PART THREE: BONUS TOPIC-FOCUSED PRACTICE

Introduction

Congratulations on completing the 18 full-length simulation exams in Part Two. You have now worked through 1,800 practice questions that mirror the format, structure, and domain weighting of the actual AAPC CPC certification exam. That level of preparation builds the broad-based competency and test-taking stamina that high-stakes exams demand.

Part Three takes a different approach. Rather than simulating the full exam experience, these 20 bonus sections isolate individual topic areas so you can drill specific subjects with precision. Each section contains 10 focused questions drawn from a single content domain, allowing you to identify and strengthen areas where additional review is needed.

How to Use These Bonus Sections

These sections are designed for targeted review. After completing the simulation exams, review your performance across all 18 exams and identify the content areas where you scored lowest or felt least confident. Then use the corresponding bonus section to reinforce your understanding of that topic before retaking a full-length simulation exam.

You can also use these sections as a warm-up tool in the days leading up to your exam. Working through two or three focused sections per study session keeps the material fresh without the time commitment of a full 100-question practice exam.

Each section includes 10 multiple-choice questions followed by an answer key with concise explanations. The questions are written in the same concise, exam-style format used throughout this study guide — one-sentence stems with brief answer options and no embedded explanations.

What to Expect

Part Three contains the following 20 bonus topic-focused sections, organized to align with the major content areas tested on the CPC exam:

Bonus Section A: Integumentary System (10 Questions) **Bonus Section B:** Musculoskeletal System (10 Questions) **Bonus Section C:** Respiratory System (10 Questions) **Bonus Section D:** Cardiovascular System (10 Questions) **Bonus Section E:** Digestive System (10 Questions) **Bonus Section F:** Urinary System (10 Questions) **Bonus Section G:** Reproductive and Endocrine Systems (10 Questions) **Bonus Section H:** Nervous System (10 Questions) **Bonus Section I:** Eye and Ocular Adnexa (10 Questions)

Bonus Section J: Ear, Nose, and Throat (10 Questions) **Bonus Section K:** Evaluation and Management (10 Questions) **Bonus Section L:** Anesthesia (10 Questions) **Bonus Section M:** Radiology (10 Questions) **Bonus Section N:** Pathology and Laboratory (10 Questions) **Bonus Section O:** Medicine Services (10 Questions) **Bonus Section P:** Medical Terminology (10 Questions) **Bonus Section Q:** Anatomy and Physiology (10 Questions) **Bonus Section R:** ICD-10-CM Diagnosis Coding (10 Questions) **Bonus Section S:** HCPCS Level II and Modifiers (10 Questions) **Bonus Section T:** Compliance, Regulatory, and Coding Guidelines (10 Questions)

Total: 200 Bonus Practice Questions

A Final Note

These bonus questions are supplementary practice — they do not replace the full-length simulation exams. The simulation exams in Part Two remain your most important assessment tool because they replicate the actual exam experience, including time pressure, domain mixing, and the cognitive endurance required for a 4-hour test. Use Part Three to sharpen specific skills, then return to a simulation exam to measure your overall readiness.

You have invested significant effort to reach this point. Trust your preparation, stay focused, and approach exam day with confidence.

BONUS SECTION A: E/M OFFICE AND OUTPATIENT VISITS (10 QUESTIONS)

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1. Under the current E/M guidelines, an established patient office visit is selected based on either medical decision-making (MDM) or total time. When using the MDM pathway, how many of the three MDM elements must meet or exceed the level being reported?

A. All three elements

B. One of three elements

C. Two of three elements

D. The number varies by code level

2. A physician sees an established patient in the office. The total time on the date of the encounter is 28 minutes. Using the time-based pathway, which code is supported?

A. 99213 (established patient, 20 minutes)

B. 99214 (established patient, 30 minutes)

C. 99212 (established patient, 10 minutes)

D. 99215 (established patient, 40 minutes)

3. Under the current E/M guidelines, "total time" for office visits includes which of the following activities?

A. Only face-to-face time with the patient

B. Only time spent performing the physical examination

C. Only time spent on medical decision-making

D. All physician/qualified health professional activities on the date of the encounter — including pre-visit preparation, face-to-face time, and post-visit documentation, ordering, and care coordination

4. A physician sees an established patient with four chronic conditions: two are stable, one is worsening, and one is a new problem requiring a workup. The physician reviews external records, orders imaging, and prescribes a drug requiring intensive monitoring. What level of MDM does this support?

A. Low

B. High

C. Straightforward

D. Moderate

5. A new patient presents to the office. The physician determines the MDM is moderate complexity. Using the MDM pathway, which new patient code should be reported?

A. 99204 (new patient, moderate MDM)

B. 99203 (new patient, low MDM)

C. 99205 (new patient, high MDM)

D. 99202 (new patient, straightforward MDM)

6. A physician performs an established patient office visit (99214) and also performs a minor surgical procedure (10-day global period) during the same encounter. The E/M is significant and separately identifiable from the procedure. Which modifier should be appended to the E/M code?

A. Modifier 57

B. Modifier 59

C. Modifier 25

D. Modifier 51

7. A physician sees a new patient in the office. The total time on the date of the encounter is 50 minutes. Using the time-based pathway, which code is supported?

A. 99205 (new patient, 60 minutes)

B. 99204 (new patient, 45 minutes)

C. 99203 (new patient, 30 minutes)

D. 99202 (new patient, 15 minutes)

8. A physician provides a prolonged office visit to an established patient. The total time is 72 minutes. Under the time-based pathway, which code(s) should be reported?

A. 99215 only; the additional time is not reportable

B. 99215 plus 99417 × 3

C. 99214 plus 99417 × 2

D. 99215 plus 99417 × 2

9. Under the current E/M guidelines, which of the following correctly describes the documentation requirements for history and physical examination in office visit code selection?

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

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

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

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

10. A physician performs an E/M office visit that results in the initial decision to perform a major surgical procedure (90-day global period). The surgery is scheduled for the following week. Which modifier should be appended to the E/M code?

A. Modifier 25

B. Modifier 59

C. Modifier 57

D. Modifier 24

BONUS SECTION A — ANSWER KEY WITH EXPLANATIONS

E/M Office and Outpatient Visits

1. **C. Two of three elements** Under the current E/M guidelines, MDM has three elements: the number and complexity of problems addressed, the amount and complexity of data reviewed, and the risk of complications and/or morbidity or mortality. Two of the three elements must meet or exceed the level being reported. The highest two elements determine the MDM level — the lowest element does not prevent reporting the higher level.

2. **A. 99213 (established patient, 20 minutes)** Under the time-based pathway, 99213 requires a minimum of 20 minutes for an established patient. The physician spent 28 minutes, which meets and exceeds the 20-minute threshold for 99213 but does not reach the 30-minute threshold for 99214. The code reflects the highest level for which the time threshold is met.

3. **D. All physician/qualified health professional activities on the date of the encounter — including pre-visit preparation, face-to-face time, and post-visit documentation, ordering, and care coordination** Under the current guidelines, total time encompasses all activities performed by the physician or qualified health professional on the date of the encounter. This includes reviewing records and data before the visit, the face-to-face evaluation, and post-visit work such as documentation, ordering tests, communicating results, and coordinating care. Time does not need to be exclusively face-to-face.

4. **B. High** Four chronic conditions with one worsening and one new problem requiring workup constitutes high-level problem complexity. Reviewing external records and ordering imaging constitutes extensive data. Prescribing a drug requiring intensive monitoring constitutes the highest risk level. Two of three MDM elements meet the high threshold, supporting 99215 for an established patient or 99205 for a new patient.

5. **A. 99204 (new patient, moderate MDM)** A new patient with moderate-complexity MDM supports code 99204. The new patient office visit codes (99202–99205) correspond to straightforward, low, moderate, and high MDM respectively. Moderate MDM maps directly to 99204. Code 99205 requires high MDM, and 99203 requires only low MDM.

6. **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 minor surgical procedure has a 10-day global period, making modifier 25 the correct choice. Modifier 57 is reserved for major procedures with 90-day global periods.

7. **B. 99204 (new patient, 45 minutes)** Under the time-based pathway, 99204 requires 45 minutes for a new patient. The physician spent 50 minutes, which meets and exceeds the 45-minute threshold for 99204 but does not reach the 60-minute threshold for 99205. The code reflects the highest level for which the minimum time requirement is met.

8. **D. 99215 plus 99417 × 2** Under the time-based pathway, 99215 requires 40 minutes for an established patient. The physician spent 72 minutes — 32 minutes beyond the 40-minute threshold. Each unit of 99417 covers 15 minutes. The first 15 minutes (minutes 41–55) supports the first unit of 99417. The next 15 minutes (minutes 56–70) supports the second unit. The remaining 2 minutes (minutes 71–72) do not meet the 15-minute threshold for a third unit. Total: 99215 + 99417 × 2.

9. **A. A medically appropriate history and exam must be performed and documented, but they no longer determine the code level — MDM or total time determines the level** Under the current E/M guidelines effective since 2021, a medically appropriate history and physical examination are still required components of the encounter but no longer serve as determining factors for code level selection. The code level is based on either the complexity of MDM or the total time spent on the date of the encounter. The previous framework requiring specific counts of history and examination elements has been eliminated.

10. **C. Modifier 57** Modifier 57 (decision for surgery) is appended to the E/M code when the visit results in the initial decision to perform a major surgical procedure with a 90-day global period. This modifier tells the payer that the E/M service was the encounter during which the surgical decision was made and should not be bundled into the surgical global package. Modifier 25 would be appropriate only for minor procedures with 0-day or 10-day global periods.

BONUS SECTION B: SURGICAL MODIFIERS AND THE GLOBAL PACKAGE (10 QUESTIONS)

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1. A surgeon performs a major surgical procedure with a 90-day global period. During the postoperative period, the patient develops a wound infection requiring an unplanned return to the operating room for irrigation and debridement. Which modifier should be appended to the I&D code?

A. Modifier 58

B. Modifier 78

C. Modifier 79

D. Modifier 24

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

A. Modifier 78

B. Modifier 79

C. Modifier 58

D. Modifier 76

3. During the 90-day global period of a right total hip arthroplasty, the patient develops an unrelated urinary tract infection and is evaluated by the same surgeon in the office. Which modifier should be appended to the E/M code for the UTI evaluation?

A. Modifier 24

B. Modifier 78

C. Modifier 58

D. Modifier 79

4. A CPT code has a global period designation of "090." Which of the following services is included in this global surgical package and should NOT be reported separately?

A. An unrelated E/M service during the postoperative period

B. An unplanned return to the OR for a complication

C. A completely unrelated surgical procedure during the postoperative period

D. Routine postoperative follow-up visits during the 90-day period

5. A surgeon performs two distinct surgical procedures on different anatomical sites through separate incisions during the same operative session. How should the secondary procedure (lower RVU) be coded?

A. With modifier 59

B. With modifier 22

C. With modifier 51

D. With modifier 76

6. A patient falls and sustains a left wrist fracture during the 90-day global period of a right inguinal hernia repair performed by the same surgeon. The surgeon treats the wrist fracture. Which modifier should be appended to the fracture treatment code?

A. Modifier 79

B. Modifier 78

C. Modifier 58

D. Modifier 24

7. A surgeon performs a procedure that involves significantly more work than typically required. The operative report documents extensive adhesiolysis, morbid obesity causing significant technical difficulty, and substantially prolonged operative time. Which modifier should be appended?

A. Modifier 52

B. Modifier 53

C. Modifier 51

D. Modifier 22

8. Under the Medicare global surgical package for a major procedure (90-day global period), which of the following is true regarding the preoperative component?

A. No preoperative services are included; all preoperative E/M visits are separately reportable

B. The preoperative evaluation on the day before or the day of surgery is included in the global package

C. All preoperative visits for 30 days before surgery are included

D. Only the preoperative H&P is included; all other preoperative services are separate

9. A physician begins a surgical procedure under general anesthesia but discontinues the procedure after the initial incision due to a sudden cardiac arrhythmia that threatens the patient's well-being. Which modifier should the physician append?

A. Modifier 52

B. Modifier 22

C. Modifier 53

D. Modifier 58

10. A surgeon provides only the surgical care for a total knee arthroplasty. A different physician will provide all postoperative management. Which modifier should the operating surgeon append to the procedure code?

A. Modifier 54

B. Modifier 55

C. Modifier 56

D. Modifier 24

BONUS SECTION B — ANSWER KEY WITH EXPLANATIONS

Surgical Modifiers and the Global Package

1. **B. Modifier 78** Modifier 78 (unplanned return to the operating room for a related procedure during the postoperative period) is appended when a complication of the original surgery requires an unplanned return to the OR during the global period. The wound infection requiring I&D is a complication directly related to the original surgical site. Modifier 58 is for planned staged procedures. Modifier 79 is for unrelated procedures. Modifier 24 is for unrelated E/M services.

2. **C. Modifier 58** Modifier 58 (staged or related procedure during the postoperative period) is appended when a planned second-stage procedure is performed during the global period of the original surgery. The tissue expander exchange for a permanent implant was prospectively planned at the time of the initial insertion. Modifier 58 initiates a new global period for the second-stage procedure.

3. **A. Modifier 24** Modifier 24 (unrelated E/M service during the postoperative period) is appended when the physician provides an E/M evaluation for a condition completely unrelated to the original surgery during the global period. The UTI is unrelated to the hip arthroplasty. Modifier 24 tells the payer the office visit is for a different condition and should not be bundled into the surgical global package.

4. **D. Routine postoperative follow-up visits during the 90-day period** The 90-day global surgical package includes routine postoperative follow-up visits, routine wound care, suture/staple removal, cast changes, and all routine monitoring related to the surgical recovery. These services are bundled into the surgical code and are not separately reportable. Unrelated E/M services (modifier 24), unrelated procedures (modifier 79), and unplanned returns to the OR (modifier 78) may be separately reported with appropriate modifiers.

5. **C. Modifier 51** Modifier 51 (multiple procedures) is appended to the secondary procedure (lower RVU) when two distinct surgical procedures are performed through separate incisions during the same operative session. This indicates multiple procedures were performed and triggers the multiple procedure payment reduction on the secondary procedure. The primary procedure (highest RVU) is reported without modifier 51.

6. **A. Modifier 79** Modifier 79 (unrelated procedure or service during the postoperative period) is appended when a completely unrelated surgical procedure is performed during the global period of a previous surgery. The left wrist fracture has no clinical relationship to the right inguinal hernia

repair — different anatomical site, different diagnosis, different mechanism. Modifier 79 initiates a new global period for the fracture treatment.

7. **D. Modifier 22** Modifier 22 (increased procedural services) is appended when the work required to perform a procedure substantially exceeds what is typically required. The documentation must support the increased work — extensive adhesiolysis, morbid obesity causing technical difficulty, and prolonged operative time all justify modifier 22. Claims with modifier 22 require detailed operative report documentation and are subject to manual payer review.

8. **B. The preoperative evaluation on the day before or the day of surgery is included in the global package** Under the Medicare global surgical package for major procedures, the preoperative evaluation performed on the day before or the day of the surgery by the operating surgeon is included. E/M visits performed earlier in the preoperative period (more than one day before surgery) are generally separately reportable. The E/M visit resulting in the decision for surgery is reported with modifier 57.

9. **C. Modifier 53** Modifier 53 (discontinued procedure) is used when the physician begins a procedure but discontinues it due to a threat to the patient's well-being. The procedure was started (initial incision was made) but not completed because of the cardiac arrhythmia. Modifier 52 (reduced services) is for procedures that are partially reduced by physician choice, not for emergency discontinuation. Modifier 53 indicates the incomplete procedure and alerts the payer to adjust reimbursement accordingly.

10. **A. Modifier 54** Modifier 54 (surgical care only) is appended when the operating surgeon provides only the surgical procedure and preoperative care but does not provide postoperative management. The physician assuming postoperative care reports the same procedure code with modifier 55 (postoperative management only). This split-care arrangement divides the global surgical fee between the two providers based on their respective contributions.

BONUS SECTION C: INTEGUMENTARY PROCEDURES AND WOUND REPAIR (10 QUESTIONS)

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1. A surgeon excises a 1.5 cm malignant melanoma from the patient's right anterior thigh with 1.0 cm margins. The wound is closed with simple sutures. What is the excised diameter and should the simple closure be coded separately?

A. 2.5 cm excised diameter; the simple closure is coded separately

B. 1.5 cm excised diameter; the simple closure is coded separately

C. 2.5 cm excised diameter; the simple closure is included in the excision code

D. 3.5 cm excised diameter; the simple closure is included in the excision code

2. A patient has three lacerations requiring repair: a 7.0 cm intermediate repair on the right forearm, a 4.0 cm intermediate repair on the left hand, and a 3.0 cm intermediate repair on the right cheek. The forearm and hand are in the same anatomical grouping. The cheek is in a different grouping. How should these be reported?

A. One intermediate repair code for 11.0 cm (forearm + hand) and one intermediate repair code for 3.0 cm (cheek)

B. Three separate intermediate repair codes

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

D. One intermediate repair code for the largest wound only

3. A surgeon performs a shave removal of a 0.7 cm raised benign lesion from the patient's neck and a full-thickness excision of a 1.2 cm benign lesion from the patient's left arm with 0.2 cm margins during the same encounter. How should these two procedures be coded?

A. One excision code combining both lesions

B. Only the excision code; the shave removal is bundled

C. Both the shave removal code and the excision code — they are different procedures on different lesions at different sites

D. Only the shave removal code; the excision is bundled

4. A surgeon performs an adjacent tissue transfer (rotation flap) to close a 20 sq cm defect on the patient's scalp after excision of a malignant lesion. The excision created the defect. How should the excision be coded?

A. With a separate malignant excision code and modifier 59

B. It is not coded separately; the excision is included in the adjacent tissue transfer code

C. With the adjacent tissue transfer code and modifier 22

D. With a separate excision code and modifier 51

5. A surgeon performs a split-thickness autograft to a 75 sq cm wound on the patient's right lower leg. The donor site is the patient's left thigh. For a free skin graft, how is the graft code determined?

A. By the square centimeter area of the recipient site (defect) and the type of graft (split-thickness vs. full-thickness)

B. By the square centimeter area of the donor site

C. By the circumference of the wound

D. By the thickness of the graft in millimeters

6. A physician performs destruction of 8 actinic keratoses using liquid nitrogen and separately performs destruction of 6 benign common warts using cryotherapy on the same patient during the same encounter. How should ALL destruction services be coded?

A. 17004 for all 14 lesions combined

B. 17000 × 1, 17003 × 13 for all lesions combined

C. 17000 × 1, 17003 × 7 only; the benign warts are bundled into the premalignant codes

D. 17000 × 1, 17003 × 7 for the actinic keratoses PLUS 17110 × 1, 17111 × 1 for the benign warts — separate code ranges for premalignant and benign lesions

7. A surgeon performs Mohs micrographic surgery on a recurrent basal cell carcinoma of the nasal ala. Four stages are required: stage 1 with 3 blocks, stage 2 with 5 blocks, stage 3 with 7 blocks, and stage 4 with 2 blocks. How should the extra blocks be coded?

A. 17315 × 7

B. 17315 × 4

C. 17315 × 2 (only stage 3 exceeded 5 blocks — 7 blocks minus 5 = 2 extra blocks)

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

8. A patient undergoes excision of a 2.0 cm benign lesion from the scalp with 0.3 cm margins. The wound is closed with intermediate layered repair. What is the excised diameter and should the intermediate repair be coded separately?

A. 2.6 cm excised diameter; yes — intermediate and complex closures may be reported separately from excision codes

B. 2.0 cm excised diameter; no — intermediate repair is bundled

C. 2.6 cm excised diameter; no — all closures are bundled into excision codes

D. 2.3 cm excised diameter; yes — with modifier 22

9. A surgeon performs debridement of a chronic diabetic foot ulcer. The debridement extends through skin and subcutaneous tissue down to exposed tendon. No bone is exposed. Which depth determines the debridement code?

A. Skin

B. Subcutaneous tissue including tendon — the deepest tissue level debrided determines the code

C. Bone

D. Only subcutaneous tissue; tendon is not a recognized debridement depth

10. A surgeon performs a wound closure using staples on a 5.0 cm linear laceration of the scalp. No layered closure of deeper structures is performed — only the skin edges are approximated with staples. Which wound repair classification does this represent?

A. Intermediate repair

B. Complex repair

C. Simple repair — single-layer skin closure using sutures, staples, or tissue adhesive

D. No repair code is reported; staple closure is not a wound repair

BONUS SECTION C — ANSWER KEY WITH EXPLANATIONS

Integumentary Procedures and Wound Repair

1. **D. 3.5 cm excised diameter; the simple closure is included in the excision code** The excised diameter is calculated as lesion diameter plus margins on both sides: 1.5 cm + (1.0 cm × 2) = 3.5 cm. Simple wound closure (sutures, staples, or tissue adhesive) is always included in the excision code and is never separately reportable. Only intermediate and complex closures may be reported in addition to the excision code because they require additional work beyond what the excision code encompasses.

2. **A. One intermediate repair code for 11.0 cm (forearm + hand) and one intermediate repair code for 3.0 cm (cheek)** Wounds of the same classification in the same anatomical grouping are combined. The forearm and hand are in the same intermediate repair grouping (extremities), so those two wounds are combined: 7.0 + 4.0 = 11.0 cm. The cheek is in a different anatomical grouping (face) and must be reported separately as 3.0 cm. Two intermediate repair codes are reported — one for each grouping.

3. **C. Both the shave removal code and the excision code — they are different procedures on different lesions at different sites** A shave removal and a full-thickness excision are fundamentally different procedures. The shave removal tangentially removes the raised lesion without full-thickness excision and has no margin calculation. The excision removes the lesion through the full thickness of the skin with margins (1.2 + 0.2 × 2 = 1.6 cm excised diameter). Both are reported with their own codes because they are distinct procedures on different lesions at different anatomical sites.

4. **B. It is not coded separately; the excision is included in the adjacent tissue transfer code** Adjacent tissue transfer codes include the excision of the lesion that created the defect. The excision is an integral component of the flap procedure — the surgeon must create the defect before the flap can be designed and transferred. Reporting both a separate excision code and the adjacent tissue transfer code constitutes unbundling. This bundling rule is specific to adjacent tissue transfer and differs from free skin grafts, where the excision may be coded separately.

5. **A. By the square centimeter area of the recipient site (defect) and the type of graft (split-thickness vs. full-thickness)** Free skin graft codes are determined by the area of the recipient site (the defect being covered) measured in square centimeters, the type of graft (split-thickness vs. full-thickness), and the anatomical location of the recipient site. The 75 sq cm wound on the right

lower leg determines the code. The donor site size does not affect the graft code selection, although donor site repair may be separately reportable depending on the complexity.

6. **D. 17000 × 1, 17003 × 7 for the actinic keratoses PLUS 17110 × 1, 17111 × 1 for the benign warts — separate code ranges for premalignant and benign lesions** Premalignant lesion destruction (actinic keratoses, codes 17000–17004) and benign lesion destruction (warts/skin tags, codes 17110–17111) use completely different code ranges. When both types are destroyed during the same encounter, both code ranges are reported. For 8 actinic keratoses: 17000 × 1 (first) plus 17003 × 7 (lesions 2–8). For 6 benign warts: 17110 × 1 (first) plus 17111 × 1 (lesions 2–14 as a flat code). The two code ranges are never combined.

7. **C. 17315 × 2 (only stage 3 exceeded 5 blocks — 7 blocks minus 5 = 2 extra blocks)** Code 17315 is reported for each tissue block beyond 5 in any single stage. Stages 1, 2, and 4 had 3, 5, and 2 blocks respectively — all within or at the 5-block limit. Stage 3 had 7 blocks, exceeding the 5-block limit by 2. Therefore, 17315 × 2 is reported for the extra blocks. The complete coding would be 17311 × 1 (first stage), 17312 × 3 (stages 2, 3, and 4), and 17315 × 2 (extra blocks in stage 3).

8. **A. 2.6 cm excised diameter; yes — intermediate and complex closures may be reported separately from excision codes** The excised diameter is calculated as lesion diameter plus margins on both sides: 2.0 cm + (0.3 cm × 2) = 2.6 cm. Simple closure is included in the excision code, but intermediate and complex closures require additional surgical work (layered closure of subcutaneous tissue) beyond what the excision code encompasses. The intermediate repair is a separately reportable service coded with the appropriate intermediate repair code for the scalp anatomical grouping.

9. **B. Subcutaneous tissue including tendon — the deepest tissue level debrided determines the code** Wound debridement codes are based on the deepest tissue level debrided. CPT provides separate codes for debridement to skin, subcutaneous tissue (which includes tendons and fascia at this depth), muscle, and bone. When the debridement extends through skin and subcutaneous tissue to exposed tendon without reaching bone, the subcutaneous/tendon-depth code is selected. The deepest tissue reached determines the code.

10. **C. Simple repair — single-layer skin closure using sutures, staples, or tissue adhesive** Staple closure of a laceration where only the skin edges are approximated without layered closure of deeper structures constitutes simple repair. Simple repair encompasses single-layer skin closure using any of three methods: sutures, staples, or tissue adhesive. Intermediate repair requires closure of one or more deeper layers (subcutaneous tissue, superficial fascia) in addition to the skin. The method of skin closure (sutures vs. staples) does not change the classification — the depth of closure does.

BONUS SECTION D: MUSCULOSKELETAL CODING AND FRACTURE CARE (10 QUESTIONS)

1. An orthopedic surgeon performs closed treatment of a displaced distal radius fracture with manipulation and applies a short arm cast. The surgeon assumes the global fracture care package and provides all follow-up care. During the global period, the patient returns for a routine cast change. How should the cast change be coded?

A. With a separate cast application code

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

C. With the fracture treatment code and modifier 76

D. With an E/M code and modifier 24

2. A patient sustains a bimalleolar ankle fracture (both medial and lateral malleolus). The surgeon performs open reduction with internal fixation of both fracture sites during the same operative session. CPT provides a single bimalleolar fracture treatment code. How should this be coded?

A. With one bimalleolar fracture treatment code that includes fixation of both malleoli

B. With two separate ORIF codes — one for each malleolus — with modifier 51

C. With two separate ORIF codes with modifier 59 on the second

D. With one ORIF code and modifier 22

3. A patient undergoes closed treatment of a fifth metacarpal fracture (boxer's fracture) without manipulation. No reduction is performed because the fracture is non-displaced. A splint is applied. What type of fracture treatment is this?

A. Open treatment with internal fixation

B. Percutaneous skeletal fixation

C. Closed treatment without manipulation

D. Closed treatment with manipulation

4. An orthopedic surgeon treats a patient's tibial shaft fracture. A different physician assumes all postoperative care. Which modifier should the physician providing only the postoperative management append to the fracture treatment code?

A. Modifier 54

B. Modifier 56

C. Modifier 24

D. Modifier 55

5. A surgeon performs an open reduction with internal fixation of a displaced supracondylar humerus fracture in a 5-year-old child using crossed Kirschner wires. During the 90-day global period, the surgeon removes the K-wires in the office. How should the K-wire removal be coded?

A. With a separate hardware removal code (20680)

B. It is included in the fracture treatment global package; routine hardware removal during the global period is not separately coded

C. With the fracture code and modifier 58

D. With an E/M code only

6. A surgeon applies a short leg cast to a patient with an ankle sprain. No fracture is present — X-rays confirm soft tissue injury only. No fracture treatment code is reported. How should the cast application be coded?

A. It is included in the E/M code; cast application cannot be coded for sprains

B. With the fracture treatment code and modifier 52

C. With a separate cast application code — when no fracture treatment code is reported, the cast application is separately reportable

D. Cast application codes are never used without a fracture treatment code

7. A patient undergoes posterior spinal fusion at L4-L5 with morselized autograft bone obtained from the local laminectomy site through the same surgical incision. How should the bone graft be coded?

A. The local autograft obtained through the same incision is included in the fusion code and is not separately coded

B. With a separate bone graft harvest code for autograft through a separate incision

C. With a HCPCS supply code for the bone material

D. With the fusion code and modifier 22

8. An orthopedic surgeon performs an arthroscopic partial meniscectomy of the right knee. During the same session, a diagnostic arthroscopy is also performed. How should the two services be coded?

A. Both the diagnostic arthroscopy code and the surgical arthroscopy code with modifier 59

B. Both codes with modifier 51 on the diagnostic arthroscopy

C. Only the diagnostic arthroscopy code; the surgical procedure is bundled

D. Only the surgical arthroscopy code; the diagnostic arthroscopy is bundled into the surgical code

9. A patient undergoes open treatment of a displaced femoral neck fracture with internal fixation using cannulated screws. The patient is 82 years old. The surgeon provides all preoperative, surgical, and postoperative care. How should the global package be reported?

A. With modifier 54 (surgical care only)

B. With modifier 55 (postoperative management only)

C. With the complete global package — no splitting modifiers needed since the surgeon provides all components of care

D. With modifier 22

10. A surgeon performs a total shoulder arthroplasty (primary anatomic replacement) on a patient with severe glenohumeral osteoarthritis and an intact rotator cuff. One year later, the patient develops prosthetic loosening requiring revision surgery. The surgeon replaces both the humeral and glenoid components. How does the revision arthroplasty code differ from the primary code?

A. There is no difference; the same code is used for both primary and revision

B. CPT provides separate codes for revision arthroplasty that reflect the greater complexity of operating in a previously altered surgical field with scar tissue, bone loss, and the need to remove existing hardware

C. The primary code is used with modifier 76 for the revision

D. The revision uses the primary code with modifier 22

BONUS SECTION D — ANSWER KEY WITH EXPLANATIONS

Musculoskeletal Coding and Fracture Care

1. **B. It is not coded separately; it is included in the fracture treatment global package** When the surgeon assumes the global fracture care package, all routine follow-up services are bundled into the fracture treatment code. This includes routine office visits, cast application, cast changes, cast removal, splint changes, and X-rays for healing assessment. The cast change is a standard part of fracture management and is not separately reportable during the global period.

2. **A. With 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 malleolus. The coder should not unbundle a bimalleolar fracture into two separate unimalleolar fracture codes. The single bimalleolar code captures the complete treatment of both fracture sites as one service.

3. **C. Closed treatment without manipulation** A non-displaced fracture treated with splint immobilization without any attempt to realign the fracture fragments constitutes closed treatment without manipulation. No reduction is needed because the fragments are already in acceptable alignment. This is the least invasive category of fracture treatment in CPT and carries a lower RVU value than closed treatment with manipulation or open treatment.

4. **D. Modifier 55** Modifier 55 (postoperative management only) is appended when a physician assumes only the postoperative care for a surgical procedure performed by a different surgeon. The operating surgeon reports the procedure with modifier 54 (surgical care only). This split-care arrangement divides the global fee between the two providers based on their respective contributions to the patient's care.

5. **B. It is included in the fracture treatment global package; routine hardware removal during the global period is not separately coded** Removal of temporary fixation devices (K-wires) during the fracture treatment global period is considered a routine part of fracture management and is bundled into the global package. The K-wires were placed as part of the original fracture treatment, and their planned removal is an expected component of the healing process. A separate hardware removal code (20680) would only be reported if the removal occurred after the global period has expired.

6. **C. With a separate cast application code — when no fracture treatment code is reported, the cast application is separately reportable** When a cast or splint is applied for a condition other

than a fracture (in this case, an ankle sprain), and no fracture treatment global package is in effect, the cast application code is reported separately. Cast application codes are only bundled when they are part of the global fracture care package. For non-fracture conditions such as sprains, strains, and soft tissue injuries, the cast application is a distinct, separately reportable service.

7. **A. The local autograft obtained through the same incision is included in the fusion code and is not separately coded** When morselized autograft bone is harvested from the local surgical site (such as bone obtained from the laminectomy performed during the same procedure) through the same incision, it is considered part of the fusion procedure and is not separately coded. A separate bone graft harvest code is only reported when the graft is obtained through a separate incision or from a separate donor site such as the iliac crest.

8. **D. Only the surgical arthroscopy code; the diagnostic arthroscopy is bundled into the surgical code** Diagnostic arthroscopy is always bundled into surgical arthroscopy when both are performed on the same joint during the same session. The partial meniscectomy is the surgical procedure — the diagnostic examination is included in the surgical code. Reporting both codes constitutes unbundling. Only the surgical arthroscopy code for the partial meniscectomy is reported.

9. **C. With the complete global package — no splitting modifiers needed since the surgeon provides all components of care** When a single surgeon provides all three components of care — preoperative evaluation, the surgical procedure, and all postoperative management — the complete global package is reported without splitting modifiers. No modifier 54, 55, or 56 is needed. The fracture treatment code captures the entire episode of care from preoperative assessment through the completion of postoperative healing.

10. **B. CPT provides separate codes for revision arthroplasty that reflect the greater complexity of operating in a previously altered surgical field with scar tissue, bone loss, and the need to remove existing hardware** Revision arthroplasty is more complex than primary arthroplasty due to scar tissue, bone loss from the original implant, distorted anatomy, and the additional work of removing the existing prosthetic components before implanting new ones. CPT provides distinct codes for revision total shoulder arthroplasty that carry higher RVU values than primary replacement codes. The revision codes are further differentiated by which components are revised — humeral only, glenoid only, or both.

BONUS SECTION E: CARDIOVASCULAR AND VASCULAR PROCEDURES (10 QUESTIONS)

1. A cardiologist inserts a new dual-chamber pacemaker system — a pulse generator, an atrial lead, and a ventricular lead. How should this be coded?

A. With a single complete system code

B. With only the generator code; the leads are bundled

C. With separate codes for each component — generator insertion, atrial lead insertion, and ventricular lead insertion

D. With only the lead codes; the generator is bundled

2. A cardiologist performs a percutaneous coronary intervention (PCI) with drug-eluting stent placement in the left anterior descending artery. How should the balloon angioplasty performed to prepare the vessel be coded?

A. It is included in the stent placement code and is not reported separately

B. With a separate angioplasty code and modifier 59

C. With a separate angioplasty code and modifier 51

D. With the stent code and modifier 22

3. A surgeon performs an endovascular repair (EVAR) of an infrarenal abdominal aortic aneurysm using a modular bifurcated endograft deployed via bilateral femoral artery access. How does EVAR differ from open AAA repair?

A. EVAR requires a laparotomy; open repair uses a femoral approach

B. EVAR deploys a stent graft through catheters via the femoral arteries without an abdominal incision; open repair requires a laparotomy

C. Both require identical surgical approaches

D. EVAR is only for thoracic aneurysms

4. A patient undergoes selective catheterization of the right renal artery. The right renal artery is a first-order branch of the abdominal aorta. What order of selective catheterization is this?

A. Non-selective

B. Second-order

C. Third-order

D. First-order

5. A cardiologist replaces the pulse generator of an existing single-chamber pacemaker. The existing lead is tested and left in place. How should this be coded?

A. With the pulse generator replacement code only — the lead was not manipulated

B. With a complete system replacement code

C. With separate codes for lead removal and generator insertion

D. With only the lead testing code

6. A patient undergoes percutaneous transcatheter closure of an atrial septal defect (ASD) using a closure device deployed via a catheter from the femoral vein. How does this approach differ from open surgical ASD repair?

A. Both approaches require sternotomy

B. Percutaneous closure requires a larger incision

C. Percutaneous closure deploys a device through a catheter without open-heart surgery; open repair requires sternotomy and cardiopulmonary bypass

D. There is no difference

7. A surgeon performs a CABG with three saphenous vein grafts. No arterial grafts are used. How should the venous grafts be coded?

A. Three separate single-graft codes

B. One venous CABG code specifying three grafts

C. A primary code for the first graft plus add-on codes for each additional graft

D. An unlisted cardiovascular procedure code

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

A. With a separate ultrasound guidance code and modifier 26

B. With a separate ultrasound guidance code without modifier

C. With a separate ultrasound guidance code and modifier 59

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

9. A surgeon performs a right carotid endarterectomy with patch angioplasty (saphenous vein patch). How should the patch angioplasty be coded?

A. It is included in the endarterectomy code; patch angioplasty closure is not separately reportable

B. With a separate vein harvest code

C. With an unlisted vascular procedure code

D. With a separate patch graft code and modifier 51

10. A patient undergoes insertion of a tunneled central venous catheter with a subcutaneous port (port-a-cath) for long-term chemotherapy. Which factor distinguishes a port from a tunneled catheter without a port?

A. A port is temporary; a tunneled catheter is permanent

B. There is no difference

C. A port has a completely implanted subcutaneous reservoir accessed by needle puncture; a tunneled catheter has an external access hub

D. A port is always placed peripherally

BONUS SECTION E — ANSWER KEY WITH EXPLANATIONS

Cardiovascular and Vascular Procedures

1. **C. With separate codes for each component — generator insertion, atrial lead insertion, and ventricular lead insertion** Pacemaker coding uses a component-based approach. Each component has its own CPT code. A dual-chamber system requires three codes: one for the pulse generator insertion, one for the atrial lead insertion, and one for the ventricular lead insertion. There is no single "complete system" code.

2. **A. It is included in the stent placement code and is not reported separately** When a coronary stent is placed, the balloon angioplasty performed to prepare the vessel is included in the stent code. The angioplasty is an integral step in the stent deployment process. Reporting both constitutes unbundling.

3. **B. EVAR deploys a stent graft through catheters via the femoral arteries without an abdominal incision; open repair requires a laparotomy** EVAR is a minimally invasive endovascular approach using catheters advanced through the femoral arteries to deploy a stent graft within the aneurysm. Open repair requires a laparotomy to directly expose and replace the diseased aortic segment. These fundamentally different approaches have different CPT codes.

4. **D. First-order** The renal artery is a direct branch of the abdominal aorta — a first-order vessel. Selective catheterization into the renal artery from a femoral access is first-order selective catheterization. Second-order would be a branch of the renal artery. Non-selective would be placement in the aorta without entering a branch.

5. **A. With the pulse generator replacement code only — the lead was not manipulated** When only the battery-depleted generator is replaced while the lead is tested and left in place, only the generator replacement code is reported. No lead codes are needed because the lead was not inserted, repositioned, or removed. Component-based coding means each component is coded only when directly involved.

6. **C. Percutaneous closure deploys a device through a catheter without open-heart surgery; open repair requires sternotomy and cardiopulmonary bypass** Percutaneous ASD closure deploys a device through a catheter from the femoral vein without opening the chest. Open repair requires sternotomy, cardiopulmonary bypass, and direct surgical closure. These different approaches have different CPT codes.

7. **B. One venous CABG code specifying three grafts** CABG codes for venous grafts are organized by the number of grafts. CPT provides specific codes for one, two, three, four, five, or six venous grafts. Three saphenous vein grafts are reported with one code specifying three grafts.

8. **D. It is not reported separately; it is included in the ablation code** Endovenous ablation codes include ultrasound guidance in the procedure. When guidance is bundled into the procedure code, a separate guidance code should not be reported.

9. **A. It is included in the endarterectomy code; patch angioplasty closure is not separately reportable** Patch angioplasty during a carotid endarterectomy is included in the endarterectomy code. The patch closure is a standard part of the technique and is not a separately reportable service.

10. **C. A port has a completely implanted subcutaneous reservoir accessed by needle puncture; a tunneled catheter has an external access hub** A port-a-cath has a reservoir completely implanted under the skin, accessed by needle puncture. A tunneled catheter has an external hub exiting the skin. Ports have lower infection rates and require less maintenance for long-term intermittent access.

BONUS SECTION F: RESPIRATORY AND PULMONARY PROCEDURES (10 QUESTIONS)

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1. A patient undergoes a diagnostic bronchoscopy with transbronchial lung biopsy and separately with bronchial brushing during the same session. How should the diagnostic bronchoscopy be coded?

A. As a separate code with modifier 59

B. As a separate code with modifier 51

C. As a separate code with modifier 25

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

2. A surgeon performs a VATS (video-assisted thoracoscopic surgery) right upper lobectomy for non-small cell lung cancer. The procedure is completed thoracoscopically without conversion to open thoracotomy. How should this be coded?

A. With the open thoracotomy lobectomy code

B. With the VATS lobectomy code

C. With both the VATS and open codes

D. With the VATS code and modifier 22

3. A surgeon performs a right thoracoscopic pleurodesis with talc poudrage for recurrent malignant pleural effusion. What does pleurodesis accomplish?

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

B. It removes the entire lung

C. It inserts a permanent chest tube

D. It biopsies the pleural tissue

4. A patient undergoes a thoracentesis on the right side under ultrasound guidance. The thoracentesis code includes ultrasound guidance. How should the ultrasound be coded?

A. With a separate ultrasound guidance code and modifier 26

B. With a separate ultrasound guidance code and modifier 59

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

D. With a separate diagnostic ultrasound code

5. A surgeon performs a right thoracotomy with decortication of the lung for chronic empyema. What does decortication accomplish?

A. It removes the lung

B. It removes the thick fibrous peel from the surface of the lung to allow it to re-expand

C. It places a chest tube for drainage

D. It repairs a diaphragmatic hernia

6. A surgeon begins a VATS lobectomy but encounters dense adhesions and must convert to an open thoracotomy to complete the procedure. How should this be coded?

A. Both the VATS and open thoracotomy codes

B. The VATS code with modifier 53 plus the open code

C. The VATS code with modifier 22

D. Only the open thoracotomy lobectomy code; the abandoned VATS approach is not separately coded

7. A surgeon performs a mediastinoscopy with biopsy of mediastinal lymph nodes for staging of lung cancer. The biopsy is included in the mediastinoscopy code. How should the biopsy be coded?

A. It is not coded separately; the biopsy is included in the mediastinoscopy code

B. With a separate biopsy code and modifier 59

C. With a separate biopsy code and modifier 51

D. With a pathology consultation code

8. A patient undergoes 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. It is not reported separately; it is included in the surgical bronchoscopy stent placement code

D. As a separate code with modifier 25

9. A surgeon performs a VATS pleural biopsy for evaluation of a suspected malignant pleural effusion. How should the diagnostic thoracoscopy be coded?

A. As a separate code with modifier 59

B. It is not reported separately; it is included in the surgical thoracoscopy biopsy code

C. As a separate code with modifier 51

D. As a separate code with modifier 25

10. A surgeon performs a total pneumonectomy for lung cancer via a thoracotomy approach. At which level of surgical pathology is a total pneumonectomy specimen classified?

A. Level IV (88305)

B. Level III (88304)

C. Level V (88307)

D. Level VI (88309)

BONUS SECTION F — ANSWER KEY WITH EXPLANATIONS

Respiratory and Pulmonary Procedures

1. **D. It is not reported separately; it is included in the surgical bronchoscopy codes** Diagnostic bronchoscopy is bundled into surgical bronchoscopy when both are performed during the same session. The transbronchial biopsy and bronchial brushing are separate surgical procedures with their own codes. The diagnostic examination is included.

2. **B. With the VATS lobectomy code** The procedure was completed thoracoscopically without conversion. CPT provides separate codes for VATS and open lobectomy. When the VATS approach is completed successfully, only the VATS code is reported.

3. **A. It creates adhesion between the visceral and parietal pleura to obliterate the pleural space and prevent recurrence of pleural effusion** Pleurodesis uses a sclerosing agent (talc) to create adhesion between the two pleural layers, eliminating the potential space where fluid collects. This prevents reaccumulation of pleural effusions.

4. **C. It is not reported separately; it is included in the thoracentesis code** When the thoracentesis code includes ultrasound guidance in its description, the guidance is bundled. A separate ultrasound code should not be reported.

5. **B. It removes the thick fibrous peel from the surface of the lung to allow it to re-expand** Decortication strips the thick fibrous membrane that forms on the visceral pleura in chronic empyema. Removing this peel allows the trapped lung to re-expand and function normally.

6. **D. Only the open thoracotomy lobectomy code; the abandoned VATS approach is not separately coded** When a VATS procedure is converted to an open approach, only the open code is reported. The abandoned endoscopic approach is not coded separately. This rule applies consistently for all endoscopic-to-open conversions.

7. **A. It is not coded separately; the biopsy is included in the mediastinoscopy code** The mediastinoscopy code includes the biopsy — tissue sampling is the primary purpose of mediastinoscopy. Reporting both would constitute unbundling.

8. **C. It is not reported separately; it is included in the surgical bronchoscopy stent placement code** Diagnostic bronchoscopy is bundled into surgical bronchoscopy when both are performed during the same session. The stent placement is the surgical procedure — the diagnostic examination is included.

9. **B. It is not reported separately; it is included in the surgical thoracoscopy biopsy code** Diagnostic thoracoscopy is bundled into surgical thoracoscopy when both are performed during the same session. The pleural biopsy is the surgical procedure — the diagnostic examination is included.

10. **D. Level VI (88309)** A total pneumonectomy specimen is classified at Level VI — the highest complexity level requiring the most extensive pathological examination including tumor extent, margins, lymph node involvement, and staging.

BONUS SECTION G: DIGESTIVE SYSTEM AND ENDOSCOPY (10 QUESTIONS)

1. A patient undergoes a colonoscopy with snare polypectomy of a polyp from the ascending colon and a separate cold forceps biopsy polypectomy of a polyp from the sigmoid colon. The two techniques are different. How should the diagnostic colonoscopy be coded?

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

B. As a separate code with modifier 59

C. As a separate code with modifier 51

D. As a separate code with modifier 25

2. A patient undergoes a colonoscopy. The gastroenterologist removes four polyps from the descending colon — all removed using the same technique (snare polypectomy). How should the polypectomies be coded?

A. Four separate snare polypectomy codes

B. Four codes with modifier 59 on each additional code

C. One diagnostic colonoscopy code plus one polypectomy code

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

3. A patient undergoes an EGD with band ligation of esophageal varices. 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

C. As a separate code with modifier 51

D. As a separate code with modifier 25

4. A surgeon performs an ERCP with sphincterotomy, balloon dilation of a biliary stricture, and removal of common bile duct stones during the same session. How should the diagnostic ERCP be coded?

A. As a separate code with modifier 59

B. As a separate code with modifier 51

C. It is not reported separately; it is bundled into the surgical ERCP codes

D. As a separate code with modifier 25

5. A surgeon performs a laparoscopic repair of a recurrent, reducible ventral hernia. Which factors determine the CPT code?

A. Hernia type, initial vs. recurrent, reducible vs. incarcerated/strangulated, and the approach (open vs. laparoscopic)

B. Only the hernia type and patient BMI

C. Only the use of mesh

D. Only the surgical approach

6. A surgeon performs a laparoscopic cholecystectomy with intraoperative cholangiography. The procedure is completed laparoscopically. During the same session, severe inflammation is encountered and the surgeon converts the approach from laparoscopic to open. How should this be coded?

A. Both the laparoscopic and open cholecystectomy codes

B. The laparoscopic code with modifier 22

C. The laparoscopic code with modifier 53 plus the open code

D. Only the open cholecystectomy with cholangiography code; the abandoned laparoscopic approach is not separately coded

7. A patient undergoes flexible sigmoidoscopy with removal of a polyp by hot biopsy forceps technique. How should the diagnostic sigmoidoscopy be coded?

A. As a separate code with modifier 59

B. It is not reported separately; it is included in the surgical sigmoidoscopy code

C. As a separate code with modifier 25

D. As a separate code with modifier 51

8. A surgeon performs an exploratory laparotomy, small bowel resection with anastomosis, and splenectomy for traumatic injuries. The exploratory laparotomy is designated as a "separate procedure" in CPT. How should the exploratory laparotomy be coded?

A. It is not reported separately; it is bundled when performed with more comprehensive procedures through the same incision

B. As a separate code with modifier 59

C. As the primary procedure code

D. As a separate code with modifier 51

9. A patient undergoes an EGD with dilation of the esophagus using a Savary dilator (over-the-wire technique) and separately with biopsy of a suspicious esophageal lesion during the same session. How should the diagnostic EGD 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 EGD codes

10. A surgeon performs a total proctocolectomy with creation of an ileal pouch-anal anastomosis (J-pouch) for ulcerative colitis. What does the J-pouch accomplish?

A. It creates a permanent external stoma

B. It bypasses the colon without removing it

C. It creates a continent internal reservoir from the ileum connected to the anus, allowing defecation without a permanent stoma

D. It removes only the rectum

BONUS SECTION G — ANSWER KEY WITH EXPLANATIONS

Digestive System and Endoscopy

1. **A. It is not reported separately; it is included in the surgical colonoscopy codes** When surgical procedures are performed during a colonoscopy, the diagnostic examination is bundled into the surgical codes. Each different technique is reported with its own code, but the diagnostic colonoscopy is not separately reported.
2. **D. One snare polypectomy code — multiple polyps removed using the same technique from the same segment are reported with one code** CPT colonoscopy polypectomy codes are reported per technique per anatomical segment — not per polyp. Four polyps removed by snare from the descending colon are reported with one snare polypectomy code.
3. **B. It is not reported separately; it is included in the surgical EGD code** When a surgical procedure (variceal banding) is performed during an EGD, the diagnostic examination is bundled into the surgical code. The endoscopic hierarchy applies consistently.
4. **C. It is not reported separately; it is bundled into the surgical ERCP codes** Diagnostic ERCP is bundled into surgical ERCP when surgical procedures are performed during the same session. Each surgical procedure is reported with its own code, but the diagnostic ERCP is not separately reported.
5. **A. Hernia type, initial vs. recurrent, reducible vs. incarcerated/strangulated, and the approach (open vs. laparoscopic)** CPT ventral hernia codes are determined by all of these factors. Each affects the code selection and reflects different levels of surgical complexity.
6. **D. Only the open cholecystectomy with cholangiography code; the abandoned laparoscopic approach is not separately coded** When a laparoscopic procedure is converted to open, only the open code is reported. The abandoned laparoscopic approach is not separately coded. The open code must include the cholangiography since it was performed.
7. **B. It is not reported separately; it is included in the surgical sigmoidoscopy code** When a surgical procedure is performed during a sigmoidoscopy, the diagnostic examination is bundled into the surgical code.
8. **A. It is not reported separately; it is bundled when performed with more comprehensive procedures through the same incision** Exploratory laparotomy is designated as a "separate

procedure." When performed with more comprehensive procedures through the same incision, it is bundled and not separately reported.

9. **D. It is not reported separately; it is included in the surgical EGD codes** When multiple surgical procedures (dilation and biopsy) are performed during an EGD, the diagnostic examination is bundled. Each surgical procedure is reported with its own code.

10. **C. It creates a continent internal reservoir from the ileum connected to the anus, allowing defecation without a permanent stoma** The J-pouch procedure creates an internal reservoir from the terminal ileum that is connected to the anus, preserving the ability to defecate without a permanent external stoma.

BONUS SECTION H: URINARY SYSTEM AND RENAL PROCEDURES (10 QUESTIONS)

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1. A urologist performs a cystoscopy with transurethral resection of a 3.0 cm bladder tumor. CPT provides separate codes based on tumor size — small (≤2.0 cm) vs. large (>2.0 cm). Which code should be used?

A. The small tumor code

B. The code is the same regardless of size

C. The large tumor code — the 3.0 cm tumor exceeds the 2.0 cm threshold

D. An unlisted urinary code

2. A patient undergoes a ureteroscopy with basket extraction of a right ureteral stone. At the conclusion of the procedure, the urologist places a ureteral stent. Are the stone extraction and stent placement separately reportable?

A. No; the stent placement is always included in the stone extraction

B. Yes; the stone extraction and stent placement are separate procedures with separate codes

C. No; only the stent placement is reportable

D. Yes, but only with modifier 22

3. A urologist performs extracorporeal shock wave lithotripsy (ESWL) for a left renal stone. What does ESWL accomplish?

A. It uses shock waves generated outside the body to fragment the kidney stone into pieces that can pass through the urinary tract

B. It surgically opens the kidney to remove the stone

C. It places a stent to bypass the stone

D. It uses a laser through a ureteroscope

4. A patient undergoes a laparoscopic radical nephrectomy for a 6.0 cm renal cell carcinoma. CPT does not have separate robotic codes. How would a robotic-assisted laparoscopic radical nephrectomy be coded?

A. With the open radical nephrectomy code plus a robotic modifier

B. With a specific robotic surgery code

C. With the laparoscopic code and modifier 22

D. With the laparoscopic radical nephrectomy code; robotic assistance is included in the laparoscopic code

5. A urologist performs a cystoscopy with fulguration of a bladder lesion and a separate cystoscopy with injection of botulinum toxin into the detrusor muscle during the same 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. It is not reported separately; the diagnostic cystoscopy is bundled into the surgical codes

D. As a separate code with modifier 25

6. A patient undergoes a percutaneous nephrostomy tube placement under fluoroscopic guidance for obstructive uropathy. What does a nephrostomy accomplish?

A. It removes a kidney stone

B. It creates a direct drainage pathway from the kidney to outside the body through a percutaneously placed tube

C. It bypasses the obstruction by placing a ureteral stent

D. It measures kidney function

7. A urologist performs a transurethral resection of the prostate (TURP) for BPH. A cystoscopy is performed as part of the approach. How should the 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; the cystoscopy is included in the TURP code

8. A urologist performs a urodynamic study including uroflowmetry, complex cystometrography, and voiding pressure study. Which CPT section contains urodynamic study codes?

A. Surgery section — urinary system subsection

B. Medicine section

C. Radiology section

D. Pathology and Laboratory section

9. A patient undergoes a cystoscopy with bilateral ureteral stent placement. The diagnostic cystoscopy is bundled. How should the bilateral nature be reported?

A. With a single code and no modifier

B. With the code and modifier 22

C. With the stent placement code and modifier 50 or RT/LT modifiers

D. With two separate cystoscopy codes

10. A urologist performs a transurethral incision of a bladder neck contracture. What causes a bladder neck contracture?

A. A congenital heart defect

B. Scarring and narrowing of the bladder neck, typically occurring after prostate surgery

C. A kidney stone

D. An enlarged prostate gland

BONUS SECTION H — ANSWER KEY WITH EXPLANATIONS

Urinary System and Renal Procedures

1. **C. The large tumor code — the 3.0 cm tumor exceeds the 2.0 cm threshold** CPT provides separate bladder tumor resection codes based on tumor size. A 3.0 cm tumor exceeds the 2.0 cm threshold and is classified as large, reflecting greater surgical complexity.

2. **B. Yes; the stone extraction and stent placement are separate procedures with separate codes** Ureteroscopic stone extraction and ureteral stent placement are distinct procedures with different clinical objectives. Both are separately reportable when performed during the same session.

3. **A. It uses shock waves generated outside the body to fragment the kidney stone into pieces that can pass through the urinary tract** ESWL uses focused shock waves generated externally to fragment stones. No surgical incision or instrument insertion is required. This is a noninvasive approach.

4. **D. With the laparoscopic radical nephrectomy code; robotic assistance is included in the laparoscopic code** CPT does not have separate robotic codes. Robotic-assisted laparoscopic procedures are coded using the laparoscopic code. The robot is a tool used to perform the laparoscopy.

5. **C. It is not reported separately; the diagnostic cystoscopy is bundled into the surgical codes** Diagnostic cystoscopy is bundled into surgical cystoscopy when surgical procedures are performed during the same session. Both surgical procedures may be reported with appropriate modifiers.

6. **B. It creates a direct drainage pathway from the kidney to outside the body through a percutaneously placed tube** A nephrostomy tube is placed through the skin into the renal pelvis to drain urine externally when the normal urinary tract is obstructed.

7. **D. It is not reported separately; the cystoscopy is included in the TURP code** The cystoscopy is the approach for the TURP and is inherently included in the TURP code. Reporting both constitutes unbundling.

8. **A. Surgery section — urinary system subsection** Urodynamic study codes are located in the Surgery section under the urinary system subsection. These diagnostic codes evaluate bladder and urethral function.

9. **C. With the stent placement code and modifier 50 or RT/LT modifiers** Ureteral stent placement codes are unilateral. When performed bilaterally, modifier 50 or RT/LT modifiers are applied.

10. **B. Scarring and narrowing of the bladder neck, typically occurring after prostate surgery** A bladder neck contracture is fibrotic narrowing caused by scar tissue, most commonly after prostate surgery. It obstructs urine flow from the bladder.

BONUS SECTION I: FEMALE REPRODUCTIVE AND MATERNITY CODING (10 QUESTIONS)

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1. A physician provides all antepartum care (13 visits), performs a vaginal delivery, and provides all postpartum care. No complications occur. Which coding approach should be used?

A. Separate codes for each antepartum visit plus the delivery-only code plus the postpartum-only code

B. The delivery-only code plus the postpartum-only code

C. The cesarean delivery global code

D. The global vaginal delivery code

2. A physician provides only the delivery and postpartum care for a patient whose antepartum care was managed by a different physician. Which coding approach should be used by the delivering physician?

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

B. The global delivery code

C. The antepartum-only code plus the delivery-only code

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

3. A surgeon performs a total abdominal hysterectomy with bilateral salpingo-oophorectomy. The CPT code for the hysterectomy includes removal of the tubes and ovaries in its description. How should the BSO be coded?

A. With a separate BSO code and modifier 50

B. With a separate BSO code and modifier 51

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

D. With a separate oophorectomy code for each side

4. A physician performs a cesarean delivery after a failed trial of labor. A different physician provided the antepartum care. The delivering physician will also provide all postpartum care. Which coding approach should be used by the delivering physician?

A. The global cesarean delivery code

B. The cesarean delivery-only code plus the postpartum care-only code

C. The vaginal delivery-only code with modifier 22

D. Only the cesarean delivery-only code

5. A surgeon performs a laparoscopic supracervical hysterectomy with bilateral salpingectomy. The CPT code description for the hysterectomy includes salpingectomy. How should the salpingectomy be coded?

A. With a separate bilateral salpingectomy code and modifier 50

B. With a separate salpingectomy code and modifier 51

C. With a separate salpingectomy code and modifier 59

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

6. A physician provides all antepartum care, performs a vaginal delivery with episiotomy, and provides all postpartum care. How should the episiotomy be coded?

A. It is not coded separately; episiotomy and its repair are included in the vaginal delivery code

B. With a separate episiotomy repair code

C. With the delivery code and modifier 22

D. With a separate wound repair code

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

A. There is no difference

B. A radical hysterectomy preserves the cervix

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

D. A radical hysterectomy is always laparoscopic

8. A surgeon performs a total laparoscopic hysterectomy on a patient with a uterine weight of 300 grams. CPT differentiates hysterectomy codes based on a uterine weight threshold of 250 grams. Which weight category applies?

A. 250 grams or less

B. The weight does not affect code selection

C. Greater than 500 grams

D. Greater than 250 grams

9. A physician provides only the antepartum care for a high-risk pregnancy. The patient transfers to a different provider at 34 weeks for delivery. How should the first physician code the antepartum care?

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

B. With the global delivery code and modifier 52

C. With the delivery-only code

D. With individual E/M codes regardless of the number of visits

10. A surgeon performs a cesarean delivery and also performs a bilateral tubal ligation for sterilization during the same operative session. How should the tubal ligation be coded?

A. It is included in the cesarean delivery code

B. With a separate tubal ligation code in addition to the cesarean delivery code

C. With the cesarean code and modifier 22

D. With only the tubal ligation code

BONUS SECTION I — ANSWER KEY WITH EXPLANATIONS

Female Reproductive and Maternity Coding

1. **D. The global vaginal delivery code** When one physician provides all three components — complete antepartum care, vaginal delivery, and all postpartum care — the global vaginal delivery code captures the entire package.

2. **A. The delivery-only code plus the postpartum care-only code** When a physician provides only the delivery and postpartum care while another physician provided antepartum care, the component codes for delivery-only and postpartum-only are reported.

3. **C. It is not coded separately; it is included in the hysterectomy code description** When the hysterectomy code description includes removal of the tubes and ovaries, the BSO is bundled. Reporting a separate code constitutes unbundling.

4. **B. The cesarean delivery-only code plus the postpartum care-only code** When a different physician provided antepartum care, the delivering physician reports only the components they provided — delivery-only and postpartum care-only codes.

5. **D. It is not coded separately; it is included in the hysterectomy code description** When the hysterectomy code description includes salpingectomy, the salpingectomy is bundled. The coder must verify the code description.

6. **A. It is not coded separately; episiotomy and its repair are included in the vaginal delivery code** Episiotomy is a standard component of the delivery service and is included in the delivery code. A separate code is not reported.

7. **C. A radical hysterectomy removes the uterus, cervix, upper vagina, and parametrial tissue with wider margins; a total hysterectomy removes only the uterus and cervix** Radical hysterectomy is more extensive, removing additional tissue with wider margins for cancer treatment.

8. **D. Greater than 250 grams** A 300-gram uterus exceeds the 250-gram threshold. CPT provides different codes based on whether the uterus is 250 grams or less versus greater than 250 grams.

9. **A. With the antepartum care-only code (if the required number of visits is met) or individual E/M codes if the threshold is not met** When only antepartum care is provided, the antepartum-only code is used if the visit threshold is met. Otherwise, individual E/M codes are reported for each visit.

10. **B. With a separate tubal ligation code in addition to the cesarean delivery code** The tubal ligation is a separate elective procedure addressing a different objective (sterilization) and is reported with its own code in addition to the delivery code.

BONUS SECTION J: NERVOUS SYSTEM AND PAIN MANAGEMENT (10 QUESTIONS)

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1. A neurosurgeon performs a lumbar laminectomy at L4-L5 with discectomy for a herniated disc. No fusion is performed. A separate laminectomy at L5-S1 is also performed during the same session. How should the second level be coded?

A. With a second primary laminectomy code and modifier 51

B. With the appropriate add-on code for laminectomy at an additional level

C. With the first code and modifier 76

D. With a second primary code and modifier 59

2. A pain management physician performs a right L4 and L5 medial branch nerve radiofrequency ablation under fluoroscopic guidance. The ablation codes include imaging guidance. How should the two levels be coded?

A. Two separate primary ablation codes

B. One ablation code for both levels combined

C. One ablation code with modifier 22

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

3. A neurosurgeon performs a craniotomy for excision of a supratentorial meningioma. The bone flap is replaced. What confirms this is a craniotomy rather than a craniectomy?

A. The bone flap was replaced at the conclusion of the procedure — a craniotomy replaces the bone; a craniectomy does not

B. The bone was permanently removed

C. The procedure was performed in the posterior fossa

D. No bone was involved

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

A. With a separate fluoroscopy code and modifier 26

B. With a separate fluoroscopy code and modifier 59

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

D. With a separate fluoroscopy code for each level

5. A patient undergoes a spinal cord stimulator trial — temporary percutaneous placement of trial electrodes in the epidural space for a 7-day evaluation. How should this be coded?

A. With the permanent implantation code

B. With the trial/temporary percutaneous electrode placement code

C. With an epidural injection code

D. With the pulse generator implantation code

6. A neurosurgeon performs a VP shunt revision — the ventricular catheter is replaced while the valve and peritoneal catheter are left in place. How should this be coded?

A. With the complete shunt creation code

B. With the shunt removal code plus a new shunt creation code

C. With both the ventricular and peritoneal catheter revision codes

D. With the shunt revision code for replacement of the ventricular (proximal) catheter

7. A pain management physician performs a lumbar sympathetic block at L2 under fluoroscopic guidance for complex regional pain syndrome. How is a sympathetic block classified differently from a somatic peripheral nerve block?

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

B. Both are classified identically

C. A sympathetic block targets motor nerves only

D. A sympathetic block is always performed without imaging guidance

8. A neurosurgeon implants a permanent spinal cord stimulator system — placing percutaneous epidural electrodes and a subcutaneous pulse generator during the same session. How should this be coded?

A. With a single complete system code

B. With separate codes for the electrode placement and the generator implantation — component-based coding

C. With only the electrode code; the generator is bundled

D. With only the generator code; the electrodes are bundled

9. A pain management physician performs a diagnostic right L3, L4, and L5 medial branch nerve block under fluoroscopic guidance. The nerve block codes include imaging guidance. How should the three levels be coded?

A. Three separate primary nerve block codes

B. One nerve block code for all three levels combined

C. One nerve block code with modifier 22

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

10. A neurosurgeon performs an anterior cervical discectomy and fusion (ACDF) at C5-C6 with interbody cage and anterior cervical plate. The instrumentation (plate) is coded separately from the fusion. How many distinct surgical component codes are reported?

A. One — a single combined code

B. Two — the fusion and the instrumentation

C. Three — the discectomy, the fusion, and the instrumentation are each coded as separate components

D. Four codes

BONUS SECTION J — ANSWER KEY WITH EXPLANATIONS

Nervous System and Pain Management

1. **B. With the appropriate add-on code for laminectomy at an additional level** Multi-level laminectomy uses a primary code for the first level and add-on codes for additional levels. Two levels require one primary plus one add-on.

2. **D. A primary ablation code for the first nerve plus an add-on code for the additional nerve** Radiofrequency ablation codes use a primary code for the first nerve and add-on codes for each additional nerve. Two levels require one primary plus one add-on.

3. **A. The bone flap was replaced at the conclusion of the procedure — a craniotomy replaces the bone; a craniectomy does not** A craniotomy temporarily removes and replaces the bone flap. A craniectomy removes the bone without replacing it. This distinction affects CPT code selection.

4. **C. It is not reported separately; it is included in the injection code** When the injection code includes fluoroscopic guidance in its description, the guidance is bundled. A separate fluoroscopy code is not reported.

5. **B. With the trial/temporary percutaneous electrode placement code** A spinal cord stimulator trial has a specific trial code distinct from the permanent implantation code. The trial determines whether permanent implantation is warranted.

6. **D. With the shunt revision code for replacement of the ventricular (proximal) catheter** When only the ventricular catheter is replaced while other components remain in place, the specific revision code for that component is reported. Component-based coding applies.

7. **A. A sympathetic block targets the autonomic sympathetic nervous system; a somatic block targets peripheral sensory or motor nerves** These are distinct nerve categories with different CPT code ranges and different clinical applications.

8. **B. With separate codes for the electrode placement and the generator implantation — component-based coding** Permanent SCS implantation uses component-based coding. The electrode placement and generator implantation each have their own CPT code.

9. **D. A primary nerve block code for the first level plus add-on codes for each additional level** Medial branch nerve block codes use a primary code for the first level and add-on codes for additional levels. Three levels require one primary plus two add-ons.

10. **C. Three — the discectomy, the fusion, and the instrumentation are each coded as separate components** ACDF involves three distinct surgical components: the discectomy (decompression), the fusion (biological), and the instrumentation (plate). Each is coded separately.

BONUS SECTION K: ANESTHESIA CALCULATIONS AND MODIFIERS (10 QUESTIONS)

1. An anesthesiologist provides general anesthesia for a total knee replacement on a 72-year-old patient with severe COPD on home oxygen (P3). Total anesthesia time is 150 minutes. The payer uses 15-minute time units and assigns 1 modifying unit for P3. Base units are 7. What is the total unit calculation?

A. 17 units

B. 19 units

C. 16 units

D. 18 units

2. A patient is classified as physical status P2. Which clinical scenario best represents P2?

A. A moribund patient with a ruptured AAA

B. A patient with severe COPD on home oxygen

C. A patient with well-controlled hypertension and mild obesity

D. A normal healthy patient with no medical problems

3. An anesthesiologist personally performs the entire anesthesia service without the involvement of a CRNA. Which modifier should be appended?

A. Modifier AA

B. Modifier QX

C. Modifier QZ

D. Modifier QY

4. A CRNA provides anesthesia under the medical direction of an anesthesiologist. Which modifier should the CRNA append?

A. Modifier AA

B. Modifier QX

C. Modifier QZ

D. Modifier QY

5. An anesthesiologist provides anesthesia for an emergency cesarean section for placental abruption on a 30-year-old patient (P1). Which qualifying circumstances code applies?

A. 99100 (extreme age)

B. 99116 (total body hypothermia)

C. 99140 (emergency conditions)

D. 99135 (controlled hypotension)

6. In the anesthesia payment formula, which component is a dollar amount that converts total adjusted units into a payment?

A. The conversion factor

B. Base units

C. Time units

D. Modifying units

7. An anesthesiologist provides general anesthesia for a laparoscopic appendectomy on a 28-year-old healthy patient (P1). Total anesthesia time is 45 minutes. The payer uses 15-minute time units. No modifying units for P1. Base units are 6. What is the total unit calculation?

A. 8 units

B. 10 units

C. 7 units

D. 9 units

8. A patient classified as P4 undergoes emergency surgery. P4 indicates what level of systemic disease?

A. Mild systemic disease

B. Severe systemic disease that is a constant threat to life

C. Normal healthy patient

D. Moribund patient not expected to survive

9. An anesthesiologist medically directs four concurrent CRNA cases. What is the maximum number of concurrent cases an anesthesiologist may medically direct under Medicare rules?

A. Four cases

B. Six cases

C. Two cases

D. Eight cases

10. Qualifying circumstances code 99100 (extreme age) applies to which patients?

A. Patients over 65 years only

B. Patients under 5 years only

C. Patients under 1 year or over 70 years

D. All Medicare patients regardless of age

BONUS SECTION K — ANSWER KEY WITH EXPLANATIONS

Anesthesia Calculations and Modifiers

1. **D. 18 units** Base units (7) + Time units (150 ÷ 15 = 10) + Modifying units (P3 = 1) = 18. The calculation: 7 + 10 + 1 = 18.
2. **C. A patient with well-controlled hypertension and mild obesity** P2 indicates mild systemic disease without functional limitation. Well-controlled hypertension and mild obesity represent mild systemic conditions.
3. **A. Modifier AA** Modifier AA indicates the anesthesiologist personally performed the entire service without CRNA involvement.
4. **B. Modifier QX** Modifier QX indicates a CRNA providing anesthesia under the medical direction of an anesthesiologist. The anesthesiologist appends modifier QY.
5. **C. 99140 (emergency conditions)** An emergency cesarean for placental abruption qualifies for 99140. The patient is 30 years old (does not meet extreme age criteria). Only 99140 applies.
6. **A. The conversion factor** The conversion factor is the dollar amount that converts total anesthesia units into a payment. It is published annually and varies by payer.
7. **D. 9 units** Base units (6) + Time units (45 ÷ 15 = 3) + Modifying units (P1 = 0) = 9. The calculation: 6 + 3 + 0 = 9.
8. **B. Severe systemic disease that is a constant threat to life** P4 indicates severe systemic disease that poses a constant threat to life — such as unstable angina, sepsis, or decompensated heart failure.
9. **A. Four cases** Under Medicare rules, an anesthesiologist may medically direct up to four concurrent CRNA cases. More than four cases constitutes medical supervision with different requirements.
10. **C. Patients under 1 year or over 70 years** Qualifying circumstances code 99100 covers extreme age — defined as under 1 year or over 70 years. This recognizes the increased anesthetic complexity in these age groups.

BONUS SECTION L: DIAGNOSTIC AND INTERVENTIONAL RADIOLOGY (10 QUESTIONS)

1. A patient undergoes a CT of the abdomen and pelvis with IV contrast. Oral contrast is also given. In CPT, which contrast determines the code designation?

A. Oral contrast determines the designation

B. IV contrast — the study is coded as "with contrast" because IV contrast was administered

C. Both oral and IV contrast must be documented separately

D. The study is coded as "without contrast followed by with contrast"

2. A radiologist at a hospital interprets a chest X-ray on an inpatient. The radiologist is employed by a separate radiology group. The hospital owns the equipment and employs the technologist. How should the radiologist bill?

A. With the global X-ray code

B. With modifier TC

C. With no modifier

D. With modifier 26

3. A patient undergoes an MRI of the brain without contrast followed by with gadolinium contrast during the same session. How should this be coded?

A. Two separate MRI codes — one without and one with contrast

B. MRI brain with contrast only

C. MRI brain without contrast followed by with contrast (single combination code)

D. MRI brain without contrast only

4. A physician in a private office performs and interprets a pelvic ultrasound using practice-owned equipment. Which modifier should be appended?

A. No modifier; the global service is reported

B. Modifier 26

C. Modifier TC

D. Modifier 59

5. In radiation oncology, treatment management code 77427 is reported per how many fractions?

A. Per 1 fraction

B. Per 10 fractions

C. Per treatment course

D. Per 5 fractions

6. A patient undergoes a screening low-dose CT of the chest for lung cancer screening. Which CPT code covers this specific study?

A. 71250 (standard diagnostic CT chest without contrast)

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

C. 71260 (CT chest with contrast)

D. 71275 (CT angiography of the chest)

7. A patient undergoes arthrography of the right shoulder — a radiologist injects contrast into the joint under fluoroscopic guidance, followed by MRI. How should the injection component be coded?

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

B. It is included in the MRI code

C. With the MRI code and modifier 22

D. With a separate IV contrast injection code

8. A patient undergoes a nuclear medicine whole-body bone scan using technetium-99m MDP to evaluate for metastatic disease. What type of imaging is this?

A. MRI

B. CT

C. Ultrasound

D. Nuclear medicine

9. A patient undergoes a CT-guided percutaneous needle biopsy of a lung mass. The CT guidance is NOT included in the biopsy code. A separate radiologist provides and interprets the CT guidance. How should the radiologist bill?

A. With the biopsy code and modifier 26

B. With the CT guidance code and modifier TC

C. With the CT guidance code and modifier 26

D. With the biopsy code and modifier TC

10. A hospital performs a two-view chest X-ray on an outpatient. A radiologist employed by the hospital interprets the study. The hospital owns the equipment and employs both the technologist and the radiologist. How should the hospital bill?

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

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

C. The radiologist bills the global code

D. Two separate global codes

BONUS SECTION L — ANSWER KEY WITH EXPLANATIONS

Diagnostic and Interventional Radiology

1. **B. IV contrast — the study is coded as "with contrast" because IV contrast was administered** In CPT, "with contrast" means intravenous or injected contrast. Oral contrast alone does not qualify. IV contrast determines the designation regardless of whether oral contrast is also given.
2. **D. With modifier 26** The radiologist provides only the interpretation (professional component). Modifier 26 is appended. The hospital bills modifier TC for the technical component.
3. **C. MRI brain without contrast followed by with contrast (single combination code)** When an MRI is performed first without and then with contrast during the same session, a single combination code is reported.
4. **A. No modifier; the global service is reported** When the physician performs and interprets the study using practice-owned equipment, both components are provided. The global code is reported without modifier.
5. **D. Per 5 fractions** Treatment management (77427) is reported per 5 fractions of radiation delivery. Incomplete final units use modifier 52.
6. **B. 71271 (low-dose CT for lung cancer screening)** LDCT for lung cancer screening has a specific code (71271) distinct from standard diagnostic chest CT codes.
7. **A. With a separate joint injection code for the contrast administration** The contrast injection into the joint is a separate service from the subsequent MRI. Both are reported with separate codes.
8. **D. Nuclear medicine** A bone scan uses a radioactive tracer (technetium-99m MDP) detected by a gamma camera. This is nuclear medicine imaging.
9. **C. With the CT guidance code and modifier 26** The radiologist provides only the professional component of the CT guidance. Modifier 26 is appended because the radiologist did not provide the technical component.
10. **B. The hospital bills the global code since both components are provided by hospital employees** When the hospital employs both the technologist and the radiologist, both components are provided by the same entity. The global code is reported.

BONUS SECTION M: PATHOLOGY, LAB PANELS, AND SURGICAL PATHOLOGY (10 QUESTIONS)

1. A physician orders a comprehensive metabolic panel (CMP) and a hemoglobin A1c (83036) on the same specimen. A1c is NOT a component of the CMP. How should these be reported?

A. Only the CMP code; the A1c is bundled

B. The CMP code with modifier 22

C. The CMP code plus the individual hemoglobin A1c code

D. Individual codes for all tests; the panel cannot be used with additional tests

2. A physician orders a basic metabolic panel (BMP) and a hepatic function panel on the same specimen. Both panels include 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

3. A pathologist examines a radical prostatectomy specimen for prostate cancer. At which level of surgical pathology is this specimen classified?

A. Level IV (88305)

B. Level III (88304)

C. Level VI (88309)

D. Level V (88307)

4. A laboratory performs a presumptive urine drug screen using an instrument chemistry analyzer (80307) testing for 10 drug classes. How many units of 80307 should be reported?

A. 10 units, one per drug class

B. One unit per date of service regardless of the number of drug classes

C. 5 units

D. One unit per specimen

5. A pathologist performs immunohistochemistry on a breast cancer specimen: ER, PR, HER2, and Ki-67 — four antibody stains. How should the IHC be coded?

A. 88342 × 4

B. One IHC panel code

C. 88342 × 1 for the first antibody plus 88341 × 3 for each additional antibody

D. 88341 × 4

6. A laboratory performs both a rapid strep antigen test (87880) and a strep throat culture (87070) on the same patient. The rapid test was negative, prompting the confirmatory culture. How should these be coded?

A. Both codes — the rapid antigen test and the culture are different tests with different CPT codes

B. Only the culture code; the rapid test is bundled

C. Only the rapid test code; the culture is bundled

D. One combined code for both tests

7. Special stains are performed on a liver biopsy specimen — trichrome, iron stain, and PAS — three different stains. How should these be coded?

A. One special stain code for all three stains

B. With a pathology consultation code

C. With immunohistochemistry codes

D. Three units of the special stain code — one per stain per specimen

8. A pathologist examines a non-incidental appendix specimen removed during an appendectomy for acute appendicitis. At which level of surgical pathology is this classified?

A. Level II (88302)

B. Level V (88307)

C. Level IV (88305)

D. Level III (88304)

9. A laboratory performs definitive drug testing for opiates (4 analytes), amphetamines (2 analytes), and benzodiazepines (3 analytes). How many definitive drug testing codes should be reported?

A. Nine codes, one per analyte

B. Three codes — one for each drug class

C. One code per date of service

D. Two codes — one for stimulants and one for depressants

10. A patient undergoes a fine needle aspiration of a thyroid nodule under ultrasound guidance. The cytopathologist performs an immediate adequacy assessment. How many distinct services are potentially reportable?

A. Three — the FNA procedure, the ultrasound guidance, and the cytopathology adequacy assessment

B. One — a single combined code

C. Two — the FNA and the ultrasound; the adequacy assessment is bundled

D. Two — the FNA and the adequacy assessment; the ultrasound is bundled

BONUS SECTION M — ANSWER KEY WITH EXPLANATIONS

Pathology, Lab Panels, and Surgical Pathology

1. **C. The CMP code plus the individual hemoglobin A1c code** A1c is not a CMP component. When additional tests not in the panel are ordered, both the panel code and the individual test code are reported.

2. **A. The overlapping albumin is included in each panel code; it is NOT reported as a separate individual code** When two panels share overlapping components, the overlap is included in each panel. Reporting it separately constitutes double billing.

3. **D. Level V (88307)** A radical prostatectomy is Level V, requiring evaluation of tumor extent, Gleason grading, margins, extraprostatic extension, and seminal vesicle involvement.

4. **B. One unit per date of service regardless of the number of drug classes** Presumptive testing by instrument chemistry analyzer (80307) is reported once per date regardless of how many drug classes are screened.

5. **C. 88342 × 1 for the first antibody plus 88341 × 3 for each additional antibody** IHC is coded per antibody. The first antibody uses 88342, and each additional uses add-on 88341. Four antibodies = 88342 × 1 + 88341 × 3.

6. **A. Both codes — the rapid antigen test and the culture are different tests with different CPT codes** Different methodologies (antigen detection vs. bacterial culture) have different codes and are separately reportable.

7. **D. Three units of the special stain code — one per stain per specimen** Special stains are reported per stain per specimen. Three stains = 3 units.

8. **C. Level IV (88305)** A non-incidental appendix (removed for appendicitis) is Level IV. This differs from an incidental appendix (Level II).

9. **B. Three codes — one for each drug class** Definitive drug testing is reported per drug class. The specific code within each class is based on the analyte count.

10. **A. Three — the FNA procedure, the ultrasound guidance, and the cytopathology adequacy assessment** These are three distinct services, each with their own CPT code, reported separately.

BONUS SECTION N: INJECTIONS, INFUSIONS, AND IMMUNIZATIONS (10 QUESTIONS)

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1. A patient receives a 2-hour IV infusion of a chemotherapy agent (oxaliplatin) as the only IV service during the encounter. How should the infusion be coded?

A. 96365 × 1 plus 96366 × 1 (therapeutic infusion codes)

B. 96413 × 2 (two units of the initial chemotherapy code)

C. 96360 × 1 plus 96361 × 1 (hydration codes)

D. 96413 × 1 (initial hour) plus 96415 × 1 (additional hour)

2. A patient receives a 90-minute IV infusion of rituximab (non-antineoplastic biologic agent for rheumatoid arthritis) as the only IV service during the encounter. Which code range should be used?

A. Chemotherapy administration codes (96413–96417)

B. Therapeutic drug infusion codes (96365–96368)

C. Hydration codes (96360–96361)

D. Moderate sedation codes

3. A patient receives the following IV services during a single outpatient encounter: a 1-hour chemotherapy infusion, an IV push of a non-chemotherapy antiemetic, and 30 minutes of IV hydration. According to the infusion hierarchy, which service is the initial service?

A. The IV hydration

B. The IV push

C. The chemotherapy infusion

D. Each service is a separate initial service

4. A 4-year-old child receives two vaccine injections at a well-child visit: DTaP (3 components) and IPV (1 component). The pediatrician provides face-to-face counseling about each vaccine. How many total administration code units should be reported?

A. Four units: 90460 × 2 (first component of each vaccine) plus 90461 × 2 (additional DTaP components) = 4 total units

B. Two units: 90471 × 1 plus 90472 × 1

C. Six units: 90460 × 6

D. Two units: 90460 × 2

5. An adult patient (age 30) receives a single influenza vaccine injection at a pharmacy. No physician counseling is provided. How should the administration be coded?

A. 90460 × 1 (pediatric code)

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

C. 90472 × 1 (additional injection code)

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

6. A patient receives an IV push of furosemide (non-chemotherapy drug) and a 1-hour IV infusion of an antibiotic (non-chemotherapy therapeutic drug) during the same encounter. No hydration or chemotherapy is given. Which service is the initial service?

A. The IV push of furosemide

B. The antibiotic therapeutic infusion — therapeutic infusion outranks IV push in the hierarchy

C. Both are reported as initial services

D. Neither; both are add-on codes

7. A patient receives a chemotherapy infusion and a sequential infusion of a different chemotherapy agent through the same IV line. How should the second chemotherapy agent be coded?

A. With the sequential chemotherapy infusion add-on code (96417)

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

C. With a therapeutic drug infusion code (96365)

D. With a hydration code (96360)

8. A patient receives a 46-hour continuous infusion of 5-fluorouracil via an ambulatory infusion pump that the patient takes home. How should the pump infusion be coded?

A. With hourly chemotherapy add-on codes for all 46 hours

B. With standard IV infusion codes

C. With hydration codes for the extended duration

D. With the chemotherapy administration code for infusion technique via a portable pump (96416) — a single code regardless of duration

9. A provider administers a subcutaneous injection of adalimumab (Humira) 40 mg in the office. The HCPCS J-code covers the drug product. What additional CPT code is needed for the injection?

A. No additional code; the J-code covers both drug and administration

B. A separate E/M code

C. CPT code 96372 for the subcutaneous/intramuscular injection administration

D. A HCPCS syringe supply code only

10. A patient receives IV services during a single outpatient encounter: 45 minutes of IV hydration, a 90-minute IV infusion of rituximab (antineoplastic agent for lymphoma — chemotherapy indication), and an IV push of dexamethasone. Which code range should be used for the rituximab?

A. Therapeutic drug infusion codes (96365–96368)

B. Chemotherapy administration codes (96413–96417) — because rituximab is being used as an antineoplastic agent

C. Hydration codes (96360–96361)

D. Moderate sedation codes

BONUS SECTION N — ANSWER KEY WITH EXPLANATIONS

Injections, Infusions, and Immunizations

1. **D. 96413 × 1 (initial hour) plus 96415 × 1 (additional hour)** Oxaliplatin is a chemotherapy agent coded with chemotherapy infusion codes. The 2-hour infusion: 96413 for the first hour, 96415 for the second hour.

2. **B. Therapeutic drug infusion codes (96365–96368)** Rituximab for rheumatoid arthritis is a non-antineoplastic agent. Non-antineoplastic drugs use therapeutic infusion codes, not chemotherapy codes.

3. **C. The chemotherapy infusion** The infusion hierarchy places chemotherapy at the highest level. It is always the initial service when provided with other IV services.

4. **A. Four units: 90460 × 2 plus 90461 × 2 = 4 total units** Pediatric component-based codes with physician counseling: DTaP (90460 × 1 + 90461 × 2 = 3) + IPV (90460 × 1 = 1) = 4 total units.

5. **D. 90471 × 1 (adult injection-based code, first vaccine)** For an adult without physician counseling, adult injection-based codes are used. A single injection = 90471 × 1.

6. **B. The antibiotic therapeutic infusion — therapeutic infusion outranks IV push in the hierarchy** The infusion hierarchy places therapeutic infusion above IV push. The antibiotic infusion is the initial service.

7. **A. With the sequential chemotherapy infusion add-on code (96417)** A different chemotherapy agent infused sequentially through the same line uses 96417. A second initial code (96413) cannot be reported.

8. **D. With the chemotherapy administration code for infusion technique via a portable pump (96416) — a single code regardless of duration** Code 96416 covers chemotherapy via portable pump as a single code regardless of infusion duration.

9. **C. CPT code 96372 for the subcutaneous/intramuscular injection administration** The HCPCS J-code covers only the drug. The administration requires a separate CPT code (96372).

10. **B. Chemotherapy administration codes (96413–96417) — because rituximab is being used as an antineoplastic agent** When rituximab is used for cancer treatment (lymphoma), chemotherapy codes are used. The indication determines the code range.

BONUS SECTION O: ICD-10-CM GENERAL CODING GUIDELINES (10 QUESTIONS)

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1. In the outpatient setting, a physician documents "rule out pneumonia" as the reason for a chest X-ray on a patient presenting with cough and fever. How should this be coded?

A. With the symptom codes for cough and fever — suspected conditions are not coded as confirmed diagnoses in the outpatient setting

B. With the pneumonia code (J18.9)

C. With both the symptom codes and the pneumonia code

D. With only a Z code for the encounter

2. A patient undergoes a screening colonoscopy. During the procedure, a polyp is found and removed. Under ICD-10-CM outpatient guidelines, which diagnosis is sequenced first?

A. The polyp code as the first-listed diagnosis

B. A personal history code

C. The screening Z code (Z12.11) as the first-listed diagnosis, with the polyp code as secondary

D. Only the polyp code; the screening code is not reported

3. Under ICD-10-CM, when a patient presents specifically for chemotherapy administration and also has the underlying malignancy, which code is sequenced first?

A. The malignancy code

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

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

D. Only the chemotherapy encounter code

4. A patient has documented hypertension and chronic kidney disease stage 3. The physician does not document a causal relationship. Under ICD-10-CM guidelines, how should these be coded?

A. With separate unlinked codes for hypertension and CKD

B. Only the CKD code

C. Only the hypertension code

D. With a code from I12 (Hypertensive chronic kidney disease) — ICD-10-CM presumes a causal relationship between hypertension and CKD

5. A patient presents with a displaced fracture of the right femoral shaft. This is the patient's first visit and active treatment is provided. Which 7th character should be used?

A. D (subsequent encounter)

B. S (sequela)

C. A (initial encounter)

D. G (subsequent encounter with delayed healing)

6. Under ICD-10-CM, when coding burns, which rule governs the sequencing of multiple burn codes?

A. The most severe burn (highest degree) is sequenced first

B. Burns are coded alphabetically by body site

C. The smallest burn is sequenced first

D. Only one burn code is reported regardless of the number of sites

7. A patient is treated for chronic pain following a healed right ankle fracture. The fracture healed 8 months ago but chronic pain persists. Which 7th character should be used on the fracture code?

A. A (initial encounter)

B. D (subsequent encounter)

C. G (subsequent encounter with delayed healing)

D. S (sequela)

8. Under ICD-10-CM, when a patient has both diabetes mellitus and a diabetic manifestation (such as diabetic retinopathy), how is the relationship captured?

A. Two completely separate codes with no linkage

B. A combination code from the diabetes category that specifies both the diabetes type and the specific manifestation

C. Only the manifestation code

D. Only the diabetes code without specifying the manifestation

9. A patient has documented both acute and chronic pancreatitis. How should these be coded under ICD-10-CM?

A. Both codes — with the acute condition sequenced first

B. Only the chronic pancreatitis code

C. Only the acute pancreatitis code

D. A single combination code for both

10. Under ICD-10-CM adverse effect coding, a patient develops lactic acidosis from correctly prescribed and correctly taken metformin. What is the sequencing order?

A. The T code for adverse effect first, followed by the lactic acidosis code

B. Only the lactic acidosis code

C. The lactic acidosis (manifestation) first, followed by the T code for adverse effect of metformin

D. Only the T code; the manifestation is not coded

BONUS SECTION O — ANSWER KEY WITH EXPLANATIONS

ICD-10-CM General Coding Guidelines

1. **A. With the symptom codes for cough and fever — suspected conditions are not coded as confirmed diagnoses in the outpatient setting** In the outpatient setting, "rule out" conditions are not coded. Only confirmed signs and symptoms are reported.
2. **C. The screening Z code (Z12.11) as the first-listed diagnosis, with the polyp code as secondary** The screening Z code remains first-listed even when findings are identified during the screening. The polyp is secondary.
3. **B. Z51.11 (Encounter for antineoplastic chemotherapy) as the first-listed diagnosis, followed by the malignancy code** When the encounter purpose is chemotherapy administration, the encounter code is sequenced first, followed by the malignancy.
4. **D. With a code from I12 — ICD-10-CM presumes a causal relationship between hypertension and CKD** ICD-10-CM guidelines presume a causal relationship between hypertension and CKD even without explicit physician documentation of causality.
5. **C. A (initial encounter)** The 7th character "A" indicates active treatment during the initial encounter. This is the first visit with active fracture treatment.
6. **A. The most severe burn (highest degree) is sequenced first** ICD-10-CM guidelines direct sequencing the most severe burn as the first-listed diagnosis.
7. **D. S (sequela)** Chronic pain persisting after fracture healing is a sequela. The 7th character "S" captures residual conditions after healing.
8. **B. A combination code from the diabetes category that specifies both the diabetes type and the specific manifestation** ICD-10-CM uses combination codes linking diabetes to specific manifestations within the E10–E13 categories.
9. **A. Both codes — with the acute condition sequenced first** When both acute and chronic forms are documented, both are coded with the acute condition sequenced first.
10. **C. The lactic acidosis (manifestation) first, followed by the T code for adverse effect of metformin** Under adverse effect coding, the manifestation is sequenced first, followed by the T code identifying the drug.

BONUS SECTION P: ICD-10-CM CHAPTER-SPECIFIC GUIDELINES (10 QUESTIONS)

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

A. Only I10 (Essential hypertension)

B. Separate codes for hypertension and heart failure without linkage

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

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

2. A patient has documented Type 2 diabetes with diabetic chronic kidney disease stage 4. How should this be coded?

A. Only the CKD code

B. A combination code from E11 specifying Type 2 diabetes with diabetic CKD, plus an additional code from N18 specifying CKD stage 4

C. Only the diabetes code without specifying the CKD

D. Separate codes for diabetes and CKD with no linkage

3. A patient undergoes treatment for poisoning from accidental ingestion of a household cleaning product. Under ICD-10-CM poisoning coding, what is the sequencing order?

A. The external cause code first

B. Only the manifestation code

C. Only the T code

D. The T code for the poisoning first, followed by the manifestation code

4. A newborn infant is born in the hospital via normal spontaneous vaginal delivery with no complications. Which ICD-10-CM code should be the principal diagnosis?

A. Z38.00 (Single liveborn infant, delivered vaginally)

B. Z00.110 (Health examination for newborn)

C. P07.39 (Preterm newborn)

D. Z38.01 (Single liveborn infant, delivered by cesarean)

5. A patient presents with acute on chronic diastolic heart failure. Which ICD-10-CM code most specifically captures this condition?

A. I50.9 (Heart failure, unspecified)

B. I50.32 (Chronic diastolic heart failure)

C. I50.33 (Acute on chronic diastolic heart failure)

D. I50.31 (Acute diastolic heart failure)

6. A patient has documented COPD with acute exacerbation. How should this be coded under ICD-10-CM?

A. Separate codes for COPD and the exacerbation

B. A single code from J44 that specifies COPD with acute exacerbation

C. Only the acute exacerbation code

D. Only the COPD code without specifying the exacerbation

7. A patient is seen for management of chronic pain syndrome. Which ICD-10-CM code category covers chronic pain?

A. G89 (Pain, not elsewhere classified) — with the appropriate chronic pain code

B. R10 (Abdominal pain)

C. Z87 (Personal history)

D. M54 (Dorsalgia) only

8. A patient is treated for an adverse effect of warfarin (correctly prescribed, correctly taken) — the patient developed gastrointestinal hemorrhage. Under ICD-10-CM, what is the sequencing?

A. The T code first, followed by the GI hemorrhage code

B. Only the warfarin code

C. Only the GI hemorrhage code

D. The GI hemorrhage (manifestation) first, followed by the T code for adverse effect of warfarin

9. A patient has documented sickle cell disease with vaso-occlusive crisis. How should this be coded?

A. Only the crisis code

B. Separate codes for sickle cell and the crisis

C. A combination code from D57 specifying sickle cell disease with crisis

D. Only the sickle cell code without specifying the crisis

10. A patient has documented morbid obesity with a BMI of 43.5. Which codes are required under ICD-10-CM?

A. Only the BMI code

B. The morbid obesity code (E66.01) plus the BMI code (Z68.43)

C. Only the obesity code without BMI

D. A Z code for the encounter only

BONUS SECTION P — ANSWER KEY WITH EXPLANATIONS

ICD-10-CM Chapter-Specific Guidelines

1. **C. A code from I11 plus an additional code from I50 specifying the type of heart failure** ICD-10-CM presumes a causal relationship between hypertension and heart disease. I11 captures hypertensive heart disease, and I50 specifies the heart failure type.
2. **B. A combination code from E11 specifying Type 2 diabetes with diabetic CKD, plus an additional code from N18 specifying CKD stage 4** The combination code links diabetes to CKD. The N18 code specifies the stage.
3. **D. The T code for the poisoning first, followed by the manifestation code** In poisoning coding, the T code is sequenced first, followed by the manifestation. This is opposite from adverse effect sequencing.
4. **A. Z38.00 (Single liveborn infant, delivered vaginally)** For newborns born in the hospital, the Z38 birth status code is the principal diagnosis on the birth admission.
5. **C. I50.33 (Acute on chronic diastolic heart failure)** ICD-10-CM provides specific codes capturing both the type (diastolic) and acuity (acute on chronic) of heart failure.
6. **B. A single code from J44 that specifies COPD with acute exacerbation** Category J44 provides combination codes for COPD with and without exacerbation. A single code captures both.
7. **A. G89 with the appropriate chronic pain code** Category G89 covers chronic pain not elsewhere classified. Specific codes exist for chronic pain syndrome and other chronic pain.
8. **D. The GI hemorrhage (manifestation) first, followed by the T code for adverse effect of warfarin** Under adverse effect coding, the manifestation is sequenced first, followed by the T code for the correctly prescribed drug.
9. **C. A combination code from D57 specifying sickle cell disease with crisis** Category D57 provides combination codes for sickle cell disease with and without crisis.
10. **B. The morbid obesity code (E66.01) plus the BMI code (Z68.43)** Both codes are required — E66.01 for the clinical condition and the Z68 code for the specific BMI value.

BONUS SECTION Q: HCPCS LEVEL II CODES AND MODIFIERS (10 QUESTIONS)

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1. A patient receives an infusion of bevacizumab (Avastin) 500 mg IV for cancer treatment. The HCPCS J-code specifies 10 mg per unit. How many units should be reported?

A. 5 units

B. 10 units

C. 1 unit

D. 50 units

2. A provider administers an IM injection of ketorolac (Toradol) 60 mg. The HCPCS J-code specifies 15 mg per unit. How many units should be reported?

A. 4 units

B. 1 unit

C. 60 units

D. 6 units

3. A Medicare patient receives a service. The provider obtained a signed ABN and appended modifier GA. Medicare denies the claim. What is the financial consequence?

A. The provider must write off the denied amount

B. The provider may bill the patient because a valid ABN was obtained

C. The provider must appeal before billing the patient

D. Medicare automatically pays on reconsideration

4. A Medicare patient receives a service. No ABN was obtained and modifier GZ was appended. Medicare denies the claim. What is the financial consequence?

A. The provider may bill the patient

B. Medicare automatically pays on appeal

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

D. The provider may bill at 50% of the charge

5. A Medicare patient receives a covered preventive screening colonoscopy. Which modifier identifies this as a preventive service?

A. Modifier GA

B. Modifier GZ

C. Modifier QW

D. Modifier 33

6. A Medicare patient receives a service that is a statutory exclusion — Medicare does not cover it by law. Which HCPCS modifier should be appended?

A. Modifier GY

B. Modifier GA

C. Modifier GZ

D. Modifier QW

7. A patient receives a rapid influenza antigen test performed in a physician's office using a CLIA-waived test kit. Which modifier should be appended to the test code?

A. Modifier 26

B. Modifier TC

C. Modifier QW

D. Modifier 91

8. A patient requires a knee brace (knee orthosis) following ACL reconstruction. Which HCPCS Level II code range covers orthotic devices?

A. E0100–E9999

B. L0000–L4999 (within the L-code range for orthotics)

C. J0000–J9999

D. A4000–A8999

9. A patient receives a standard manual wheelchair for mobility. Which HCPCS Level II code range covers wheelchairs?

A. J0000–J9999

B. L0000–L9999

C. A0000–A0999

D. E1000–E1399 (within the E-code range for DME)

10. A patient receives a home oxygen concentrator for chronic hypoxemic respiratory failure. Which HCPCS code range covers oxygen equipment?

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

B. J0000–J9999

C. L0000–L9999

D. A4000–A8999

BONUS SECTION Q — ANSWER KEY WITH EXPLANATIONS

HCPCS Level II Codes and Modifiers

1. **D. 50 units** Bevacizumab specifies 10 mg per unit. 500 mg ÷ 10 mg/unit = 50 units.
2. **A. 4 units** Ketorolac specifies 15 mg per unit. 60 mg ÷ 15 mg/unit = 4 units.
3. **B. The provider may bill the patient because a valid ABN was obtained** With modifier GA (valid ABN), the provider may transfer the cost to the patient when Medicare denies the claim.
4. **C. The provider cannot bill the patient and must absorb the denied amount** With modifier GZ (no ABN), the provider cannot bill the patient and must absorb the loss.
5. **D. Modifier 33** Modifier 33 identifies mandated preventive services, signaling the payer to waive cost-sharing.
6. **A. Modifier GY** Modifier GY indicates a statutory exclusion — a service Medicare does not cover by law.
7. **C. Modifier QW** Modifier QW identifies CLIA-waived tests performed in the physician's office.
8. **B. L0000–L4999 (within the L-code range for orthotics)** Orthotic devices including knee braces are coded in the L-code orthotic range.
9. **D. E1000–E1399 (within the E-code range for DME)** Wheelchairs are coded within the E-code DME range.
10. **A. E0400–E0486 (within the E-code range for DME)** Oxygen equipment is coded within the E-code DME range.

BONUS SECTION R: MEDICAL TERMINOLOGY ACROSS BODY SYSTEMS (10 QUESTIONS)

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

A. Visual examination

B. Surgical removal

C. Surgical repair or reconstruction

D. Inflammation

2. Which combining form refers to the joint?

A. Oste/o

B. Arthr/o

C. My/o

D. Neur/o

3. The prefix "peri-" means which of the following?

A. Around or surrounding

B. Within

C. Above

D. Below

4. What does the medical term "cholecystitis" mean?

A. Surgical removal of the gallbladder

B. Visual examination of the gallbladder

C. Gallstones

D. Inflammation of the gallbladder

5. The suffix "-emia" means which of the following?

A. Surgical repair

B. Blood condition

C. Inflammation

D. Pain

6. Which combining form refers to the stomach?

A. Hepat/o

B. Enter/o

C. Gastr/o

D. Col/o

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

A. Excessive or above normal

B. Below normal

C. Normal

D. Without

8. What does the medical term "nephrolith" mean?

A. Inflammation of the kidney

B. Surgical removal of the kidney

C. Enlarged kidney

D. Kidney stone

9. The suffix "-itis" means which of the following?

A. Surgical removal

B. Inflammation

C. Pain

D. Enlargement

10. What does the medical term "pneumonectomy" mean?

A. Inflammation of the lung

B. Visual examination of the lung

C. Surgical removal of a lung

D. Lung infection

BONUS SECTION R — ANSWER KEY WITH EXPLANATIONS

Medical Terminology Across Body Systems

1. **C. Surgical repair or reconstruction** "-Plasty" means surgical repair. Examples: rhinoplasty (nose repair), arthroplasty (joint repair), mammoplasty (breast reconstruction).
2. **B. Arthr/o** "Arthr/o" refers to the joint. Examples: arthritis (joint inflammation), arthroscopy (joint examination), arthroplasty (joint repair).
3. **A. Around or surrounding** "Peri-" means around. Examples: pericardium (around the heart), periosteum (around the bone), perinatal (around the time of birth).
4. **D. Inflammation of the gallbladder** Cholecystitis = "cholecyst/o" (gallbladder) + "-itis" (inflammation). Cholecystectomy would be surgical removal.
5. **B. Blood condition** "-Emia" means blood condition. Examples: anemia (decreased blood cells), septicemia (infection in blood), hyperglycemia (high blood sugar).
6. **C. Gastr/o** "Gastr/o" refers to the stomach. Examples: gastritis (stomach inflammation), gastrectomy (stomach removal), gastroscopy (stomach examination).
7. **A. Excessive or above normal** "Hyper-" means excessive. Examples: hypertension (high blood pressure), hyperglycemia (high blood sugar), hyperthyroidism (excessive thyroid function).
8. **D. Kidney stone** Nephrolith = "nephr/o" (kidney) + "lith" (stone). Nephrolithiasis is the condition of having kidney stones.
9. **B. Inflammation** "-Itis" means inflammation. Examples: appendicitis, bronchitis, arthritis, hepatitis, gastritis.
10. **C. Surgical removal of a lung** Pneumonectomy = "pneumon/o" (lung) + "-ectomy" (surgical removal). This refers to complete removal of a lung.

BONUS SECTION S: ANATOMY AND PHYSIOLOGY FOR CODERS (10 QUESTIONS)

1. The left ventricle pumps oxygenated blood into which blood vessel?

A. The pulmonary artery

B. The superior vena cava

C. The pulmonary vein

D. The aorta

2. The sinoatrial (SA) node — the heart's natural pacemaker — is located in the wall of which chamber?

A. The right atrium

B. The left ventricle

C. The right ventricle

D. The left atrium

3. The common bile duct is formed by the junction of which two ducts?

A. The left and right hepatic ducts

B. The pancreatic duct and the hepatic duct

C. The cystic duct and the common hepatic duct

D. The cystic duct and the thoracic duct

4. Which organ produces insulin?

A. The liver

B. The pancreas (islets of Langerhans)

C. The adrenal gland

D. The thyroid gland

5. The rotator cuff is composed of the tendons of how many muscles?

A. Two

B. Six

C. Three

D. Four (supraspinatus, infraspinatus, teres minor, subscapularis)

6. Which part of the brain is primarily responsible for coordination, balance, and fine motor control?

A. The cerebellum

B. The frontal lobe

C. The temporal lobe

D. The medulla oblongata

7. The median nerve passes through which anatomical structure at the wrist?

A. The cubital tunnel

B. The carpal tunnel

C. The Guyon canal

D. The tarsal tunnel

8. The tympanic membrane (eardrum) separates which two parts of the ear?

A. The middle ear and the inner ear

B. The inner ear and the auditory nerve

C. The cochlea and the vestibular apparatus

D. The external ear and the middle ear

9. The aortic valve is located between which two structures?

A. The left ventricle and the aorta

B. The right atrium and the right ventricle

C. The left atrium and the left ventricle

D. The right ventricle and the pulmonary artery

10. The prostate gland surrounds which anatomical structure?

A. The ureter

B. The vas deferens

C. The prostatic urethra

D. The seminal vesicle

BONUS SECTION S — ANSWER KEY WITH EXPLANATIONS

Anatomy and Physiology for Coders

1. **D. The aorta** The left ventricle pumps oxygenated blood through the aortic valve into the aorta for systemic distribution.
2. **A. The right atrium** The SA node is located in the wall of the right atrium near the junction of the superior vena cava. It initiates each heartbeat.
3. **C. The cystic duct and the common hepatic duct** The common bile duct is formed by the junction of the cystic duct (from the gallbladder) and the common hepatic duct (from the liver).
4. **B. The pancreas (islets of Langerhans)** Insulin is produced by beta cells within the islets of Langerhans in the pancreas. It regulates blood glucose levels.
5. **D. Four (supraspinatus, infraspinatus, teres minor, subscapularis)** The rotator cuff consists of four muscle tendons (SITS mnemonic). The supraspinatus is most commonly torn.
6. **A. The cerebellum** The cerebellum controls coordination, balance, posture, and fine motor control. It is located in the posterior fossa.
7. **B. The carpal tunnel** The median nerve passes through the carpal tunnel at the wrist. Compression causes carpal tunnel syndrome.
8. **D. The external ear and the middle ear** The tympanic membrane separates the external auditory canal from the tympanic cavity (middle ear).
9. **A. The left ventricle and the aorta** The aortic valve is between the left ventricle and the ascending aorta. It opens during systole to allow ejection.
10. **C. The prostatic urethra** The prostate surrounds the prostatic urethra just below the bladder. BPH compresses the urethra, causing obstruction.

BONUS SECTION T: COMPLIANCE, FRAUD, AND MEDICARE REGULATIONS (10 QUESTIONS)

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

A. Only intentional fraud with specific criminal intent

B. Only actual knowledge of the false claim

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

D. Only criminal negligence

2. Which federal law imposes strict liability (no intent required) for physician self-referrals to entities in which they have a financial relationship for designated health services?

A. The Anti-Kickback Statute

B. The Stark Law (Physician Self-Referral Law)

C. HIPAA

D. The False Claims Act

3. A medical practice discovers through an internal audit that a coder has been consistently upcoding E/M services, resulting in overpayments. Under an effective compliance program, what is the appropriate action?

A. Investigate the scope of the error, refund overpayments to affected payers, retrain the coder, and implement corrective action to prevent recurrence

B. Terminate the coder immediately without investigation

C. Continue billing the same way until an external audit discovers the problem

D. Ignore the findings if the total is under $50,000

4. Under Medicare, which type of coverage policy applies uniformly across the entire country?

A. Local Coverage Determinations (LCDs)

B. Provider-specific policies

C. MAC bulletins

D. National Coverage Determinations (NCDs)

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

A. Financial records only

B. Employment records only

C. Protected health information (PHI)

D. Marketing data only

6. Under the Anti-Kickback Statute, "safe harbors" protect certain business arrangements from prosecution. Which of the following is required for a safe harbor to apply?

A. Only verbal agreement between the parties

B. The arrangement must meet ALL requirements of the specific safe harbor provision — partial compliance does not qualify

C. Only one requirement of the safe harbor must be met

D. Safe harbors apply automatically to all business arrangements

7. Under Medicare's 60-Day Rule, when a provider identifies an overpayment, what is required?

A. The overpayment must be reported to the OIG only

B. The overpayment may be applied as a credit to future claims

C. There is no deadline for returning overpayments

D. The overpayment must be reported and returned within 60 days of identification

8. 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. Practice Expense (PE) RVU

B. Work RVU

C. Professional Liability Insurance (PLI) RVU

D. The conversion factor

9. Under Medicare, the Geographic Practice Cost Index (GPCI) adjusts payment for which factor?

A. The physician's years of experience

B. The patient's insurance type

C. Geographic variations in the cost of practicing medicine

D. The complexity of the procedure

10. Which entity processes and pays Medicare Part B claims in a specific geographic region?

A. The Office of Inspector General (OIG)

B. The Medicare Administrative Contractor (MAC)

C. The Department of Justice (DOJ)

D. The State Medicaid Agency

BONUS SECTION T — ANSWER KEY WITH EXPLANATIONS

Compliance, Fraud, and Medicare Regulations

1. **C. Actual knowledge, deliberate ignorance, or reckless disregard of the truth or falsity of the claim** The False Claims Act's "knowingly" standard encompasses three mental states. Specific intent to defraud is not required.
2. **B. The Stark Law (Physician Self-Referral Law)** The Stark Law is strict liability — no intent required. If a prohibited referral occurs and no exception applies, the referral is illegal regardless of knowledge or intent.
3. **A. Investigate the scope, refund overpayments, retrain the coder, and implement corrective action** An effective compliance program requires prompt corrective action: investigation, refund, retraining, and systemic changes to prevent recurrence.
4. **D. National Coverage Determinations (NCDs)** NCDs apply uniformly nationwide. All MACs must follow NCDs. NCDs take precedence over LCDs when there is a conflict.
5. **C. Protected health information (PHI)** The HIPAA Privacy Rule governs the use and disclosure of individually identifiable health information created or maintained by covered entities.
6. **B. The arrangement must meet ALL requirements of the specific safe harbor provision — partial compliance does not qualify** Safe harbors protect specific arrangements from AKS prosecution only when every requirement is met. Partial compliance provides no protection.
7. **D. The overpayment must be reported and returned within 60 days of identification** The 60-Day Rule requires reporting and returning identified overpayments within 60 days. Failure to comply can result in False Claims Act liability.
8. **A. Practice Expense (PE) RVU** The PE RVU differs between facility and non-facility settings. In non-facility settings, PE RVUs are higher because the physician bears all overhead costs.
9. **C. Geographic variations in the cost of practicing medicine** The GPCI adjusts national RVU values for geographic cost differences in each Medicare locality.
10. **B. The Medicare Administrative Contractor (MAC)** MACs are private companies contracted by CMS to process and pay claims within specific geographic jurisdictions.