SIMULATION EXAM 9

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

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

1. A surgeon excises a 1.6 cm benign compound nevus from the patient's neck with 0.3 cm margins. What is the excised diameter for code selection?

A. 2.2 cm

B. 1.6 cm

C. 1.9 cm

D. 2.8 cm

2. A patient has three lacerations requiring repair: a 6.0 cm intermediate repair on the right forearm, a 4.0 cm intermediate repair on the left hand, and a 2.5 cm complex repair on the right forehead. How should these be reported?

A. One complex repair code for 12.5 cm combining all wounds

B. Three separate repair codes, one for each wound

C. One intermediate repair code for 10.0 cm and one complex repair code for 2.5 cm

D. One intermediate repair code for the largest wound and one complex repair code

3. A physician performs destruction of 16 actinic keratoses on a patient's face, scalp, and forearms using cryotherapy. Which code should be reported?

A. 17000 × 1 plus 17003 × 15

B. 17000 × 16

C. 17000 × 1 plus 17003 × 13

D. 17004

4. A surgeon harvests a split-thickness skin graft from the patient's right thigh and applies it to a 50 sq cm wound on the patient's left lower leg. The graft code is based on what measurement?

A. The thickness of the graft in millimeters

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

C. The square centimeter area of the donor site

D. The circumference of the wound

5. A physician performs a punch biopsy of a suspicious pigmented lesion on the patient's left shoulder and separately performs a shave removal of a raised benign skin tag on the patient's right chest during the same encounter. How should these be reported?

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

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

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

D. One excision code combining both procedures

6. A patient undergoes Mohs surgery on a lesion of the right ear. Three stages are required: stage 1 with 4 tissue blocks, stage 2 with 6 tissue blocks, and stage 3 with 2 tissue blocks. How should the stages and extra blocks be coded?

A. 17311 × 3

B. 17311 × 1, 17312 × 2

C. 17311 × 1, 17312 × 2, 17315 × 2

D. 17311 × 1, 17312 × 2, 17315 × 1

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

7. A surgeon performs an arthroscopic partial meniscectomy of the lateral meniscus of the left knee. During the same session, a diagnostic arthroscopy reveals a Grade IV chondral defect on the lateral femoral condyle, and the surgeon performs microfracture of the defect. How should the diagnostic arthroscopy be coded?

A. As a separate code with modifier 59

B. As a separate code with modifier 51

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

D. As a separate code with modifier 25

8. An orthopedic surgeon performs closed treatment of a comminuted distal radius fracture with manipulation and applies a long arm cast. The surgeon will provide all follow-up care. A week later, the patient returns and the surgeon changes the long arm cast to a short arm cast. How should the cast change be coded?

A. With a separate cast application code

B. It is included in the fracture treatment global package; no separate cast change code is reported

C. With the original fracture treatment code and modifier 76

D. With an E/M code only

9. A patient undergoes an anterior cervical discectomy and fusion (ACDF) at two levels (C5-C6 and C6-C7) with placement of an interbody cage at each level and an anterior cervical plate spanning C5-C7. How is the instrumentation (plate) coded?

A. With a separate anterior spinal instrumentation code in addition to the fusion codes

B. It is included in the fusion code

C. With a HCPCS Level II supply code only

D. With modifier 22 on the fusion code

10. A patient undergoes aspiration of the right knee joint for a suspected septic joint. No injection is performed. Which CPT code range covers joint aspiration?

A. Medicine section — injection codes

B. Radiology section — guidance codes

C. Anesthesia section

D. Musculoskeletal system (20,000 series) — joint aspiration codes

11. A surgeon performs a revision total knee arthroplasty on a patient whose previous knee prosthesis has failed due to aseptic loosening. What distinguishes revision arthroplasty from primary arthroplasty?

A. Revision arthroplasty uses a smaller incision

B. Revision arthroplasty involves removing and replacing a previously implanted prosthesis; primary arthroplasty is the initial prosthetic implantation

C. Primary arthroplasty always requires general anesthesia; revision uses regional

D. There is no difference between the two

12. A surgeon performs an open reduction with internal fixation (ORIF) of both a medial malleolus fracture and a lateral malleolus fracture of the left ankle during the same session. CPT provides a single code for bimalleolar fracture treatment. How should this be coded?

A. Two separate ORIF codes — one for medial, one for lateral — with modifier 51

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

C. One bimalleolar fracture treatment code that includes fixation of both malleoli

D. One ORIF code with modifier 22

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

13. A patient undergoes a bronchoscopy with placement of a bronchial stent for treatment of a malignant airway obstruction. How should the diagnostic bronchoscopy be coded?

A. As a separate code with modifier 59

B. As a separate code with modifier 51

C. As a separate code with modifier 25

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

14. A cardiologist inserts a new single-chamber pacemaker system — a ventricular lead and a pulse generator. How should this be coded?

A. Separate codes for the lead insertion and the generator insertion

B. A single code for the complete single-chamber system

C. Only the generator insertion code; the lead is included

D. Only the lead insertion code; the generator is included

15. A surgeon performs a CABG with four saphenous vein grafts. No arterial grafts are used. How should the bypass grafts be coded?

A. Four separate single-graft codes

B. One code for the first graft plus add-on codes for each additional graft

C. One venous CABG code specifying four grafts

D. An unlisted cardiovascular procedure code

16. A patient has an existing tunneled central venous catheter that has become infected. The surgeon removes the catheter. A new tunneled catheter is not placed during the same session. How should the removal be coded?

A. With the catheter insertion code and modifier 52

B. With the tunneled catheter removal code

C. With an E/M code only; catheter removal is not a separate procedure

D. With the catheter insertion code and modifier 76

17. A patient undergoes a right thoracoscopic (VATS) pleurodesis with talc poudrage for recurrent malignant pleural effusion. What does pleurodesis accomplish?

A. It creates adhesion between the visceral and parietal pleura to prevent recurrence of pleural effusion

B. It removes the entire lung

C. It inserts a chest tube for drainage

D. It biopsies the pleural tissue

18. A surgeon performs a repair of a traumatic laceration of the right subclavian artery using a vein patch graft. Which vascular subsection contains codes for repair of upper extremity and great vessels?

A. The coronary artery subsection

B. The venous system subsection

C. The peripheral vascular subsection

D. The aorta and great vessel/upper extremity artery repair subsection

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

19. A patient undergoes a colonoscopy with cold snare polypectomy of a 0.6 cm polyp from the sigmoid colon and a separate hot biopsy forceps polypectomy of a 0.3 cm polyp from the descending colon. How should the diagnostic colonoscopy be coded?

A. As a separate code with modifier 25

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

C. As a separate code with modifier 59

D. As a separate code with modifier 51

20. A surgeon performs a laparoscopic appendectomy on a patient with acute appendicitis without rupture. During the same operative session, the surgeon also performs a diagnostic laparoscopy to evaluate the pelvis for suspected endometriosis (which is confirmed). How should the diagnostic laparoscopy be coded?

A. As a separate code with modifier 59

B. As a separate code with modifier 51

C. It depends on whether the diagnostic laparoscopy evaluated a separate anatomical area and served an independent diagnostic purpose

D. It is always included in the laparoscopic appendectomy

21. A patient undergoes an EGD with injection of a sclerosing agent for treatment of a bleeding gastric ulcer. How should the diagnostic EGD be coded?

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

B. As a separate code with modifier 59

C. As a separate code with modifier 25

D. As a separate code with modifier 51

22. A surgeon performs an open repair of a recurrent, strangulated inguinal hernia on a 50-year-old patient. Which factors are relevant to CPT code selection?

A. Only the hernia type and whether mesh is used

B. Only the patient's age and gender

C. Only the surgical approach

D. Hernia type (inguinal), initial vs. recurrent, reducible vs. incarcerated/strangulated, and the patient's age

23. A patient undergoes percutaneous liver biopsy under CT guidance. The CT guidance code is NOT included in the biopsy code. How should the CT guidance be coded?

A. It is included in the biopsy code

B. With a separate CT guidance code in addition to the biopsy code

C. With modifier 26 on the biopsy code

D. With the biopsy code and modifier 22

24. A patient undergoes an ERCP with placement of a nasobiliary drainage catheter. How should the diagnostic ERCP be coded?

A. As a separate code with modifier 59

B. As a separate code with modifier 51

C. It is not reported separately; it is included in the surgical ERCP code

D. As a separate code with modifier 25

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

25. A urologist performs a cystoscopy with fulguration of a 1.5 cm bladder tumor and separately performs a transurethral resection of the prostate (TURP) during the same operative session. How should the diagnostic cystoscopy be coded?

A. As a separate code with modifier 59

B. As a separate code with modifier 51

C. As a separate code with modifier 25

D. It is not reported separately; it is included in the surgical cystoscopy/TURP codes

26. A patient undergoes a ureteroscopy with insertion of a double-J ureteral stent for ureteral obstruction due to a pelvic mass. The cystoscopy performed as the approach to the ureter is bundled. Which body system section contains the ureteroscopy codes?

A. Urinary system

B. Cardiovascular system

C. Male genital system

D. Digestive system

27. A physician provides only the delivery and postpartum care for a patient whose antepartum care was provided by another physician. The delivery is a routine vaginal delivery. Which coding approach should be used?

A. The global vaginal delivery code

B. The antepartum care-only code plus the delivery-only code

C. The delivery-only code plus the postpartum care-only code

D. Only the delivery-only code; postpartum care is bundled into the delivery

28. A surgeon performs a laparoscopic total hysterectomy with bilateral salpingectomy on a patient with abnormal uterine bleeding. The CPT code for the hysterectomy includes the removal of the fallopian tubes in its description. How should the salpingectomy be coded?

A. With a separate bilateral salpingectomy code and modifier 50

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

C. With a separate salpingectomy code and modifier 51

D. With a separate salpingectomy code and modifier 59

29. A patient undergoes a radical nephrectomy for a 7.0 cm renal cell carcinoma. The surgeon also performs an ipsilateral adrenalectomy and regional lymph node dissection. How is the adrenalectomy coded?

A. It is always coded separately from the radical nephrectomy

B. It is always included in the radical nephrectomy code

C. With a modifier 51 on the adrenalectomy code

D. It depends on whether the radical nephrectomy code description includes the adrenalectomy; the coder must read the specific code description

30. A surgeon performs a subtotal thyroidectomy (leaving a small remnant of thyroid tissue) for Graves' disease. What distinguishes a subtotal thyroidectomy from a total thyroidectomy?

A. A subtotal thyroidectomy removes most of the thyroid but leaves a small remnant; a total thyroidectomy removes all thyroid tissue

B. A subtotal thyroidectomy removes one lobe; a total removes both

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

D. A subtotal thyroidectomy is always laparoscopic; a total is always open

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

31. A neurosurgeon performs a posterior fossa craniotomy for clipping of a vertebrobasilar aneurysm. The bone flap is replaced at the conclusion of the procedure. Which craniotomy code category is based on the location of the aneurysm?

A. Craniotomy codes for hematoma evacuation

B. Craniotomy codes for tumor excision

C. Craniotomy codes for intracranial aneurysm repair, organized by vascular territory

D. Craniectomy codes for decompression

32. An ophthalmologist performs a scleral buckle procedure for repair of a rhegmatogenous retinal detachment of the right eye. What does a scleral buckle accomplish?

A. It removes the crystalline lens

B. It creates a drainage pathway for aqueous humor

C. It realigns the extraocular muscles

D. It indents the wall of the eye inward to push it against the detached retina, facilitating reattachment

33. A pain management physician performs a celiac plexus neurolytic block using alcohol injection under CT guidance for treatment of intractable abdominal pain from pancreatic cancer. How is this procedure classified?

A. Somatic peripheral nerve block

B. Neurolysis (destruction) of a sympathetic nerve plexus

C. Epidural injection

D. Spinal cord stimulator placement

34. A patient undergoes programmable VP shunt valve reprogramming using an external magnetic device. No surgery is performed. How should this be coded?

A. With the shunt reprogramming code — a non-invasive adjustment of the valve setting

B. With the shunt revision code

C. With the shunt creation code and modifier 52

D. With an E/M code only; reprogramming is not a procedural service

35. A patient undergoes cataract surgery (66984) in the right eye. The surgeon also performs a minimally invasive glaucoma surgery (MIGS) — insertion of an iStent trabecular micro-bypass stent — during the same session. CPT provides combination codes for cataract surgery with MIGS. How should this be coded?

A. Two separate codes — 66984 plus the standalone MIGS code

B. The standalone MIGS code only

C. The combination cataract surgery with MIGS code

D. 66984 with modifier 22

36. An otolaryngologist performs a stapedectomy with insertion of a prosthesis for treatment of otosclerosis. What does a stapedectomy accomplish?

A. It removes the tympanic membrane

B. It inserts a tympanostomy tube

C. It removes the malleus bone

D. It removes or partially removes the stapes bone (the third ossicle) and replaces it with a prosthesis to restore sound conduction

Evaluation and Management (Questions 37–42)

37. An established patient presents to the office with a new complaint of severe abdominal pain. The physician performs an extensive evaluation, orders a CT scan, laboratory tests, and a surgical consultation. The management involves significant risk with a decision for emergency surgery. What level of MDM does this support?

A. Low

B. High

C. Straightforward

D. Moderate

38. A physician sees a patient in the office on Monday and admits the same patient to the hospital on Monday evening due to worsening of the same condition. How should the services be coded?

A. Only the initial hospital care code for Monday; the office visit is rolled into the admission when performed by the same physician on the same date

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

C. Only the office visit code; the admission is bundled

D. The office visit code with modifier 25 plus the admission code

39. A neonatologist provides initial critical care services to a critically ill neonate (birth weight 2,500 grams) on the first day of life. Which E/M code category covers this initial service?

A. Adult critical care codes (99291–99292)

B. Subsequent neonatal critical care (99469)

C. Continuing intensive care codes (99478–99480)

D. Initial neonatal critical care (99468)

40. A physician performs a comprehensive preventive medicine visit on an established 65-year-old patient. During the visit, the physician also evaluates and adjusts medications for the patient's poorly controlled diabetes (significant, separately identifiable problem). How should both services be coded?

A. Only the preventive medicine code; the diabetes management is included

B. Only the E/M office visit code; the preventive visit is bundled

C. The preventive medicine code plus an E/M office visit code with modifier 25

D. The preventive medicine code with modifier 22

41. A physician provides critical care services totaling 110 minutes on a single date. How should this be coded?

A. 99291 × 1 plus 99292 × 2

B. 99291 × 1 plus 99292 × 1

C. 99291 × 2

D. 99291 × 1 only

42. Under the current E/M guidelines for office visits, which statement correctly describes the documentation requirements for history and physical examination?

A. A medically appropriate history and exam must be performed and documented, but they are no longer the determining factors for code level — MDM or total time determines the level

B. A comprehensive history is required for all level 4 and 5 visits

C. The 1997 documentation guidelines must be used for all visits

D. No history or examination is required for established patient visits

Anesthesia (Questions 43–46)

43. An anesthesiologist provides general anesthesia for a craniotomy for excision of a posterior fossa brain tumor on a 60-year-old patient with controlled hypertension (P2). Total anesthesia time is 300 minutes. The payer uses 15-minute time units and assigns no modifying units for P2. Base units are 11. What is the total unit calculation?

A. 30 units

B. 32 units

C. 29 units

D. 31 units

44. A patient undergoes a surgical procedure under regional anesthesia (spinal block) provided by an anesthesiologist. How is the spinal anesthesia coded?

A. With moderate sedation codes (99151–99157)

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

C. With the standard anesthesia code for the surgical procedure — the type of anesthetic (general, regional, MAC) does not change the anesthesia CPT code

D. With a neuraxial injection code and modifier QS

45. An anesthesiologist provides anesthesia for a total hip replacement on a 78-year-old patient (P3). The payer recognizes qualifying circumstances code 99100 (extreme age over 70). How many modifying units does 99100 contribute?

A. The value depends on the payer, but 99100 is reported as an add-on code and may add 1 unit to the formula

B. Zero; qualifying circumstances codes do not add units

C. Five units

D. Three units

46. A CRNA provides anesthesia under the medical direction of an anesthesiologist who is directing three concurrent cases. Which modifier should the CRNA append to their claim?

A. Modifier AA

B. Modifier QX

C. Modifier QZ

D. Modifier QY

Radiology (Questions 47–52)

47. A patient undergoes an MRI of the right shoulder with intravenous gadolinium contrast. How should the contrast designation be coded?

A. MRI shoulder without contrast; gadolinium is not considered contrast

B. MRI shoulder without contrast followed by with contrast

C. MRI shoulder without contrast plus a separate contrast injection code

D. MRI shoulder with contrast

48. A radiologist at a hospital performs and interprets a fluoroscopic swallowing study (modified barium swallow) on a patient with dysphagia. The hospital owns the equipment and employs the radiologist. How should this be billed?

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

B. The radiologist bills the global code only

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

D. Two separate global codes — one for the hospital and one for the radiologist

49. A patient undergoes a screening mammogram. No abnormalities are found. Which CPT code and diagnosis code should be reported?

A. Screening mammography code (77067) with diagnosis Z12.31

B. Diagnostic mammography code (77066) with diagnosis Z12.31

C. Screening mammography code (77067) with diagnosis R92.8

D. Diagnostic mammography code (77065) with a breast mass diagnosis code

50. In radiation oncology, which service covers the physician's review of the treatment plan, evaluation of the patient for side effects, and coordination of care during the radiation course, reported per 5 fractions?

A. Treatment planning (77261–77263)

B. Treatment management (77427)

C. Treatment delivery (77385–77386)

D. Simulation (77280–77295)

51. A patient undergoes a CT of the neck (soft tissue) with IV contrast to evaluate a neck mass. A CT of the cervical spine without contrast is also performed during the same session to evaluate neck pain. How should these be coded?

A. One CT code covering both the neck and cervical spine

B. One CT code for the most comprehensive study only

C. Two separate CT codes — one for the neck soft tissue and one for the cervical spine — since they evaluate different anatomical targets

D. Two separate CT codes — one for the neck soft tissue and one for the cervical spine — since they evaluate different anatomical targets with appropriate modifiers if needed

52. A patient undergoes a DEXA bone density scan of the lumbar spine and left hip. The patient has documented osteopenia on a previous scan and is being monitored. Which diagnosis code category supports the medical necessity of the DEXA?

A. Z12 (Encounter for screening for malignant neoplasm)

B. Z00 (Encounter for general examination)

C. M81 or M85 (Osteoporosis or disorders of bone density) or Z87 (personal history) — a code reflecting the documented bone density abnormality or risk factor

D. R10 (Abdominal pain)

Pathology and Laboratory (Questions 53–58)

53. A physician orders a hepatic function panel and a basic metabolic panel (BMP) on the same specimen. The hepatic panel includes albumin. The BMP also includes albumin. How should the overlapping albumin be handled?

A. The overlapping albumin is included in each panel code; it is NOT reported as a separate individual code in addition to both panels

B. A separate albumin code is reported in addition to both panels

C. Only one panel can be reported; the second is bundled

D. The albumin is reported with modifier 91

54. A pathologist examines a radical prostatectomy specimen for prostate cancer. The examination includes complete surgical margin assessment. At which level of surgical pathology is a radical prostatectomy classified?

A. Level IV (88305)

B. Level V (88307)

C. Level III (88304)

D. Level VI (88309)

55. A laboratory performs a urine culture, quantitative, to evaluate for urinary tract infection. The culture grows 100,000 CFU/mL of E. coli. Sensitivity testing is performed against 8 different antibiotics using the microdilution method. How should the sensitivity testing be coded?

A. One sensitivity code for all 8 antibiotics combined

B. One culture code with modifier 22

C. Eight units of the sensitivity code — one per antibiotic agent tested

D. Eight units of the sensitivity code — one per antibiotic agent tested (using the microdilution MIC method code)

56. A patient undergoes a rapid influenza antigen test in the physician's office. The test is CLIA-waived. Which codes should be reported?

A. Only the E/M code; the rapid test is included

B. Only the influenza NAAT code

C. The rapid influenza antigen detection code (87804) with modifier QW

D. The influenza culture code

57. A laboratory performs a complete blood count with automated differential (85025) on a blood sample. The automated differential flags the white blood cell count as abnormal. A pathologist reviews the peripheral blood smear manually. How should the manual review be coded?

A. With the manual differential code (85004) in addition to the CBC code (85025)

B. With a repeat CBC code and modifier 91

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

D. With a pathology consultation code

58. A patient has a quantitative serum PSA (prostate-specific antigen) level drawn for prostate cancer screening. Which type of laboratory test is this?

A. Qualitative test (positive/negative result)

B. Quantitative clinical chemistry test (numerical result measuring the exact concentration)

C. Presumptive drug screen

D. Cytopathology test

Medicine (Questions 59–64)

59. A patient receives a 90-minute IV infusion of a non-chemotherapy therapeutic drug as the only IV service during the encounter. How should this be coded?

A. 96360 × 1, 96361 × 1 (hydration codes)

B. 96413 × 1, 96415 × 1 (chemotherapy codes)

C. 96365 × 1 only (initial hour of therapeutic infusion)

D. 96365 × 1 (initial hour) plus 96366 × 1 (additional 30 minutes of therapeutic infusion)

60. A patient undergoes a complete pulmonary function test including spirometry, lung volumes, and diffusing capacity (DLCO). Which CPT section contains the pulmonary function testing codes?

A. Radiology section

B. Pathology and Laboratory section

C. Medicine section

D. Surgery section — respiratory system

61. An established patient receives an annual preventive medicine visit. No other problems are addressed. The patient is 50 years old. Which E/M code set is used?

A. Preventive medicine services codes (99391–99397) based on the patient's age

B. Office visit codes (99211–99215) with modifier 25

C. Consultation codes

D. Critical care codes

62. A therapist provides 8 minutes of electrical stimulation (constant attendance modality, 97032) and 23 minutes of therapeutic exercise (97110) during the same physical therapy session. How many total timed units are reported?

A. 3 units total

B. 2 timed units — 1 unit of 97032 and 1 unit of 97110; the remaining time allocated based on minutes

C. 1 unit of 97110 only

D. 4 units total

63. A cardiologist performs an exercise treadmill stress test (without imaging) on a patient with exertional chest pain. The physician supervises the test and interprets the results. Which Medicine subsection contains the stress test codes?

A. Pulmonary function testing

B. Neurology

C. Allergy and immunology

D. Cardiovascular diagnostic services

64. An ophthalmologist performs fluorescein angiography of the retina on a patient with diabetic retinopathy. This involves injection of fluorescein dye followed by sequential photography of the retinal vasculature. How is fluorescein angiography coded?

A. With the intravitreal injection code (67028)

B. With only an E/M code

C. With the fluorescein angiography code (92235) as a special ophthalmological service reported separately from the eye examination

D. With the fundus photography code (92250)

Medical Terminology (Questions 65–68)

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

A. Surgical repair

B. Disease or abnormal condition

C. Inflammation

D. Blood condition

66. Which combining form refers to the nerve?

A. Neur/o

B. My/o

C. Oste/o

D. Cardi/o

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

A. Between

B. Above

C. Below

D. Within

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

A. Surgical removal of the colon

B. Visual examination of the colon

C. Creation of a new opening from the colon to the body surface

D. Incision into the colon

Anatomy (Questions 69–72)

69. The sinoatrial (SA) node is the natural pacemaker of the heart. Where is it located?

A. In the wall of the right atrium

B. In the wall of the left ventricle

C. In the interventricular septum

D. At the base of the aorta

70. Which anatomical structure connects the pharynx to the stomach?

A. Trachea

B. Esophagus

C. Duodenum

D. Larynx

71. The prostate gland surrounds which anatomical structure?

A. The ureter

B. The seminal vesicle

C. The vas deferens

D. The urethra (prostatic urethra)

72. The peritoneum is the serous membrane that lines which body cavity?

A. The thoracic cavity

B. The cranial cavity

C. The abdominal/pelvic cavity

D. The spinal canal

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

73. A patient presents with a new diagnosis of iron deficiency anemia. The physician documents the anemia as due to chronic blood loss from a gastric ulcer. How should this be coded under ICD-10-CM?

A. Only the anemia code

B. The gastric ulcer code with the appropriate complication code for hemorrhage, plus the iron deficiency anemia code

C. Only the gastric ulcer code

D. The anemia code with modifier 25

74. In ICD-10-CM, which guideline applies when a patient presents for a planned surgical procedure that is subsequently cancelled?

A. Report a Z code for the encounter reason (Z53 — persons encountering health services for specific procedures not carried out) as the first-listed code, followed by the code for the reason the procedure was cancelled

B. Report the procedure code with modifier 73

C. Do not report any diagnosis code for the encounter

D. Report only the surgical procedure code with modifier 52

75. A patient has documented chronic systolic heart failure. Under ICD-10-CM, how is heart failure classified?

A. Only by the presence or absence of symptoms

B. By location (right vs. left) only

C. By a single unspecified code for all types

D. By type (systolic, diastolic, combined) and acuity (acute, chronic, acute on chronic)

76. A patient is treated for a left ankle sprain sustained while playing basketball. The 7th character "A" is used for the initial encounter. Which ICD-10-CM chapter contains external cause codes that describe how the injury occurred?

A. Chapter 19 (Injury, poisoning, and certain other consequences)

B. Chapter 13 (Diseases of the musculoskeletal system)

C. Chapter 20 (External causes of morbidity — V00–Y99)

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

77. A coder is assigning diagnosis codes for a patient with documented obesity with a BMI of 35.2. Under ICD-10-CM, how should the BMI be coded?

A. With a code from Z68 (Body mass index) as an additional code reported with the obesity diagnosis code

B. The BMI code is reported as the primary diagnosis

C. Only the obesity code is needed; BMI is not separately coded

D. BMI codes are only used for morbid obesity (BMI ≥40)

HCPCS Level II (Questions 78–80)

78. A patient receives a home oxygen concentrator for treatment of chronic hypoxemic respiratory failure. Which HCPCS Level II code range covers oxygen equipment?

A. J0000–J9999

B. E0400–E0486 (within the E-code range for DME)

C. L0000–L9999

D. A4000–A8999

79. A Medicare provider performs a service and appends modifier GZ to the claim. What does this indicate?

A. A signed ABN was obtained from the patient

B. The service is a statutory exclusion

C. The service is a covered preventive service

D. The provider expects Medicare to deny the service as not medically necessary, and NO ABN was obtained

80. A patient receives an injection of Depo-Medrol (methylprednisolone acetate) 80 mg intramuscularly. The HCPCS J-code specifies 40 mg per unit. How many units should be reported?

A. 1 unit

B. 80 units

C. 2 units

D. 4 units

Coding Guidelines (Questions 81–87)

81. A surgeon performs a diagnostic endoscopy and determines that a surgical endoscopic procedure is needed. Both are performed during the same session on the same anatomical site. How should the diagnostic endoscopy be coded?

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

B. As a separate code with modifier 59

C. As a separate code with modifier 51

D. As a separate code with modifier 25

82. A patient undergoes a scheduled surgical procedure. After anesthesia is administered but before the procedure begins, the patient develops an adverse cardiac event and the surgeon cancels the procedure. Which modifier should be appended?

A. Modifier 52 (reduced services)

B. Modifier 51 (multiple procedures)

C. Modifier 76 (repeat procedure)

D. Modifier 73 (discontinued outpatient procedure prior to anesthesia) or modifier 53 (discontinued procedure) depending on the setting

83. Under the 90-day global surgical package, a surgeon performs an unrelated E/M service during the postoperative period. Which modifier should be appended to the E/M code?

A. Modifier 58

B. Modifier 24

C. Modifier 78

D. Modifier 79

84. A CPT code is designated as an add-on code (+). Which of the following is true about add-on codes?

A. They are always reported with modifier 51

B. They may be reported as standalone codes

C. They must always accompany a designated primary procedure code and are never reported alone

D. They have a 90-day global period

85. Under the NCCI, what is the purpose of Column 1/Column 2 edits?

A. To identify code pairs where the Column 2 code is bundled into the Column 1 code when reported together for the same patient on the same date by the same provider

B. To establish the maximum number of units for each code

C. To determine the conversion factor for each code

D. To assign global periods to surgical codes

86. A surgeon performs a bilateral procedure. CPT describes the procedure as unilateral. The payer requires modifier 50 for bilateral procedures. How does modifier 50 typically affect reimbursement under Medicare?

A. The code is paid at 200% of the single-unit rate

B. The code is paid at 100% for one side only

C. The code is paid at 100% with no additional payment

D. The code is typically paid at 150% of the single-unit rate (100% + 50%)

87. In CPT, which appendix provides clinical examples for E/M code selection?

A. Appendix A (Modifiers)

B. Appendix C (Clinical Examples)

C. Appendix D (Add-On Codes)

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

Compliance and Regulatory (Questions 88–90)

88. Under the RBRVS payment formula, which RVU component differs between facility and non-facility settings and is the primary reason the same CPT code has different payment amounts in different settings?

A. Work RVU

B. Professional Liability Insurance (PLI) RVU

C. Practice Expense (PE) RVU

D. The conversion factor

89. A physician consistently reports modifier 25 on every E/M service performed on the same day as a procedure, regardless of whether the E/M is truly significant and separately identifiable. This practice is considered which of the following?

A. A compliance violation — modifier 25 should only be used when the E/M is genuinely significant and separately identifiable from the procedure

B. Standard billing practice

C. Required by Medicare for all same-day E/M and procedure combinations

D. Acceptable as long as the E/M is documented

90. Place of service code 22 represents which clinical setting?

A. Physician's office

B. Emergency department

C. Ambulatory surgical center

D. On-campus outpatient hospital

Cases — Integrated Coding Scenarios (Questions 91–100)

Case 1 (Questions 91–92):

A 40-year-old patient undergoes excision of a 1.0 cm benign dermatofibroma from the left upper arm with 0.4 cm margins. The wound is closed with intermediate layered repair.

91. What is the excised diameter for code selection?

A. 1.0 cm

B. 1.8 cm

C. 1.4 cm

D. 2.0 cm

92. The wound is closed with intermediate layered repair. Should the intermediate closure be coded separately from the excision?

A. No; all closures are included in excision codes

B. No; intermediate repair is bundled into benign excision codes

C. Yes; intermediate and complex closures may be reported separately from excision codes

D. Yes, but only with modifier 22

Case 2 (Questions 93–94):

A 72-year-old Medicare patient presents for evaluation of new-onset atrial fibrillation. The cardiologist performs an established patient office visit with high-complexity MDM and also performs a 12-lead ECG (93000) in the office using practice-owned equipment. The physician interprets the ECG.

93. Which E/M code should be reported for the office visit?

A. 99213 (established patient, low MDM)

B. 99214 (established patient, moderate MDM)

C. 99205 (new patient, high MDM)

D. 99215 (established patient, high MDM)

94. The physician performs and interprets the ECG using practice-owned equipment. Which modifier should be appended to the ECG code?

A. No modifier; the global ECG code (93000) is reported since both components are provided

B. Modifier 26 only

C. Modifier TC only

D. Modifier 59

Case 3 (Questions 95–96):

A surgeon performs a laparoscopic cholecystectomy with intraoperative cholangiography on a patient with acute cholecystitis. The procedure is completed laparoscopically without conversion.

95. Which CPT code should be reported?

A. Open cholecystectomy with cholangiography

B. Laparoscopic cholecystectomy with cholangiography

C. Laparoscopic cholecystectomy without cholangiography

D. Open cholecystectomy without cholangiography

96. The patient's diagnosis is acute cholecystitis with cholelithiasis. Under ICD-10-CM, how should this be coded?

A. Two separate codes — one for cholecystitis and one for cholelithiasis

B. Only the cholelithiasis code

C. A combination code from category K80 that captures both the cholelithiasis and the acute cholecystitis

D. Only the cholecystitis code

Case 4 (Questions 97–98):

A pain management physician performs bilateral L3, L4, and L5 medial branch nerve radiofrequency ablation under fluoroscopic guidance. The ablation codes include imaging guidance.

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

A. Three primary ablation codes, one for each level

B. One ablation code for all three levels combined

C. One ablation code with modifier 22

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

98. The procedure is performed bilaterally. How should the bilateral nature be reported?

A. With modifier 50 or RT/LT modifiers on the ablation codes

B. With modifier 22 on each code

C. Bilateral spinal procedures cannot be coded

D. With a single code and no modifier; the codes are inherently bilateral

Case 5 (Questions 99–100):

A patient receives IV services during a single outpatient encounter: 30 minutes of IV hydration with normal saline, followed by a 2-hour IV infusion of rituximab (non-antineoplastic biologic agent for rheumatoid arthritis), followed by an IV push of ondansetron (antiemetic).

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

A. The IV hydration

B. The IV push of ondansetron

C. The rituximab therapeutic infusion

D. Each service is reported as a separate initial service

100. The rituximab is a non-antineoplastic biologic agent. Which code range should be used for its administration?

A. Chemotherapy administration codes (96413–96417)

B. Therapeutic drug infusion codes (96365–96368)

C. Hydration codes (96360–96361)

D. Moderate sedation codes (99151–99157)

SIMULATION EXAM 9 — ANSWER KEY WITH EXPLANATIONS

10,000 Series — Integumentary System

1. **A. 2.2 cm** The excised diameter is calculated as lesion diameter plus margins on both sides: 1.6 cm + (0.3 cm × 2) = 2.2 cm. The margin is doubled because normal tissue is removed circumferentially around the entire lesion. This 2.2 cm excised diameter determines the correct code within the benign excision range for the neck/trunk anatomical grouping.

2. **C. One intermediate repair code for 10.0 cm and one complex repair code for 2.5 cm** Wounds of different repair classifications cannot be combined. The two intermediate repairs on the forearm and hand (6.0 + 4.0 = 10.0 cm) are in the same anatomical grouping and same classification, so they are combined into one intermediate repair code. The complex repair on the forehead (2.5 cm) is a different classification and is reported separately with its own code.

3. **D. 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 destruction series. At 16 lesions, the threshold of 15 or more is met, so 17004 is the only code needed. Codes 17000 and 17003 are not reported in addition to 17004.

4. **B. The square centimeter area of the recipient site (defect)** Skin graft codes are measured by the square centimeter area of the recipient site — the defect being covered. The 50 sq cm wound on the left lower leg determines the code. The donor site size and location do not affect the graft code selection. Donor site closure may be separately reportable depending on complexity.

5. **A. Both the punch biopsy code and the shave removal code — they are distinct procedures on different lesions at different sites** The punch biopsy and the shave removal are different procedures performed on different lesions at different anatomical sites. Both are separately reportable. The biopsy code (11102) captures the diagnostic tissue sampling, and the shave removal code captures the tangential removal of the benign lesion. Modifier 59 or XS may be appended to the second procedure to indicate distinct services.

6. **D. 17311 × 1, 17312 × 2, 17315 × 1** Code 17311 covers the first stage (up to 5 tissue blocks — stage 1 had 4 blocks, within the limit). Code 17312 is reported for each additional stage (stages 2 and 3 = 2 units). Code 17315 is reported for each tissue block beyond 5 in any single stage — stage 2 had 6 blocks, exceeding the 5-block limit by 1, so 17315 × 1. Stage 3 had only 2 blocks, within the limit.

20,000 Series — Musculoskeletal System

7. **C. 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 partial meniscectomy and the microfracture are both surgical arthroscopic procedures — the diagnostic examination is included. Both surgical procedures may be reported separately with appropriate modifiers per NCCI guidelines.

8. **B. It is included in the fracture treatment global package; no separate cast change code is reported** When the surgeon assumes the global fracture care package, all routine follow-up visits, cast application, cast changes, and cast removal are bundled into the fracture treatment code. The cast change from a long arm to a short arm cast is a routine part of fracture management and is not separately coded. Only initial cast application by a different provider or casting for non-fracture conditions is separately reportable.

9. **A. With a separate anterior spinal instrumentation code in addition to the fusion codes** The anterior cervical plate is spinal instrumentation that is coded separately from the fusion using the appropriate anterior instrumentation code. The plate stabilizes the fusion construct spanning C5-C7. Instrumentation codes are distinct from fusion codes and are always reported as separate components. The interbody cages may also have separate instrumentation codes depending on the specific CPT guidelines.

10. **D. Musculoskeletal system (20,000 series) — joint aspiration codes** Joint aspiration codes (20600–20611) are located in the musculoskeletal system section of CPT. These codes cover aspiration of small, intermediate, and large joints. Aspiration without injection uses the same code range as injection — the codes cover aspiration and/or injection. The knee is classified as a large joint.

11. **B. Revision arthroplasty involves removing and replacing a previously implanted prosthesis; primary arthroplasty is the initial prosthetic implantation** Revision arthroplasty involves removing a failed prosthesis and implanting a new one. This is more complex than primary arthroplasty due to scar tissue, bone loss, and the need to remove the existing hardware. CPT provides separate codes for revision arthroplasty that carry higher RVU values than primary replacement codes.

12. **C. One bimalleolar fracture treatment code that includes fixation of both malleoli** CPT provides a specific code for bimalleolar ankle fracture treatment that includes fixation of both the medial and lateral malleoli. The coder should not unbundle a bimalleolar fracture into two separate fracture codes. The single bimalleolar code captures the complete treatment as one service.

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

13. **D. It is not reported separately; it is included in the surgical bronchoscopy code** Diagnostic bronchoscopy is always bundled into surgical bronchoscopy when both are performed during the

same session. The bronchial stent placement is a surgical bronchoscopic procedure — the diagnostic examination is included and is not reported separately. This follows the standard endoscopic hierarchy rule.

14. **A. Separate codes for the lead insertion and the generator insertion** Pacemaker coding uses a component-based approach. The lead insertion and the generator insertion are coded separately — there is no single "complete system" code. A single-chamber system requires one code for the ventricular lead insertion and one code for the pulse generator insertion. Each component has its own CPT code.

15. **C. One venous CABG code specifying four grafts** CABG codes for venous grafts are organized by the number of grafts performed. CPT provides specific codes for one, two, three, four, five, or six venous grafts. Four saphenous vein grafts are reported with the single code specifying four venous grafts — not four separate single-graft codes or a primary-plus-add-on structure.

16. **B. With the tunneled catheter removal code** CPT provides separate codes for tunneled catheter removal (36589). When a tunneled catheter is removed without replacement during the same session, only the removal code is reported. The insertion code is not applicable because no new catheter is being placed. A separate E/M code may be reported if a significant, separately identifiable evaluation is performed.

17. **A. It creates adhesion between the visceral and parietal pleura to prevent recurrence of pleural effusion** Pleurodesis creates adhesion (obliteration of the pleural space) between the visceral and parietal pleura using a sclerosing agent (talc) or mechanical abrasion. This prevents the reaccumulation of pleural fluid by eliminating the potential space where fluid collects. It is performed for recurrent malignant pleural effusions and recurrent pneumothorax.

18. **D. The aorta and great vessel/upper extremity artery repair subsection** Repair of the subclavian artery — a great vessel arising from the aortic arch — is coded in the vascular subsection covering the aorta, great vessels, and upper extremity arteries. The subclavian artery is classified as a great vessel. The specific code depends on the type of repair (primary, patch graft, or bypass) and the location.

40,000 Series — Digestive System

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

20. **C. It depends on whether the diagnostic laparoscopy evaluated a separate anatomical area and served an independent diagnostic purpose** When a diagnostic laparoscopy evaluates a different anatomical area (pelvis) for a separate clinical question (endometriosis) from the surgical

laparoscopy (appendectomy for appendicitis), it may be separately reportable if it served an independent diagnostic purpose. The coder must evaluate whether the diagnostic examination was truly distinct or simply part of the standard surgical approach. Clinical documentation determines reportability.

21. **A. It is not reported separately; it is included in the surgical EGD code** When a surgical procedure (injection of sclerosing agent) is performed during an EGD, the diagnostic examination is bundled into the surgical code. Only the surgical EGD code for injection therapy is reported. The endoscopic hierarchy rule applies consistently across all GI endoscopy.

22. **D. Hernia type (inguinal), initial vs. recurrent, reducible vs. incarcerated/strangulated, and the patient's age** CPT codes for inguinal hernia repair are determined by the hernia type (inguinal), whether initial or recurrent, whether reducible or incarcerated/strangulated, the patient's age (pediatric vs. adult codes), and the approach (open vs. laparoscopic). All of these factors affect code selection. This question describes a recurrent, strangulated inguinal hernia in a 50-year-old — all factors are relevant.

23. **B. With a separate CT guidance code in addition to the biopsy code** When the biopsy code does NOT include imaging guidance and CT guidance is used, the guidance code is reported separately. The coder must always check whether the procedure code includes imaging guidance before reporting a separate guidance code. In this case, since CT guidance is not included, the separate code is appropriate.

24. **C. It is not reported separately; it is included in the surgical ERCP code** Diagnostic ERCP is bundled into surgical ERCP when surgical procedures are performed during the same session. The nasobiliary drainage catheter placement is a surgical ERCP procedure. The diagnostic examination is included and is not reported as an additional code.

50,000 Series — Urinary, Reproductive, and Endocrine

25. **D. It is not reported separately; it is included in the surgical cystoscopy/TURP codes** Diagnostic cystoscopy is bundled into surgical cystoscopy when both are performed during the same session. The fulguration of the bladder tumor and the TURP are both surgical procedures performed through the cystoscope. The diagnostic examination is included in the surgical codes and is not separately reportable.

26. **A. Urinary system** Ureteroscopy codes are located in the urinary system subsection of CPT. The ureters are part of the urinary system, connecting the kidneys to the bladder. Procedures on the ureters — including ureteroscopy, stent placement, and stone extraction — are coded under the urinary system.

27. **C. The delivery-only code plus the postpartum care-only code** When a physician provides only the delivery and postpartum care while another physician provided the antepartum care, the delivery-only code plus the postpartum care-only code are reported. CPT provides separate codes

for each obstetric care component to accommodate split-care arrangements. The global code is not appropriate because the physician did not provide all three components.

28. **B. It is not coded separately; it is included in the hysterectomy code description** When the hysterectomy CPT code description specifically includes removal of the fallopian tubes, the salpingectomy is bundled into the hysterectomy code. The coder must read the complete code description to verify what is included. Reporting a separate salpingectomy code when it is already included constitutes unbundling.

29. **D. It depends on whether the radical nephrectomy code description includes the adrenalectomy; the coder must read the specific code description** Some radical nephrectomy codes include the ipsilateral adrenalectomy in the code description, while others do not. The coder must read the specific code description to determine whether the adrenalectomy is bundled or requires a separate code. When the code description includes the adrenalectomy, it should not be coded separately. When it does not, a separate code is appropriate.

30. **A. A subtotal thyroidectomy removes most of the thyroid but leaves a small remnant; a total thyroidectomy removes all thyroid tissue** A subtotal thyroidectomy removes the majority of both thyroid lobes but intentionally leaves a small remnant of thyroid tissue (typically on one side near the recurrent laryngeal nerve) to preserve some thyroid function. A total thyroidectomy removes all thyroid tissue from both lobes and the isthmus. CPT provides separate codes for each extent of thyroidectomy.

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

31. **C. Craniotomy codes for intracranial aneurysm repair, organized by vascular territory** Craniotomy codes for aneurysm repair (61697–61710) are organized by the vascular territory of the aneurysm — carotid circulation versus vertebrobasilar circulation. The vertebrobasilar location in the posterior fossa determines the specific code. This is different from craniotomy codes for tumor excision or hematoma evacuation, which are organized by different criteria.

32. **D. It indents the wall of the eye inward to push it against the detached retina, facilitating reattachment** A scleral buckle involves suturing a silicone band or sponge to the outside of the eye (sclera), which indents the eye wall inward. This pushes the retinal pigment epithelium closer to the detached sensory retina, closing the space between them and facilitating reattachment. Cryotherapy or laser is typically applied to create a seal around retinal tears.

33. **B. Neurolysis (destruction) of a sympathetic nerve plexus** A celiac plexus neurolytic block using alcohol is classified as neurolysis — permanent destruction of the nerve plexus. The celiac plexus is a sympathetic nerve structure in the abdomen. Neurolytic blocks use chemical agents (alcohol, phenol) to destroy nerve tissue permanently, unlike diagnostic/therapeutic blocks that use local anesthetics for temporary relief. The CPT code reflects destruction of a sympathetic nerve plexus.

34. **A. With the shunt reprogramming code — a non-invasive adjustment of the valve setting** Programmable VP shunt valve reprogramming (62252) is a non-invasive procedure where an external magnetic device adjusts the pressure setting of the valve without surgery. This is a distinct service from shunt revision (which involves surgical replacement of components). The reprogramming code captures the physician's work of evaluating the patient and adjusting the valve setting.

35. **C. The combination cataract surgery with MIGS code** CPT provides combination codes (66989–66991) for cataract surgery performed with MIGS procedures such as iStent insertion. When both are performed during the same session, the combination code captures both services in a single code. Reporting the cataract code and a separate MIGS code when a combination code exists would be incorrect.

36. **D. It removes or partially removes the stapes bone (the third ossicle) and replaces it with a prosthesis to restore sound conduction** A stapedectomy removes all or part of the stapes — the third and smallest ossicle in the middle ear — and replaces it with a prosthetic device to restore the ossicular chain's sound conduction mechanism. Otosclerosis causes fixation of the stapes footplate, preventing normal vibration and causing conductive hearing loss. The prosthesis restores the mechanical transmission of sound.

Evaluation and Management

37. **B. High** A new complaint of severe abdominal pain with a decision for emergency surgery constitutes high-level problem complexity. Ordering a CT, labs, and a surgical consultation constitutes extensive/high-level data. Emergency surgery involves the highest level of management risk. All three MDM elements meet the high threshold, supporting code 99215 for an established patient.

38. **A. Only the initial hospital care code for Monday; the office visit is rolled into the admission when performed by the same physician on the same date** When the same physician provides an office evaluation and subsequently admits the patient to the hospital on the same date, only the initial hospital care code (99221–99223) is reported. The office visit is rolled into the admission service. This prevents double billing for the same physician's cognitive services on the same date.

39. **D. Initial neonatal critical care (99468)** Initial neonatal critical care code 99468 covers the first day of critical care for a critically ill neonate. This code is specific to neonates (28 days or younger) and is a per-day code — not time-based like adult critical care codes. Subsequent days use 99469. The birth weight of 2,500 grams does not qualify for the very low or low birth weight continuing intensive care codes.

40. **C. The preventive medicine code plus an E/M office visit code with modifier 25** When a significant, separately identifiable problem (poorly controlled diabetes requiring medication adjustment) is addressed during a preventive medicine visit, both the preventive code and an appropriate E/M code are reported. Modifier 25 is appended to the 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 diabetes code.

41. **B. 99291 × 1 plus 99292 × 1** Critical care code 99291 covers the first 30–74 minutes. Code 99292 covers each additional 30 minutes. For 110 total minutes: 99291 × 1 (first 74 minutes), leaving 36 remaining minutes. The 36 minutes exceeds the 15-minute minimum threshold for one unit of 99292. A second unit of 99292 would require an additional 30 minutes (total of 135 minutes). Total: 99291 × 1, 99292 × 1.

42. **A. A medically appropriate history and exam must be performed and documented, but they are no longer the determining factors for code level — MDM or total time determines the level** Under the current E/M guidelines, a medically appropriate history and examination are still required but do not determine the code level. The code level is selected based on either MDM complexity or total time — whichever supports the higher level. The old framework requiring specific history and exam elements has been replaced by this simplified two-pathway model.

Anesthesia

43. **D. 31 units** Base units (11) + Time units (300 minutes ÷ 15 minutes/unit = 20.0) + Modifying units (P2 = 0) = 31.0 total units. Physical status P2 (controlled hypertension) typically does not add modifying units. The calculation: 11 + 20 + 0 = 31. Long neurosurgical procedures generate high time unit values.

44. **C. With the standard anesthesia code for the surgical procedure — the type of anesthetic (general, regional, MAC) does not change the anesthesia CPT code** The anesthesia CPT code is based on the surgical procedure being performed — not the type of anesthetic administered. A spinal block, general anesthesia, or MAC for the same procedure all use the same anesthesia code. The type of anesthetic may be identified with modifiers (such as QS for MAC) but does not change the base CPT code.

45. **A. The value depends on the payer, but 99100 is reported as an add-on code and may add 1 unit to the formula** Qualifying circumstances code 99100 (extreme age) is reported as an add-on code. The specific unit value varies by payer — Medicare typically assigns 1 unit for 99100. Some commercial payers may assign different values or may not recognize qualifying circumstances codes at all. The coder should verify the payer's specific policy.

46. **B. Modifier QX** Modifier QX indicates a CRNA providing anesthesia services under the medical direction of an anesthesiologist. The CRNA appends modifier QX to their claim. The anesthesiologist appends modifier QY to their claim for the same case. Modifier AA indicates the anesthesiologist personally performed the service. Modifier QZ indicates a CRNA without medical direction.

Radiology

47. **D. MRI shoulder with contrast** When an MRI is performed with intravenous gadolinium contrast, it is coded as "with contrast." Gadolinium is the standard MRI contrast agent and qualifies as "with contrast" in CPT. If the study were performed first without contrast and then repeated with contrast, the combination code would be used instead.

48. **C. The hospital bills the global code since both components are provided by hospital employees** When the hospital employs both the technologist (technical component) and the radiologist (professional component), the hospital bills the global code without any modifier. The components are not split because both are provided by the same entity. If the radiologist were an independent contractor, the components would be split with modifiers TC and 26.

49. **A. Screening mammography code (77067) with diagnosis Z12.31** A screening mammogram on an asymptomatic patient with no abnormal findings is coded with the screening mammography code (77067) and diagnosis Z12.31 (encounter for screening mammogram). Diagnostic mammography codes are used when a clinical indication exists. The screening code and Z code together correctly capture the preventive nature of the service.

50. **B. Treatment management (77427)** Treatment management code 77427 covers the physician's ongoing supervision and evaluation during a radiation therapy course — including review of the treatment plan, evaluation of the patient for side effects, and coordination of care. It is reported per 5 treatment fractions. Treatment planning designs the course. Treatment delivery administers the radiation. Simulation establishes the setup.

51. **D. Two separate CT codes — one for the neck soft tissue and one for the cervical spine — since they evaluate different anatomical targets with appropriate modifiers if needed** CT of the neck soft tissue and CT of the cervical spine are different studies evaluating different anatomical structures for different clinical indications. The neck soft tissue CT evaluates masses, lymph nodes, and vascular structures. The cervical spine CT evaluates vertebral bodies, discs, and the spinal canal. Both may be reported separately with appropriate modifiers if NCCI edits require them.

52. **C. M81 or M85 (Osteoporosis or disorders of bone density) or Z87 (personal history) — a code reflecting the documented bone density abnormality or risk factor** A DEXA scan performed to monitor documented osteopenia requires a diagnosis code that supports the medical necessity of the study. Codes from the M81 (osteoporosis) or M85 (bone density disorders) categories, or a Z code for personal history of bone density abnormality, provide appropriate clinical justification. Screening Z codes or unrelated symptom codes would not support the indication.

Pathology and Laboratory

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

54. **B. Level V (88307)** A radical prostatectomy specimen is classified at Level V surgical pathology (88307). Level V covers complex specimens requiring extensive examination including complete surgical margin assessment and cancer staging. The pathologist must evaluate the entire specimen for tumor extent, Gleason grading, margin status, extraprostatic extension, and seminal vesicle involvement.

55. **D. Eight units of the sensitivity code — one per antibiotic agent tested (using the microdilution MIC method code)** Sensitivity testing codes are reported per antibiotic agent tested. The microdilution method (MIC — minimum inhibitory concentration) code is reported for each of the 8 antibiotics tested. Eight antibiotics = 8 units. The culture code is reported separately for the initial organism identification.

56. **C. The rapid influenza antigen detection code (87804) with modifier QW** The rapid influenza antigen test is an infectious agent detection test coded with 87804. Since the test is CLIA-waived and performed in a physician's office, modifier QW is appended. The influenza NAAT code would be used for molecular/PCR testing, which is a different and more sensitive detection method.

57. **A. With the manual differential code (85004) in addition to the CBC code (85025)** When the automated differential is flagged as abnormal and a manual blood smear review is performed by a pathologist, the manual differential code (85004) is reported in addition to the CBC code (85025). The manual review provides additional clinical information beyond the automated result and constitutes a separate service.

58. **B. Quantitative clinical chemistry test (numerical result measuring the exact concentration)** A serum PSA level is a quantitative clinical chemistry test that measures the exact concentration of prostate-specific antigen in the blood, reported as a numerical value in ng/mL. It is not a qualitative test (which would provide only positive/negative), not a drug screen, and not a cytopathology test. PSA codes are in the chemistry section of the Pathology and Laboratory chapter.

Medicine

59. **D. 96365 × 1 (initial hour) plus 96366 × 1 (additional 30 minutes of therapeutic infusion)** A non-chemotherapy therapeutic drug infusion is coded with the therapeutic infusion codes (96365–96368). The initial hour is coded with 96365. The additional 30 minutes exceeds the midpoint

threshold for an additional unit and is reported with add-on code 96366. Since this is the only IV service, the therapeutic infusion is appropriately reported as the initial service.

60. **C. Medicine section** Pulmonary function testing codes (94010–94799) are located in the Medicine section of CPT. These codes cover spirometry, lung volumes, diffusing capacity, bronchospasm evaluation, and other respiratory function tests. Despite evaluating the respiratory system, these diagnostic tests are classified in Medicine — not in the Surgery section under respiratory system.

61. **A. Preventive medicine services codes (99391–99397) based on the patient's age** When an established patient presents solely for an annual preventive visit with no other problems addressed, the preventive medicine services codes are used. For established patients, the code range is 99391–99397, with specific codes based on the patient's age group. A 50-year-old falls in the 40–64 age range.

62. **B. 2 timed units — 1 unit of 97032 and 1 unit of 97110; the remaining time allocated based on minutes** Both electrical stimulation (constant attendance modality, 97032) and therapeutic exercise (97110) are timed codes reported per 15-minute unit. Electrical stimulation at 8 minutes meets the 8-minute minimum for 1 unit. Therapeutic exercise at 23 minutes qualifies for 1 unit (with 8 remaining minutes not meeting the threshold for a second unit). Total: 2 timed units.

63. **D. Cardiovascular diagnostic services** Exercise treadmill stress test codes are located in the Medicine section under the cardiovascular diagnostic services subsection. These codes cover the physician supervision, interpretation, and report of the exercise stress test. When performed with imaging (nuclear or echo), additional imaging codes are reported.

64. **C. With the fluorescein angiography code (92235) as a special ophthalmological service reported separately from the eye examination** Fluorescein angiography (92235) is a special ophthalmological diagnostic service coded separately from the eye examination. It involves IV injection of fluorescein dye followed by sequential photography of the retinal vasculature. This is not the same as an intravitreal injection (67028) or fundus photography (92250) — it is a distinct vascular imaging study.

Medical Terminology

65. **B. Disease or abnormal condition** The suffix "-pathy" means disease or abnormal condition. Common examples include neuropathy (disease of the nerves), nephropathy (disease of the kidneys), cardiomyopathy (disease of the heart muscle), and retinopathy (disease of the retina). "-Itis" means inflammation, "-plasty" means surgical repair, and "-emia" means blood condition.

66. **A. Neur/o** The combining form "neur/o" refers to the nerve. Common terms include neurology (study of the nervous system), neuropathy (nerve disease), neuritis (nerve inflammation), and neurosurgery (surgery on the nervous system). "My/o" refers to muscle, "oste/o" refers to bone, and "cardi/o" refers to the heart.

67. **D. Within** The prefix "intra-" means within or inside. Common terms include intravenous (within a vein), intracranial (within the skull), intra-articular (within a joint), and intrathecal (within the spinal canal). "Inter-" means between, "supra-" means above, and "sub-" means below.

68. **C. Creation of a new opening from the colon to the body surface** Colostomy means creation of a new opening (stoma) from the colon to the surface of the body, from the combining form "col/o" (colon) and the suffix "-ostomy" (creating a new opening). Colectomy means removal of the colon. Colonoscopy means visual examination of the colon. Colotomy means incision into the colon.

Anatomy

69. **A. In the wall of the right atrium** The sinoatrial (SA) node is located in the wall of the right atrium near the junction of the superior vena cava. It is the heart's natural pacemaker, generating electrical impulses that initiate each heartbeat. The impulse spreads through the atria to the atrioventricular (AV) node, then through the bundle of His and Purkinje fibers to stimulate ventricular contraction.

70. **B. Esophagus** The esophagus is a muscular tube approximately 25 cm long that connects the pharynx (throat) to the stomach. It passes through the thoracic cavity, pierces the diaphragm at the esophageal hiatus, and joins the stomach at the gastroesophageal junction. The trachea connects the larynx to the bronchi (airway, not digestive). The duodenum connects the stomach to the jejunum.

71. **D. The urethra (prostatic urethra)** The prostate gland surrounds the prostatic urethra — the portion of the urethra that passes through the prostate just below the bladder. This anatomical relationship explains why benign prostatic hyperplasia (BPH) causes urinary obstruction — the enlarging prostate compresses the urethra passing through it. TURP resects tissue from within the prostate to relieve this obstruction.

72. **C. The abdominal/pelvic cavity** The peritoneum is the serous membrane that lines the abdominal and pelvic cavities (parietal peritoneum) and covers the abdominal organs (visceral peritoneum). The peritoneal cavity is the potential space between these two layers. The pleura lines the thoracic cavity, the meninges surround the brain and spinal cord, and the pericardium surrounds the heart.

ICD-10-CM / Diagnosis Coding

73. **B. The gastric ulcer code with the appropriate complication code for hemorrhage, plus the iron deficiency anemia code** When iron deficiency anemia is documented as due to chronic blood loss from a gastric ulcer, ICD-10-CM requires coding the underlying cause (gastric ulcer with hemorrhage) along with the anemia. The gastric ulcer code from K25 with the hemorrhage specification captures the source of bleeding. The iron deficiency anemia due to chronic blood loss code captures the resulting anemia.

74. **A. Report a Z code for the encounter reason (Z53) as the first-listed code, followed by the code for the reason the procedure was cancelled** When a planned procedure is cancelled, a code

from Z53 (persons encountering health services for specific procedures and treatment not carried out) is reported as the first-listed diagnosis, followed by the code for the reason the procedure was cancelled (e.g., contraindication, patient's decision). The procedure code is not reported because the procedure was not performed.

75. **D. By type (systolic, diastolic, combined) and acuity (acute, chronic, acute on chronic)** ICD-10-CM classifies heart failure by type — systolic (reduced ejection fraction), diastolic (preserved ejection fraction), or combined systolic and diastolic — and by acuity — acute, chronic, or acute on chronic. This provides a high level of clinical specificity. The coder must match the code to the specific type and acuity documented.

76. **C. Chapter 20 (External causes of morbidity — V00–Y99)** External cause codes describing how the injury occurred (activity, place, mechanism) are found in ICD-10-CM Chapter 20 (V00–Y99). These codes capture the cause, intent, place, and activity associated with an injury. Chapter 19 contains the injury codes themselves. External cause codes are supplementary and are reported in addition to the injury codes.

77. **A. With a code from Z68 (Body mass index) as an additional code reported with the obesity diagnosis code** ICD-10-CM guidelines direct coders to report BMI codes from Z68 as additional codes with the obesity diagnosis. The BMI code provides specificity about the severity of the obesity. BMI codes should not be reported as primary diagnoses — they are always supplementary to the obesity diagnosis. BMI codes cover the full range from pediatric through adult percentiles and values.

HCPCS Level II

78. **B. E0400–E0486 (within the E-code range for DME)** Home oxygen equipment including oxygen concentrators, portable oxygen systems, and related supplies are coded within the E-code range for durable medical equipment. Specific codes exist for different types of oxygen delivery systems (concentrators, liquid oxygen, compressed gas) and related accessories. J-codes cover drugs, L-codes cover orthotics/prosthetics.

79. **D. The provider expects Medicare to deny the service as not medically necessary, and NO ABN was obtained** Modifier GZ indicates that the provider expects the service to be denied as not reasonable and necessary and did not obtain a signed ABN from the patient. When modifier GZ is used and the claim is denied, the provider cannot bill the patient — the provider must absorb the cost. This is the financial consequence of failing to obtain an ABN.

80. **C. 2 units** The HCPCS J-code for Depo-Medrol specifies 40 mg per unit. The physician administered 80 mg: 80 mg ÷ 40 mg/unit = 2 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 dosage.

Coding Guidelines

81. **A. It is not reported separately; it is bundled into the surgical endoscopy code** When a diagnostic endoscopy is followed by a surgical endoscopy during the same session on the same anatomical site, only the surgical endoscopy code is reported. The diagnostic examination is bundled into the surgical code. This is the standard endoscopic hierarchy that applies across all endoscopic procedures.

82. **D. Modifier 73 (discontinued outpatient procedure prior to anesthesia) or modifier 53 (discontinued procedure) depending on the setting** When a procedure is cancelled after anesthesia is administered but before the procedure begins, the appropriate modifier depends on the setting and who is reporting. Modifier 73 is used in the hospital outpatient/ASC setting by the facility. Modifier 53 is used by the physician. Both indicate the procedure was discontinued due to a complicating event.

83. **B. Modifier 24** Modifier 24 (unrelated E/M service during the postoperative period) is appended when the physician provides an E/M service for a condition completely unrelated to the original surgery during the 90-day global period. Modifier 79 is for unrelated procedures. Modifier 78 is for complications requiring return to the OR. Modifier 58 is for planned staged procedures.

84. **C. They must always accompany a designated primary procedure code and are never reported alone** Add-on codes (identified with the "+" symbol) are never reported as standalone services. They must always be reported with a designated primary procedure code. They represent additional work performed in conjunction with the primary procedure. Add-on codes are exempt from modifier 51 and are reimbursed at 100% without multiple procedure payment reduction.

85. **A. To identify code pairs where the Column 2 code is bundled into the Column 1 code when reported together for the same patient on the same date by the same provider** NCCI Column 1/Column 2 edits identify code pairs where the Column 2 code is a component of the Column 1 code. When both are reported together, the Column 2 code is denied. The modifier indicator determines whether a modifier may be used to bypass the edit when clinically justified.

86. **D. The code is typically paid at 150% of the single-unit rate (100% + 50%)** Under Medicare, when modifier 50 is reported for a bilateral procedure, the typical reimbursement is 150% of the single-unit allowed amount — 100% for the primary side and 50% for the contralateral side. This follows the multiple procedure payment reduction principle. Some commercial payers may have different bilateral payment policies.

87. **B. Appendix C (Clinical Examples)** Appendix C of the CPT manual contains clinical examples (vignettes) for E/M code selection. These examples illustrate typical patient encounters at different E/M code levels to help providers and coders understand the intended complexity for each level. Appendix A covers modifiers. Appendix D covers add-on codes. Appendix B covers annual changes.

Compliance and Regulatory

88. **C. Practice Expense (PE) RVU** The Practice Expense RVU is the component that differs between facility and non-facility settings. In non-facility settings (physician's office), the PE RVU is higher because the physician bears overhead costs. In facility settings (hospital), the PE RVU is lower because the facility provides overhead and bills separately. Work RVUs and PLI RVUs are generally the same regardless of setting.

89. **A. A compliance violation — modifier 25 should only be used when the E/M is genuinely significant and separately identifiable from the procedure** Routinely appending modifier 25 to every same-day E/M and procedure combination without verifying that the E/M is truly significant and separately identifiable is a compliance violation. Modifier 25 should only be used when the documentation supports a distinct, separately identifiable E/M service beyond the standard pre-procedure evaluation included in the surgical package.

90. **D. On-campus outpatient hospital** Place of service code 22 represents an on-campus outpatient hospital department — a department of a hospital that provides diagnostic, therapeutic, or rehabilitation services on an outpatient basis located on the main hospital campus. POS 11 is physician's office, POS 23 is emergency department, POS 24 is ambulatory surgical center.

Cases — Integrated Coding Scenarios

91. **B. 1.8 cm** The excised diameter is calculated as lesion diameter plus margins on both sides: 1.0 cm + (0.4 cm × 2) = 1.8 cm. The margin is doubled because tissue is removed circumferentially. This 1.8 cm excised diameter determines the correct code within the benign excision range for the arm anatomical grouping.

92. **C. Yes; intermediate and complex closures may be reported separately from excision codes** Simple closure is included in the excision code. However, intermediate and complex closures require additional work beyond what the excision code encompasses and may be reported separately. The intermediate layered repair of the excision site is a separately reportable service coded with the appropriate intermediate repair code.

93. **D. 99215 (established patient, high MDM)** An established patient with high-complexity MDM — new-onset atrial fibrillation requiring extensive evaluation and high-risk management — supports 99215. The patient is established (has been seen before by this cardiologist or a physician of the same specialty in the same group), and the MDM complexity is high. Code 99205 is for new patients only.

94. **A. No modifier; the global ECG code (93000) is reported since both components are provided** When the physician performs the ECG using practice-owned equipment and also interprets the study, both the technical and professional components are provided by the same entity. The global ECG code (93000) is reported without any modifier. Modifier 26 would only apply if the physician provided only the interpretation at an outside facility.

95. **B. Laparoscopic cholecystectomy with cholangiography** The procedure was completed laparoscopically with intraoperative cholangiography. The correct code is the laparoscopic cholecystectomy with cholangiography. The code must match exactly what was performed — laparoscopic approach with cholangiography. The code without cholangiography would miss a performed component.

96. **C. A combination code from category K80 that captures both the cholelithiasis and the acute cholecystitis** ICD-10-CM provides combination codes in category K80 that capture both cholelithiasis and the associated cholecystitis in a single code. Separate codes for gallstones and cholecystitis are not needed. The specific code depends on whether obstruction is documented.

97. **D. A primary ablation code for the first nerve plus add-on codes for each additional nerve** Radiofrequency ablation of medial branch nerves uses a primary code for the first facet joint nerve destroyed and an add-on code for each additional nerve in the same spinal region. Three lumbar levels require one primary code plus two add-on codes.

98. **A. With modifier 50 or RT/LT modifiers on the ablation codes** Spinal radiofrequency ablation codes are unilateral. When performed bilaterally, modifier 50 or RT/LT modifiers are applied to indicate the procedure was performed on both sides. The bilateral modifier is applied to both the primary and add-on codes as appropriate per payer requirements.

99. **C. The rituximab therapeutic infusion** The infusion hierarchy places therapeutic drug infusion above hydration. Even though the hydration was administered first chronologically, the rituximab therapeutic infusion is the initial service because it ranks higher in the hierarchy. The hydration is reported as a secondary service. The IV push is reported as an add-on.

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