct service from the transforaminal injection at L4-L5. Can both injection codes be reported on the same date?

A. No; only one spinal injection is allowed per date of service

B. No; the facet injection is always bundled into the transforaminal injection

C. Yes, but only with modifier 51 and no other modifier

D. Yes; both may be reported with appropriate modifiers (modifier 59 or XS) to indicate distinct services

Case 4 (Questions 97–98):

A surgeon performs a right inguinal hernia repair on a 5-year-old child. The hernia is reducible and this is the initial repair. The surgeon provides all postoperative care.

97. Which factor specific to pediatric inguinal hernia coding distinguishes the code from adult hernia codes?

A. The patient's age (pediatric codes exist for patients under a certain age, typically under 6 months or 6 months to 5 years)

B. The use of mesh

C. The specific type of suture material

D. The operating room facility type

98. The surgeon also provided a separately identifiable E/M service that led to the decision to perform the surgery on the same date. The hernia repair has a 90-day global period. Which modifier should be appended to the E/M code?

A. Modifier 25

B. Modifier 57

C. Modifier 59

D. Modifier 24

Case 5 (Questions 99–100):

A patient undergoes a right total knee arthroplasty. The anesthesiologist provides general anesthesia. Total anesthesia time is 165 minutes. The patient is classified as P3 (poorly controlled diabetes and morbid obesity). The payer uses 15-minute time units and assigns 1 modifying unit for P3. Base units for the procedure are 7.

99. What is the total number of anesthesia units?

A. 17 units

B. 18 units

C. 19 units

D. 20 units

100. If the same anesthesiologist also provided anesthesia for a second unrelated procedure on the same patient the following day, how would the second day's anesthesia be coded?

A. With the same anesthesia code and modifier 76

B. With the same base units and time units as the first day

C. As a duplicate claim with modifier 91

D. With the appropriate anesthesia code for the second procedure, calculated independently with its own base units, time units, and modifying units

SIMULATION EXAM 3 — ANSWER KEY WITH EXPLANATIONS

10,000 Series — Integumentary System

1. **D. 3.5 cm** The excised diameter is calculated as lesion diameter plus margins on both sides: 1.5 cm + (1.0 cm × 2) = 3.5 cm. Wide margins are common with malignant melanoma due to the aggressive nature of the cancer. The margin is always doubled because normal tissue is removed circumferentially around the entire lesion.
2. **B. By the square centimeter area of the recipient site (defect)** Skin graft codes — both split-thickness and full-thickness — are measured by the square centimeter area of the recipient site (the defect being covered), not the donor site. The defect size determines the code because it reflects the amount of graft material needed and the complexity of the reconstruction. A 15 sq cm defect would be coded based on that measurement.
3. **C. One simple repair code for 5.0 cm and one intermediate repair code for 3.0 cm** Wounds of different repair classifications cannot be combined. The simple repair on the scalp (5.0 cm) is reported with one simple repair code, and the intermediate repair on the forearm (3.0 cm) is reported with one intermediate repair code. Only wounds of the same classification and same anatomical grouping are added together.
4. **A. Subcutaneous tissue and/or superficial fascia** Intermediate repair requires layered closure of one or more deeper layers of subcutaneous tissue and/or superficial fascia in addition to the skin closure. Simple repair involves only single-layer skin closure. Complex repair involves techniques beyond layered closure such as undermining, stents, retention sutures, or tissue rearrangement.
5. **D. 17311 × 1, 17312 × 1** Code 17311 covers the first stage of Mohs surgery (up to 5 tissue blocks — stage 1 had 3 blocks, within the limit). Code 17312 is reported for each additional stage (stage 2 = 1 unit). No tissue blocks in any single stage exceeded 5, so code 17315 (each additional block beyond 5 in a single stage) is not reported.
6. **B. 17004** When 15 or more actinic keratoses are destroyed, only the flat code 17004 is reported. This single code replaces all other codes in the premalignant lesion destruction series. Codes 17000 and 17003 are not reported in addition to 17004. With 22 lesions, 17004 is the only code needed.

20,000 Series — Musculoskeletal System

7. **A. The code reflects a lower complexity treatment because no reduction was performed** Closed treatment without manipulation means the fracture is treated with immobilization (splint

or cast) only — no reduction or realignment of the fracture fragments is performed. This is the simplest form of fracture treatment and carries the lowest RVU. Treatment with manipulation involves manually reducing the fracture, which is more complex and has a separate, higher-valued code.

8. **C. It depends on whether the decompression is considered integral to the rotator cuff repair or a distinct service per NCCI guidelines** Whether subacromial decompression is separately reportable with arthroscopic rotator cuff repair depends on NCCI edits and the clinical documentation. In many cases, subacromial decompression performed through the same portal is considered integral to the rotator cuff repair and is bundled. However, if it is a distinct service with separate clinical justification, it may be reported with modifier 59. The coder must check the current NCCI edits.
9. **B. As a separate category of treatment with its own code structure** External fixation has its own code structure in CPT. The application of an external fixation device is coded separately from the fracture treatment code. External fixation is not classified as open treatment (the fracture site is not surgically exposed), closed treatment, or percutaneous fixation — it is a distinct category with dedicated codes (20690–20697).
10. **D. Two add-on codes** Three interspaces are being fused (L3-L4, L4-L5, and L5-S1). The primary fusion code covers the first interspace, and add-on codes are reported for each additional interspace. Three interspaces minus one primary = two add-on codes. Instrumentation (pedicle screws) is coded separately from the fusion using the appropriate spinal instrumentation codes.
11. **A. A primary replacement involves a first-time prosthetic implant; a revision replaces or modifies a previously implanted prosthesis** Primary arthroplasty is the initial placement of a joint prosthesis in a native joint. Revision arthroplasty involves removing, replacing, or modifying a previously implanted prosthesis that has failed due to wear, loosening, infection, or fracture. Revision procedures are more complex due to scar tissue, bone loss, and removal of the existing hardware, and they carry higher RVU values.
12. **C. A code for open treatment of the bimalleolar fracture that includes fixation of both malleoli** CPT provides specific codes for bimalleolar ankle fracture treatment that include fixation of both malleoli in a single code. The coder should not unbundle a bimalleolar fracture into two separate fracture codes (one for medial, one for lateral). The bimalleolar code captures the complete treatment as a single service.

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

13. **B. It is not reported separately; it is included in the surgical bronchoscopy codes** Diagnostic bronchoscopy is always bundled into surgical bronchoscopy when both are performed during the same session. The endobronchial biopsy and bronchoalveolar lavage are separate surgical bronchoscopic procedures, each reported with their own code. The diagnostic examination is included in the surgical codes and is not reported separately.

14. **D. Separate codes for the lead removal and the new lead insertion** When a pacemaker lead is removed and a new lead is inserted during the same session, both the removal and the insertion are coded separately. CPT provides distinct codes for lead removal (33234–33235) and lead insertion (33216–33217). This is not a "lead exchange" — each component is coded individually.
15. **C. It is not reported separately; temporary shunting is included in the endarterectomy code** Temporary internal carotid shunting performed during a carotid endarterectomy is included in the endarterectomy code (35301). The shunt is placed to maintain cerebral blood flow while the artery is clamped and is considered an integral part of the surgical technique. It is not a separately reportable service.
16. **A. It is a dual-chamber system** A pacemaker system with both an atrial lead and a ventricular lead is classified as a dual-chamber system. A single-chamber system has one lead in either the atrium or the ventricle. A biventricular (CRT) system has leads in both ventricles plus the right atrium. Leadless pacemakers have no transvenous leads. The number of chambers being paced determines the system classification.
17. **B. The open thoracotomy wedge resection code only** When a VATS procedure is converted to an open thoracotomy, only the open procedure code is reported. The abandoned VATS approach is not coded separately. This follows the same rule that applies to laparoscopic-to-open conversions throughout CPT — the final approach determines the code.
18. **D. The breast excision code, the sentinel node biopsy add-on code (38900), and the axillary lymph node dissection code** All three services are reported. The breast excision is the primary procedure. The sentinel node biopsy (38900) is an add-on code reported with the primary tumor excision. The complete axillary lymph node dissection is a separate procedure performed after the positive sentinel node result and is reported with its own code. These are three distinct surgical services.

40,000 Series — Digestive System

19. **C. One code for the hot biopsy forceps removal and one code for the snare polypectomy, since they represent different techniques** When polyps are removed using different techniques during the same colonoscopy, each technique is reported with its own code. The hot biopsy forceps removal and the snare polypectomy have different CPT codes because they represent different levels of complexity. The diagnostic colonoscopy is bundled into the surgical codes. Multiple polyps removed with the same technique are reported with a single code for that technique.
20. **A. It wraps the gastric fundus around the lower esophagus to reinforce the lower esophageal sphincter** A Nissen fundoplication wraps the gastric fundus 360 degrees around the distal esophagus to create a mechanical barrier that prevents gastric acid from refluxing into the esophagus. This reinforces the lower esophageal sphincter and is the standard surgical treatment for GERD that does not respond to medical management.

21. **B. It is not reported separately; it is included in the surgical EGD code for hemostasis** When a surgical procedure (cauterization for hemostasis) is performed during an EGD, only the surgical EGD code is reported. The diagnostic examination is bundled into the surgical code. Reporting both the diagnostic EGD and the surgical EGD constitutes unbundling.
22. **D. The hernia type, whether initial or recurrent, whether incarcerated or strangulated, and the approach** CPT codes for ventral/incisional hernia repair are determined by the hernia type (incisional), whether the repair is initial or recurrent, whether the hernia is incarcerated or strangulated, and the surgical approach (open vs. laparoscopic). All of these factors affect code selection. The use of mesh alone does not change the CPT code.
23. **A. It is included in the colectomy code when described as part of the same procedure** When a total colectomy includes creation of an ileostomy as an integral part of the procedure, the ileostomy is included in the colectomy code. CPT provides specific colectomy codes that include ileostomy creation (such as 44150–44158). The coder should read the complete code description to verify that the ileostomy is included before determining whether it should be coded separately.
24. **C. Two codes: stent placement and sphincterotomy only; the diagnostic ERCP is bundled into the surgical codes** The diagnostic ERCP is bundled into the surgical ERCP codes when surgical procedures are performed during the same session. Both the biliary stent placement and the sphincterotomy are separately reportable surgical ERCP procedures, each with their own code. The diagnostic examination is included and is not reported as a third code.

50,000 Series — Urinary, Reproductive, and Endocrine

25. **B. It is not reported separately; it is included in the surgical cystourethroscopy codes** Diagnostic cystourethroscopy is bundled into surgical cystourethroscopy when both are performed during the same session. The urethral dilation and the bladder biopsy are both surgical procedures. The diagnostic examination that precedes the surgical interventions is included in each surgical code and is not reported separately.
26. **A. With the procedure code reported bilaterally using modifier 50 or RT/LT modifiers** Ureteroscopy codes are unilateral procedures. When performed bilaterally, the procedure is reported with modifier 50 (bilateral procedure) or on two separate lines with modifiers RT and LT. The payer's specific requirements determine which reporting method is used. A single code without a laterality modifier would indicate only one side was treated.
27. **D. With the antepartum care-only code** When a physician provides only antepartum care and another physician performs the delivery, the antepartum-only code is reported. CPT provides separate codes for antepartum care only, delivery only, and postpartum care only to accommodate split obstetric care. Individual E/M visit codes would only be used if fewer than 4 antepartum visits were provided.

28. **C. Female genital system (reproductive)** The fallopian tubes are part of the female reproductive system. CPT codes for fallopian tube procedures — including salpingectomy, tubal ligation, and salpingostomy — are found in the female genital system subsection (58600–58770) of the surgery section. The uterus, ovaries, and vagina are also coded under this subsection.

29. **A. Separate services — the thyroidectomy and the lymph node dissection are reported with separate codes** The total thyroidectomy and the central compartment lymph node dissection are distinct procedures reported with separate CPT codes. The lymph node dissection is not included in the thyroidectomy code. These procedures address different structures (thyroid gland vs. lymph nodes) and have separate surgical objectives, even when performed through the same or adjacent incisions.

30. **B. A resectoscope is passed through the urethra to access the prostate** TURP is a transurethral procedure — a resectoscope is passed through the urethra to access the prostate gland. Obstructing prostate tissue is resected from within the gland using an electrosurgical loop. No external incision is made. This is fundamentally different from open prostatectomy (abdominal incision) and laparoscopic prostatectomy (abdominal ports).

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

31. **D. With a laminectomy/decompression code based on the spinal level** A lumbar laminectomy for decompression of spinal stenosis without fusion is coded using the appropriate laminectomy/decompression code for the lumbar spine. The code is based on the spinal level and the approach. When no fusion is performed, only the decompression code is reported. If fusion were also performed, separate codes for both the decompression and the fusion would be reported.

32. **C. Surgical removal of the vitreous humor from the posterior chamber of the eye** A vitrectomy is the surgical removal of the vitreous humor — the gel that fills the posterior chamber of the eye. The vitreous is removed and replaced with gas, silicone oil, or saline. Vitrectomy is performed for retinal detachment repair, vitreous hemorrhage, macular hole, and epiretinal membrane. It is not a lens procedure, glaucoma procedure, or muscle surgery.

33. **A. Neurolysis (nerve destruction)** Radiofrequency ablation of the trigeminal nerve is classified as neurolysis — the destruction of nerve tissue to relieve pain. Neurolysis codes (64600–64681) cover nerve destruction by chemical, thermal, or surgical methods. A nerve block is a temporary injection that interrupts pain signals. Nerve repair reconnects severed nerves. Nerve grafting bridges a gap between nerve ends.

34. **B. With the shunt revision code for replacement of the ventricular catheter component** VP shunt revision codes distinguish between replacement of specific components — the ventricular catheter, the valve, or the distal (peritoneal) catheter. Since only the ventricular catheter was replaced while the other components were left intact, the revision code for ventricular catheter replacement is reported. The complete shunt creation code would be incorrect because this is not a new system.

35. **D. The number of muscles operated on and whether they are horizontal or vertical** Strabismus surgery CPT codes are based on the number of muscles operated on (one, two, or more) and whether the muscles are horizontal (medial or lateral rectus) or vertical (superior or inferior rectus, oblique muscles). The codes are not based on the specific diagnosis (esotropia vs. exotropia), the patient's age, or the individual muscle names.
36. **A. The surgical placement of the internal receiver-stimulator and electrode array insertion into the cochlea** CPT code 69930 covers the surgical implantation of the internal components of the cochlear implant — the receiver-stimulator placed under the skin behind the ear and the electrode array threaded into the cochlea. The fitting and programming of the external speech processor is a separate service performed after surgical healing and is coded using audiology codes in the Medicine section.

Evaluation and Management

37. **C. Straightforward** A single uncomplicated problem with no data review and minimal risk meets the criteria for straightforward MDM. This supports code 99202 for a new patient or 99212 for an established patient. Low MDM would require at least two or more problems, limited data, or low-risk management. Straightforward is the lowest level of MDM.
38. **B. Initial inpatient consultation codes (99252–99255)** Dr. Baker is providing a consultation — there is a documented request from Dr. Adams, Dr. Baker renders an opinion, and a report is sent back to the requesting physician. The initial inpatient consultation codes are used when all three consultation criteria are met. Subsequent hospital care codes would be used for follow-up visits by the admitting physician, not for consultations.
39. **D. The history and physical examination are not the determining factors for code level selection; MDM or total time determines the level** Under the current (2021+) E/M guidelines for office and outpatient visits, the code level is determined by either medical decision-making or total time. While a medically appropriate history and examination must still be performed and documented, they are no longer the determining factors for code level selection. The 1995/1997 documentation guidelines for history and exam no longer dictate code level.
40. **A. 99291 × 1 (first 74 minutes) plus 99292 × 1 (additional 21 minutes)** Critical care code 99291 covers the first 30–74 minutes. Code 99292 covers each additional 30 minutes beyond the first 74 minutes. For 95 total minutes: 99291 × 1 (first 74 minutes) plus 99292 × 1 (the remaining 21 minutes — which falls in the 15–44 minute range for the first additional unit). A second unit of 99292 would require at least 15 more minutes.
41. **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. The benign lesion removal has a 0-day global period, making modifier 25 the correct choice. Modifier 57 would only be used for major procedures with a 90-day global period.

42. **B. 99285 based solely on MDM complexity** Emergency department E/M codes (99281–99285) are selected based solely on MDM complexity. High-complexity MDM supports 99285. Unlike office visit codes, ED codes do not have a time-based pathway and do not distinguish between new and established patients. High MDM does not automatically qualify for critical care — critical care requires direct personal management of a life-threatening condition.

Anesthesia

43. **D. 7 units** Base units (5) + Time units (30 minutes ÷ 15 minutes/unit = 2.0) + Modifying units (P1 = 0) = 7.0 total units. Physical status P1 (normal healthy patient) does not add modifying units. The calculation is straightforward: 5 + 2 + 0 = 7.
44. **A. P1** Physical status P1 indicates a normal healthy patient with no organic, physiological, or psychiatric disturbance. P2 indicates mild systemic disease. P3 indicates severe systemic disease. P4 indicates severe systemic disease that is a constant threat to life. P5 indicates a moribund patient not expected to survive without the operation.
45. **C. 24 units** Base units (10) + Time units (210 minutes ÷ 15 minutes/unit = 14.0) + Modifying units (P2 = 0, as most payers do not assign additional units for P2) = 24.0 total units. P2 (well-controlled hypertension) typically does not generate additional modifying units. The calculation: 10 + 14 + 0 = 24.
46. **B. Modifier QY** Modifier QY indicates medical direction of a CRNA by an anesthesiologist. When an anesthesiologist medically directs one to four concurrent cases, modifier QY is appended to the anesthesiologist's claim. Modifier QX is appended to the CRNA's claim to indicate services provided under medical direction. Modifier AA indicates the anesthesiologist personally performed the entire service.

Radiology

47. **A. Contrast administered intravenously or by injection — not oral contrast alone** In CPT radiology coding, "with contrast" specifically means contrast administered intravenously or by injection (intrathecal, intra-articular). Oral or rectal contrast alone does not qualify as "with contrast." A CT performed with oral contrast only is coded as "without contrast." IV contrast must be administered for the "with contrast" code designation.
48. **D. No modifier; the global service is reported** When a radiologist owns the imaging center, employs the technologist, and performs both the technical and professional components, the global code is reported without any modifier. Modifier 26 would only apply if the radiologist provided only the interpretation. Modifier TC would only apply if the facility provided only the technical component.
49. **C. Bone mineral density** DEXA (dual-energy X-ray absorptiometry) measures bone mineral density to diagnose osteoporosis and assess fracture risk. It uses two X-ray beams at different

energy levels to calculate bone density at the spine, hip, or peripheral sites. DEXA does not measure blood flow, lesion size, or joint space width.

50. **B. PET provides metabolic activity information while CT provides anatomical detail** PET/CT fusion combines two complementary imaging modalities. PET detects metabolic activity using radioactive tracers (FDG) — cancer cells with high metabolic rates show increased tracer uptake. CT provides detailed anatomical images showing the size, shape, and location of structures. The fusion of both datasets shows where abnormal metabolic activity is occurring within the patient's anatomy.

51. **A. Complex planning (three or more treatment areas, custom shielding, multiple modalities)** Treatment planning code 77263 represents the highest complexity level — complex planning involving three or more treatment areas, complex blocking, custom shielding, and/or the use of multiple treatment modalities. Code 77261 covers simple planning, and 77262 covers intermediate planning. The complexity level reflects the physician work required to design the treatment course.

52. **D. The hospital bills with modifier TC, and the radiologist bills with modifier 26** When the technical component (equipment, sonographer) is provided by the hospital and the professional component (interpretation and report) is provided by a separate radiologist, each entity bills for their component. The hospital appends modifier TC, and the radiologist appends modifier 26. The sum of both components equals the global service value.

Pathology and Laboratory

53. **B. Both panel codes — the CMP and the lipid panel are separate panels with no overlapping components** The CMP and the lipid panel do not share overlapping component tests — they measure completely different analytes. The CMP includes metabolic and liver markers. The lipid panel includes cholesterol, HDL, triglycerides, and LDL. Since there is no overlap, both panel codes are reported in full. The coder should always compare panel components to check for overlap before reporting multiple panels.

54. **C. Level IV (88305)** A prostate needle biopsy is classified at Level IV surgical pathology (88305). Level IV is the most commonly reported level and covers most diagnostic biopsies including prostate needle biopsy, breast biopsy (without complete margin assessment), lymph node biopsy, cervix biopsy, and skin excision specimens. Level V would apply to more complex specimens requiring complete margin evaluation.

55. **A. Two codes — one for benzodiazepines (4 analytes) and one for opiates (6 analytes)** Definitive drug testing codes are reported per drug class, with the specific code selected based on the number of analytes identified within each class. Two drug classes require two separate codes — one for benzodiazepines (selecting the code for 3–4 analytes) and one for opiates (selecting the code for 5 or more analytes). Each drug class is coded independently.

56. **D. The performing reference laboratory bills for the test; the physician's office does not bill for the test performance** The performing laboratory bills the payer directly for laboratory tests. The physician's office does not bill for tests performed by an outside reference laboratory — even though the physician ordered the test and will interpret the results clinically. The physician may bill for the venipuncture (blood draw) if performed in the office, but the test performance is billed by the lab.

57. **B. Pathology and Laboratory section** Cytopathology codes for Pap smears (88141–88167) are located in the Pathology and Laboratory section of CPT. Cytopathology is a subspecialty of pathology that involves the microscopic examination of individual cells. The codes cover both the technical preparation/screening and the physician interpretation of cervical and vaginal cytology specimens.

58. **C. 88342 × 1 for the first antibody plus 88341 × 7 for each additional antibody** Immunohistochemistry is coded per antibody per specimen. Code 88342 is reported for the first antibody stain procedure, and code 88341 (add-on) is reported for each additional antibody. Eight antibodies require 88342 × 1 plus 88341 × 7. There is no panel code for multiple antibodies — each is counted individually using the primary-plus-add-on structure.

Medicine

59. **D. The chemotherapy infusion, because infusion outranks push in the hierarchy** The infusion hierarchy places chemotherapy infusion at the highest level. When both a chemotherapy infusion and a chemotherapy push are provided on the same date, the infusion is reported as the initial service (96413) because it outranks the push. The IV push of the second chemotherapy drug is reported as an add-on (96411). Only one initial service is reported per encounter.

60. **A. 90460 × 1 (pediatric component-based code for the first antigen component)** For a patient through 18 years of age with physician counseling, the pediatric component-based administration codes are used. The influenza vaccine contains one antigen component, so only 90460 × 1 is reported for the administration. Code 90461 would be reported for each additional component within a multi-component vaccine — but influenza has only one component.

61. **B. 90937 (repeated physician evaluations with or without substantial revision of the dialysis prescription)** Code 90937 is reported when the physician must evaluate the patient more than once during a hemodialysis session — typically due to complications requiring adjustment of the treatment. The patient developed hypotension requiring two separate evaluations and prescription adjustments. Code 90935 covers a single evaluation during the session.

62. **C. 3 units — the total treatment time of 38 minutes divided by 15 equals 2.5, rounded up to 3 units, allocated based on actual time spent** The 8-minute rule considers total treatment time across all timed services. Total time is 38 minutes (30 + 8). At 15 minutes per unit, 38 minutes supports either 2 or 3 units. Since 38 minutes exceeds the midpoint for 3 units (37.5 minutes), 3

total units are appropriate. They are allocated based on actual time: 2 units to 97110 (30 minutes) and 1 unit to 97112 (8 minutes, which meets the 8-minute minimum).

63. **D. 90834 (45 minutes)** Fifty minutes of psychotherapy falls within the 38–52 minute range for code 90834 (45-minute session). Since no E/M services were provided, the standalone psychotherapy code is used — not the add-on codes (90833, 90836, 90838), which are only used when psychotherapy is provided with an E/M service. Code 90837 (60 minutes) would require 53 or more minutes.

64. **A. 20 units of the appropriate intradermal testing code, one per allergen** Intradermal allergy testing codes are reported per test — each allergen extract injected constitutes one test. With 20 allergen extracts, 20 units of the appropriate intradermal testing code are reported. There are no panel codes or combination codes for allergy testing. Each allergen is counted individually.

Medical Terminology

65. **C. Surgical repair or reconstruction** The suffix "-plasty" means surgical repair or reconstruction. Common examples include rhinoplasty (nose repair/reshaping), arthroplasty (joint reconstruction), and angioplasty (vessel repair). "-Ectomy" means surgical removal, "-scopy" means visual examination, and "-otomy" means incision into.

66. **B. Hepat/o** The combining form "hepat/o" refers to the liver. Common terms include hepatitis (inflammation of the liver), hepatectomy (removal of liver tissue), and hepatomegaly (enlarged liver). "Nephr/o" refers to the kidney, "cardi/o" refers to the heart, and "pneum/o" refers to the lung or air.

67. **A. Below or under** The prefix "sub-" means below, under, or beneath. Common terms include subcutaneous (below the skin), sublingual (under the tongue), and subdural (below the dura mater). "Supra-" means above, "peri-" means around, and "inter-" means between.

68. **D. Difficulty swallowing** Dysphagia means difficulty swallowing, from the prefix "dys-" (difficult, painful) and the root "phag/o" (swallowing, eating). Dyspnea means difficulty breathing. Dysphasia means difficulty speaking. Polyuria means excessive urination. The prefix "dys-" consistently indicates difficulty, pain, or abnormality.

Anatomy

69. **B. Production of insulin and glucagon** The endocrine function of the pancreas is the production of hormones — primarily insulin (which lowers blood glucose) and glucagon (which raises blood glucose) — secreted by the islets of Langerhans directly into the bloodstream. The exocrine function is the secretion of digestive enzymes through the pancreatic duct into the duodenum. Bile is produced by the liver.

70. **C. Alveoli** The alveoli are the microscopic air sacs at the terminal ends of the bronchial tree where gas exchange occurs — oxygen diffuses from the inhaled air into the blood, and carbon dioxide

diffuses from the blood into the alveolar air for exhalation. The bronchi and bronchioles are conducting airways that transport air but do not participate in gas exchange.

71. **A. Long bone** The femur (thigh bone) is the longest and strongest bone in the human body and is classified as a long bone. Long bones have a shaft (diaphysis) and two ends (epiphyses) and function as levers for movement. Other long bones include the humerus, radius, ulna, tibia, and fibula. Short bones (carpals), flat bones (scapula), and irregular bones (vertebrae) have different structures and functions.

72. **D. Liver** The liver produces bile, which is stored in the gallbladder and released into the duodenum to aid in the digestion and absorption of fats. The gallbladder stores and concentrates bile but does not produce it. The pancreas produces digestive enzymes and hormones. The stomach produces hydrochloric acid and pepsin for protein digestion.

ICD-10-CM / Diagnosis Coding

73. **C. R07.9 (Chest pain, unspecified)** When the physician documents chest pain without confirming an underlying cardiac or pulmonary diagnosis, the symptom code is reported. In the outpatient setting, unconfirmed conditions ("rule out," "suspected") are not coded — only the documented signs and symptoms. R07.9 captures the presenting complaint as documented.

74. **B. The excluded condition is not included in the code but may coexist, and both codes may be reported together** An Excludes2 note means "not included here" — the excluded condition is not part of the condition represented by the code, but the two conditions may coexist in the same patient. When both conditions are documented, both codes may be reported. This differs from Excludes1, where the two conditions are mutually exclusive and cannot be coded together.

75. **A. A code from E11 with the appropriate kidney complication code, plus an additional code from N18 for the CKD stage** ICD-10-CM requires coding diabetic chronic kidney disease with a combination code from E11.22 (Type 2 diabetes with diabetic chronic kidney disease) plus an additional code from N18 to specify the CKD stage (N18.4 for stage 4). Both codes are needed to completely capture the condition and its severity.

76. **D. Sequela — a residual condition resulting from the previous injury after healing** The 7th character "S" indicates sequela — a late effect or residual condition that develops after the acute injury has healed. Examples include scarring after a burn or chronic pain after a fracture. "A" indicates initial encounter (active treatment), and "D" indicates subsequent encounter (routine healing care). The sequela extension is used when treating the residual condition, not the original injury.

77. **C. Z80 (Family history of primary malignant neoplasm)** Z80 codes report family history of malignant neoplasms. Family history of colon cancer would be coded with Z80.0 (family history of malignant neoplasm of digestive organs). Z12 codes cover screening encounters (the reason for

the colonoscopy). Z85 codes cover personal history of malignant neoplasm. Z87 codes cover personal history of other diseases.

HCPCS Level II

78. **A. L0000–L9999** HCPCS Level II L-codes (L0000–L9999) cover orthotic and prosthetic procedures and devices, including spinal orthoses, upper and lower extremity orthoses, prosthetic limbs, and related services. E-codes cover durable medical equipment, J-codes cover drugs administered by healthcare professionals, and A-codes cover supplies and miscellaneous items.
79. **B. Modifier 33** Modifier 33 (preventive services) is appended to identify services that are mandated preventive services under applicable law. When a preventive service is covered without cost-sharing under the Affordable Care Act, modifier 33 signals the payer to waive the copay, coinsurance, and deductible. Modifier GZ indicates no ABN obtained. Modifier GA indicates ABN obtained. Modifier QW indicates CLIA-waived testing.
80. **D. 4 units** The HCPCS J-code for ketorolac covers 15 mg per unit. The physician administered 60 mg: 60 mg ÷ 15 mg/unit = 4 units. HCPCS drug codes specify a defined quantity per unit, and the total units reported must reflect the total amount administered. Always check the code description for the per-unit quantity.

Coding Guidelines

81. **C. The code is not subject to the multiple procedure payment reduction and does not require modifier 51** Modifier 51 exempt codes are paid at 100% of their allowed amount regardless of how many other procedures are performed during the same session. They do not require modifier 51 and are not subject to the standard multiple procedure payment reduction. These codes typically represent procedures that are inherently distinct from other services.
82. **A. Modifier 58** Modifier 58 (staged or related procedure during the postoperative period) is appended when a planned return to the operating room is performed during the global period of the original surgery. This includes planned prospective procedures, procedures that are more extensive than the original, and therapeutic procedures following a diagnostic procedure. Modifier 78 is for unplanned returns for complications.
83. **B. To establish the maximum number of units of a service that a provider can report for a single patient on a single date of service** MUEs establish per-day, per-patient unit limits for CPT/HCPCS codes. They prevent billing errors where an implausible number of units are reported. If a code has an MUE of 1, only one unit may be reported per patient per day. Claims exceeding MUE limits are automatically denied for the excess units.
84. **D. Major surgical procedures** A 90-day global period applies to major surgical procedures. During this period, all routine preoperative and postoperative care is bundled into the surgical code. Minor procedures typically have a 0-day or 10-day global period. The 90-day global period

is designated by Medicare and includes the day before surgery, the day of surgery, and the 90 days following.

85. **A. Modifier 78** Modifier 78 (unplanned return to the operating room by the same physician for a related procedure during the postoperative period) is appended when a complication of the original surgery requires a return to the OR. Modifier 58 is for planned staged procedures. Modifier 79 is for unrelated procedures. The distinction between planned (58) and unplanned (78) returns is critical for correct modifier selection.
86. **C. Appendix D (Summary of CPT Add-On Codes)** Appendix D of the CPT manual contains a complete list of add-on codes designated by the "+" symbol. This appendix serves as a reference for coders to quickly identify all add-on codes. Appendix A covers modifiers. Appendix B covers additions, deletions, and revisions. Appendix C contains clinical examples for E/M services.
87. **B. Modifier 59 (or the appropriate X modifier)** When NCCI edits with modifier indicator 1 flag two procedures as potentially bundled, modifier 59 (or the more specific X modifiers — XE, XS, XP, XU) may be appended to indicate that the procedures were performed as distinct services at separate anatomical sites through separate incisions. Modifier 51 indicates multiple procedures but does not bypass NCCI edits.

Compliance and Regulatory

88. **D. The Anti-Kickback Statute** The Anti-Kickback Statute (AKS) is the federal criminal law that prohibits offering, paying, soliciting, or receiving anything of value to induce or reward referrals of patients covered by federal healthcare programs. Violations can result in criminal prosecution, imprisonment, fines, and exclusion from federal programs. The False Claims Act addresses fraudulent claims. The Stark Law addresses physician self-referral.
89. **A. It identifies high-risk billing areas that are likely to be audited, allowing practices to proactively review their compliance in those areas** The OIG Work Plan is published annually and identifies specific areas of healthcare billing that the OIG intends to investigate. Coders and compliance officers use the Work Plan to proactively audit their own practices in these targeted areas before external auditors arrive. It does not provide CPT codes, conversion factors, or filing deadlines.
90. **C. Promptly investigate, quantify the overpayments, initiate refunds to affected payers, and implement corrective action to prevent recurrence** Under an effective compliance program, discovered billing errors must be promptly investigated, overpayments must be quantified and refunded, and corrective action must be implemented. Ignoring findings, destroying records, or continuing to bill incorrectly would compound the original violation with additional fraud and obstruction. Self-disclosure and voluntary refunds demonstrate good faith compliance.

Cases — Integrated Coding Scenarios

91. **B. Laparoscopic cholecystectomy without cholangiography** The procedure was a laparoscopic cholecystectomy completed without conversion and without intraoperative cholangiography. The correct code is the laparoscopic cholecystectomy without cholangiography. If cholangiography had been performed, a different code would be required. The code must match exactly what was done — not what was initially planned or what might have been done.
92. **D. A combination code from category K80 that captures both the cholelithiasis and the acute cholecystitis in a single code** ICD-10-CM provides combination codes in category K80 that capture both cholelithiasis (gallstones) and the associated cholecystitis in a single code. The coder does not report separate codes for gallstones and cholecystitis — the combination code captures both conditions. The specific code depends on whether obstruction is documented.
93. **A. The preventive medicine code plus an E/M code (99214) with modifier 25** When a significant, separately identifiable problem (worsening knee pain with moderate MDM) is addressed during a preventive medicine visit, both the preventive code and an E/M code are reported. Modifier 25 is appended to the E/M code to indicate it is a significant, separately identifiable service. The knee evaluation is not part of the routine wellness assessment.
94. **C. The appropriate Z code for the wellness visit (e.g., Z00.00 or Z00.01)** The first-listed diagnosis for the preventive medicine service is the appropriate Z code for the wellness encounter. The knee pain diagnosis is linked to the separately reported E/M code. Each service has its own diagnosis pointer — the preventive code links to the wellness Z code, and the E/M code links to the knee pain code.
95. **B. It is not reported separately; it is included in the transforaminal injection code** The transforaminal epidural injection code includes fluoroscopic guidance in its code description. When imaging guidance is bundled into the procedure code, no separate fluoroscopy code is reported. Reporting a separate guidance code in addition to an injection code that already includes guidance constitutes double billing.
96. **D. Yes; both may be reported with appropriate modifiers (modifier 59 or XS) to indicate distinct services** The transforaminal epidural injection and the facet joint injection are distinct procedures performed at different anatomical sites using different techniques and different CPT code series. Both may be reported on the same date with modifier 59 or XS appended to the secondary procedure to indicate it is a separate and independent service.
97. **A. The patient's age (pediatric codes exist for patients under a certain age, typically under 6 months or 6 months to 5 years)** CPT provides age-specific codes for pediatric inguinal hernia repair. The age ranges (under 6 months, 6 months to under 5 years) are specifically defined in CPT and carry different codes than adult hernia repairs. Pediatric inguinal hernias are typically indirect and are treated with high ligation of the hernia sac without the complex floor reconstruction used in adult repairs.

98. **B. Modifier 57** Modifier 57 (decision for surgery) is appended to the E/M code when the evaluation results in the initial decision to perform a major surgical procedure with a 90-day global period. The inguinal hernia repair has a 90-day global period, making modifier 57 the correct choice. Modifier 25 would be appropriate only for minor procedures with 0-day or 10-day global periods.

99. **C. 19 units** Base units (7) + Time units (165 minutes ÷ 15 minutes/unit = 11.0) + Modifying units (P3 = 1) = 19.0 total units. The calculation: 7 + 11 + 1 = 19. Always verify each component — base units from the anesthesia code, time units from the total minutes divided by the per-unit value, and modifying units from the physical status classification.

100. **D. With the appropriate anesthesia code for the second procedure, calculated independently with its own base units, time units, and modifying units** Each anesthesia encounter is coded independently based on the specific procedure performed. The second day's anesthesia uses the appropriate anesthesia code for the second surgical procedure with its own base units, its own time units calculated from the actual anesthesia time, and its own modifying units. Anesthesia units do not carry over between dates or procedures.