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QUESTION NO: 1

A patient with three thyroid nodules is seen for an FNA biopsy. Using ultrasonic guidance, the provider inserts a 25-gauge needle into each nodule. Nodular tissue is aspirated and sent to pathology.

What CPT® coding reported?

A. 10005, 10006 x 2, 76942

B. 10006 x 3

C. 10005, 10006 x 2

D. 10021, 10004 x 2, 76942

ANSWER: C

Explanation:

10005, 10006 x 2 is reported because the service is fine needle aspiration biopsy of three separate lesions performed with ultrasound guidance. CPT® code 10005 describes the initial fine needle aspiration biopsy lesion when ultrasound guidance is used; the imaging guidance is included in the code and is not separately reported. CPT® code 10006 is an add-on code for each additional lesion biopsied using ultrasound guidance. Because each thyroid nodule is a distinct lesion, report 10005 once for the first nodule and 10006 twice for the second and third nodules. The needle gauge does not change selection of these codes, and the pathology submission supports that tissue was obtained by FNA biopsy. CPT® guidance identifies 10006 as an add-on code that must be reported with the applicable primary FNA biopsy code, including 10005. For coding principles related to reporting distinct lesions and add-on services, see the CMS billing and coding guidance for fine needle aspiration and the AMA CPT® overview.

QUESTION NO: 2

During a laparoscopic hemicolectomy, the left kidney is accidentally perforated. A nephrologist performs open repair of the kidney laceration and places a JP drain.

What CPT® and ICD-10-CM coding is reported by the nephrologist?

A. 50500, 44206-80, N99.72

B. 50500, S37.062A

C. 50500, N99.72

D. 50500, 44206-80, S37.062A

ANSWER: C

Explanation:

50500, N99.72 correctly reports the nephrologist's distinct service and the nature of the intraoperative complication. CPT® 50500 describes repair of a kidney laceration, which matches the open operative repair performed by the nephrologist after the kidney was accidentally perforated. The placement of a Jackson-Pratt drain is integral to management of the repaired renal laceration in this circumstance and does not change the primary repair code selection. The diagnosis is reported with N99.72, accidental puncture and laceration of the genitourinary system during other procedure, because the renal injury occurred during a hemicolectomy rather than from external trauma. Coding guidelines classify an injury that arises during a procedure as a procedural complication when the documentation supports that it was accidental and required treatment. The nephrologist reports the kidney-repair service actually performed, rather than the colectomy performed by the operating surgeon. Current ICD-10-CM code files and code descriptions are available from CMS ICD-10-CM resources; the CPT® code descriptor can be reviewed through AAPC Codify.

QUESTION NO: 3

A patient presents with fever, cough, SOB, and fatigue. PCR test is positive for COVID-19. Final diagnosis: pneumonia due to COVID-19. What ICD-10-CM coding is reported?

A. U07.1, J12.82

B. U07.1, J20.9

C. U07.1, J18.9

D. U07.1, J20.8

ANSWER: A

Explanation:

Report **U07.1, COVID-19**, followed by **J12.82, Pneumonia due to coronavirus disease 2019**. The positive PCR result supports assignment of U07.1 because the provider has documented a confirmed COVID-19 diagnosis. The ICD-10-CM Official Guidelines direct coders to assign U07.1 first when COVID-19 is confirmed, except in circumstances not relevant here, such as obstetric cases or newborn records. When COVID-19 is associated with pneumonia, the classification provides the specific additional code J12.82 to identify pneumonia due to COVID-19. This code combination communicates both the underlying confirmed viral disease and its documented respiratory manifestation. Coding the pneumonia specifically as due to COVID-19 is important because the final diagnostic statement establishes a causal relationship, rather than merely documenting pneumonia and COVID-19 as unrelated coexisting conditions. Symptoms such as fever, cough, shortness of breath, and fatigue are not separately coded when they are integral to the confirmed conditions and no separate reportable condition is documented. See the CDC's ICD-10-CM Official Guidelines for Coding and Reporting and the CMS ICD-10-CM code files and resources.

QUESTION NO: 4

A 20-year-old female is being seen for the first time by a primary care physician to have a yearly physical. During the examination for the physical, the provider discovers non-inflammed lesions on her legs and arms. The physician performs a complete physical and additional separate documentation for the treatment of the lesions on the bilateral upper and lower extremities. The provider has the patient buy an over-the-counter ointment and will continue to watch them.

What CPT® coding is reported for this visit?

A. 99385

B. 99202

C. 99385-25, 99203

D. 99385, 99203-25

ANSWER: D

Explanation:

99385, 99203-25 is correct. Code 99385 reports an initial comprehensive preventive medicine evaluation for a new patient age 18 through 39 years. The yearly physical is a preventive service and includes the age- and gender-appropriate history, examination, counseling, and anticipatory guidance associated with preventive care. The patient is 20 years old and is being seen by this primary care physician for the first time, so this preventive-service code fits the documented encounter.

In addition to the preventive examination, the physician identified lesions and performed a separately documented evaluation and management service addressing those lesions. The documented assessment and treatment plan—including recommending an over-the-counter ointment and ongoing observation—supports reporting a distinct, problem-oriented new-patient visit at the stated level. Modifier 25 is appended to 99203, the problem-oriented evaluation and management code, to show that the service was significant and separately identifiable from the preventive medicine service performed by the same physician on the same date. This modifier allows both the preventive service and the distinct lesion-management service to be recognized appropriately. CMS describes modifier 25 at CMS Modifier 25 guidance. Preventive medicine service code descriptors are available through the AMA CPT code set.

QUESTION NO: 5

A woman at 36-weeks gestation goes into labor with twins. Fetus 1 is an oblique position, and the decision is made to perform a cesarean section to deliver the twins. The obstetrician who delivered the twins, provided the antepartum care, and will provide the postpartum care.

What CPTÂ® coding is reported for the twin delivery?

A. 59510, 59515

B. 59510 x 2

C. 59510, 59514, 59515

D. 59510

ANSWER: D

Explanation:

59510 is reported because the same obstetrician provided the complete global maternity service: the antepartum care, cesarean delivery, and postpartum care. CPT code 59510 represents routine obstetric care that includes all three components for a cesarean delivery. The fact that the pregnancy involves twins does not create separate global obstetric service claims for each fetus. The global code describes the physician's comprehensive maternity care for the pregnancy and delivery episode, so it is submitted once for this cesarean delivery. The documented oblique presentation supports the clinical decision to perform the cesarean delivery, while the multiple gestation and fetal presentation should also be captured with the appropriate ICD-10-CM diagnosis coding. When payer policy permits recognition of substantially increased work for a multiple gestation, documentation and payer-specific requirements should be reviewed; however, the applicable global CPT service in this scenario remains 59510. See the CPT code listing from AAPC and CMS guidance regarding global surgical service concepts in the Medicare Claims Processing Manual, Chapter 12.

QUESTION NO: 6

Dr. Burns sees newborn baby James at the birthing center on the same day after the cesarean delivery. Dr. Burns examined baby James, the maternal and newborn history, ordered appropriate blood test tests and hearing screening. He met with the family at the end of the exam.

How would Dr. Bums report his services?

A. 99463

B. 99460

C. 99461

D. 99462

ANSWER: B

Explanation:

99460 is the appropriate code because the documented service is the initial evaluation and management of a normal newborn infant in a hospital or birthing center setting. The physician saw the infant after delivery, performed the initial newborn assessment, reviewed maternal and newborn history, arranged routine newborn testing and hearing screening, and discussed the findings with the family. These activities are consistent with initial newborn care furnished on a per-day basis. The delivery method does not change selection of the normal-newborn initial-care code; the key facts are that this is the infant's first physician evaluation following birth and that the care occurred at a birthing center. There is no indication that the infant was discharged on the same date as the initial service, so the standard initial hospital or birthing center newborn-care code applies. CPT coding guidance identifies 99460 as initial hospital or birthing center care, per day, for evaluation and management of a normal newborn infant. The code is also listed in the CMS physician fee schedule lookup resources: CMS Physician Fee Schedule. Additional code-reference information is available from AAPC's CPT 99460 page.

QUESTION NO: 7

(Which place of service code is submitted on the claim for a procedure that is performed in a patient'sprivate residence?)

A. 41

B. 42

C. 65

D. 12

ANSWER: D

Explanation:

The correct place of service code is **12**. CMS defines Place of Service 12, "Home," as a location other than a hospital or other facility where the patient receives care in a private residence. Therefore, when a professional service or procedure is performed in the patient's own private residence, the claim should report POS 12. Place of service reporting communicates the setting in which the practitioner rendered the service and is an important component of accurate professional claim submission. Payers use the POS code in claim adjudication and, depending on the service and payer policy, it may affect payment methodology or whether separate facility considerations apply. The coder should select the POS based on the actual location documented for the encounter, rather than the provider's office location or the patient's mailing address. CMS's current POS code set lists code 12 as Home and provides the applicable descriptor for this setting. See the CMS Place of Service Code Sets and the CMS Physician Place of Service Code Set.

QUESTION NO: 8

Mrs. Wilder presents with right and left leg swelling. Venous thrombosis imaging of each leg is done and shows deep venous embolism and thrombosis in each leg.

What CPT® and ICD-10-CM codes are reported?

A. 78458, 182.403

B. 78457-50, 182.403

C. 78457-RT, 78457-LT, 182.401, 182.402

D. 74858-50, 182.401, 182.402

E. 78457, I82.403

ANSWER: E

Explanation:

78457, I82.403 is correct. CPT® 78457 reports venous thrombosis imaging (venogram) and its code descriptor encompasses imaging performed unilaterally or bilaterally. Because the service was performed on both legs, but bilateral performance is already included in the descriptor, it is reported once without modifier 50 and without separate RT and LT line items. The documented imaging finding is thrombosis involving deep veins in both lower extremities. ICD-10-CM code I82.403 specifically represents acute embolism and thrombosis of unspecified deep veins of bilateral lower extremities. This code captures both the deep-vein location and the bilateral lower-extremity involvement described in the clinical scenario. The documentation does not identify a more specific named deep vein, such as the femoral, popliteal, iliac, or calf vein; therefore, the unspecified deep-vein code is appropriate. For CPT® descriptor information, see AAPC's CPT® code listing for 78457. For the diagnosis-code description, see AAPC's ICD-10-CM listing for I82.403.

QUESTION NO: 9

(A 58-year-old patient undergoes diagnostic facet joint injections. The physician performsbilateral paravertebral facet joint injectionsat theT2–T3, T3–T4, and T4–T5levels, usingfluoroscopic guidanceat each site. What CPT® coding is reported for this encounter?)

A. 64490-50, 64491 × 2, 64492 × 2

B. 64493, 64494

C. 64493-50, 64494-50, 64495-50, 76000

D. 64490-50, 64491-50, 64492-50

ANSWER: D

Explanation:

64490-50, 64491-50, 64492-50 correctly represents bilateral diagnostic paravertebral facet joint injections in the thoracic spine at three distinct facet-joint levels. The cervical/thoracic facet injection code family is selected because T2–T3, T3–T4, and T4–T5 are thoracic levels. Code 64490 reports the initial cervical or thoracic facet joint level, 64491 is the add-on code for the second level, and 64492 is the add-on code for the third and each additional level in that same region during the encounter. Thus, the three treated levels require all three codes in sequence. Because the documented injections are bilateral, modifier -50 is appended in accordance with the coding convention used in this answer set to identify the bilateral service. Fluoroscopy is not separately coded because image guidance—fluoroscopy or computed tomography—is included in the facet injection code descriptors. The procedure is therefore reported by region, level count, and bilateral status, without a separate guidance code. See the CPT code summary for 64490 and CMS guidance concerning facet-joint intervention coding in the Facet Joint Interventions for Pain Management LCD.

QUESTION NO: 10

A 1-year-old is with his mom to have his scheduled vaccinations. The physician provides counseling for routine immunizations and carries out measles, mumps, rubella and varicella (MMRV)

subcutaneously and dose 3 of Hepatitis B intramuscularly without difficulty.

What CPTÂ® codes are reported?

A. 90471, 90472 x 4, 90707, 90746

B. 90460, 90461, 90710, 90744

C. 90460 x 2, 90461 x 3, 90710, 90744

D. 90471, 90472, 90707, 90746

ANSWER: C

Explanation:

90460 x 2, 90461 x 3, 90710, 90744 is correct because the child is 18 years of age or younger and the physician personally provides immunization counseling. CPT® 90460 is reported for the first or only component of each vaccine administered with qualifying counseling. There are two separate vaccine products: MMRV and hepatitis B. Therefore, report 90460 twice—once for the initial component of the MMRV product and once for the single hepatitis B component. CPT® 90461 is reported for each additional component within a combination vaccine. MMRV contains four vaccine components: measles, mumps, rubella, and varicella. After the initial MMRV component reported with 90460, the remaining three components require 90461 x 3. Hepatitis B is a one-component vaccine, so it does not generate an additional-component administration unit. CPT® 90710 identifies the measles, mumps, rubella, and varicella live vaccine product administered subcutaneously. CPT® 90744 identifies the pediatric/adolescent hepatitis B vaccine, a three-dose schedule product, administered intramuscularly. The administration-code selection is driven by the patient's age, physician counseling, and vaccine-component count rather than by the routes of administration. See the AAPC CPT® code information for 90460 and the CDC vaccine administration guidance.

QUESTION NO: 11

(A provider documents â€œpericarditis with effusionâ€□ in the assessment. Based on medical terminology, which structure is inflamed?)

A. The heart muscle

B. The sac surrounding the heart

C. The blood vessels supplying the heart

D. The inner lining of the heart chambers

ANSWER: B

Explanation:

The sac surrounding the heart is correct because pericarditis is inflammation of the pericardium. The pericardium is a double-layered, saclike membrane that encloses the heart, helps hold it in position, and contains a small amount of lubricating fluid between its layers. In medical terminology, the prefix *peri-* means around, *cardi-* refers to the heart, and *-itis* denotes inflammation; together, these elements identify inflammation of the membrane around the heart. The accompanying phrase “with effusion” means that excess fluid has accumulated in the pericardial space. That finding does not change the structure named by pericarditis; it further describes the associated fluid collection. Accurate recognition of the anatomic term is important when interpreting provider documentation and selecting a diagnosis code, because the documented condition is specifically an inflammatory disorder of the pericardium. The National Heart, Lung, and Blood Institute describes the pericardium as the sac around the heart and explains that pericarditis is its inflammation. See NHLBI: Pericardial Diseases and Merck Manual: Pericarditis.

QUESTION NO: 12

The human shoulder is made of which three bones?

A. Olecranon, radius, ulna

B. Carpal, radius, humerus

C. Metatarsal, tibia, navicular

D. Clavicle, scapula, humerus

ANSWER: D

Explanation:

Clavicle, scapula, humerus is correct because these are the three bones that comprise the shoulder complex. The clavicle, commonly called the collarbone, connects medially to the sternum and laterally to the scapula. The scapula, or shoulder blade, provides the glenoid cavity, which forms the socket portion of the glenohumeral joint. The humerus is the upper-arm bone; its rounded head articulates with the glenoid cavity to form the primary ball-and-socket joint of the shoulder. Together, these bones and their associated joints—including the sternoclavicular, acromioclavicular, and glenohumeral joints—allow the shoulder its substantial range of motion. This anatomy is foundational when selecting CPT® codes in the Musculoskeletal System section because code descriptions commonly identify the involved shoulder structure, joint, or bone. For an anatomical overview of the shoulder’s bones and articulations, see StatPearls: Anatomy, Shoulder and Upper Limb. A visual and clinical description is also available from Cleveland Clinic: Shoulder Joint.

QUESTION NO: 13

A provider performs a mastoidectomy and complete labyrinthectomy for right-sided peripheral vertigo.

What CPTÂ® and ICD-10-CM codes are reported?

A. 69905, 69990-51, R42

B. 69910, 69990, H81.391

C. 69905, 69990, H81.391

D. 69910, 69990-51, R42

ANSWER: C

Explanation:

The correct code set is **69905, 69990, H81.391**. CPT® code 69905 reports a transmastoid labyrinthectomy and encompasses the mastoidectomy performed as part of that surgical approach. The documented complete labyrinthectomy for treatment of peripheral vertigo therefore supports this primary otologic procedure code. CPT® code 69990 reports microsurgical techniques requiring use of an operating microscope when its separate reporting is supported by the operative documentation and payer policy. It is listed in addition to the primary procedure rather than as an unrelated additional procedure. For the diagnosis, H81.391 identifies other peripheral vertigo, right ear, which matches the documented right-sided peripheral vertigo. The code assignment should reflect the established condition treated by the provider, rather than a nonspecific symptom such as dizziness. ICD-10-CM coding conventions direct coders to report the confirmed diagnosis when it is documented and applicable to the encounter. CPT® code details can be verified through the AAPC CPT® 69905 code reference, and the diagnosis-code structure is available in the CMS ICD-10-CM resources.

QUESTION NO: 14

The patient came in with an inflamed seborrheic keratosis on her nose for a shave removal. After applying local anesthesia, a 0.7 cm dermal lesion was removed using an 11 blade.

What CPT® and ICD-10-CM codes are reported?

A. 11401, L82.1

B. 11421, L82.0

C. 11311, L82.0

D. 11306, L82.1

ANSWER: C

Explanation:

11311, L82.0 is correct because the documented technique is a shave removal of a single epidermal or dermal lesion. CPT® code 11311 describes shaving of a single lesion located on the face, ears, eyelids, nose, or lips when the lesion's diameter is 0.6 cm to 1.0 cm. The nose is included in this anatomic grouping, and the documented 0.7 cm diameter falls squarely within the code's size range. Use of an 11 blade and the provider's stated shave-removal intent support reporting a shaving procedure rather than an excision code. Local anesthetic administration is integral to the procedure and is not separately reported in this circumstance. The diagnosis is inflamed seborrheic keratosis, which is classified to ICD-10-CM code L82.0. Accurate code selection requires matching both the lesion-removal method and the measured lesion size to the CPT® descriptor, while assigning the diagnosis code at the documented level of specificity. The ICD-10-CM code set and official guidance are available from the CDC ICD-10-CM resources; CPT® coding information is maintained by the American Medical Association.

QUESTION NO: 15

A 58-year-old male suffered an acute STEMI of the inferolateral wall while running a marathon on June 15 and had received treatment. Three weeks later, the patient presents to the ED complaining of SOB and left arm pain. An EKG is performed as well as blood tests. Patient is admitted for further evaluation.

What diagnosis code is reported for this encounter?

A. I22.2

B. I21.29

C. I21.19

D. I21.3

ANSWER: B

Explanation:

I21.29 is reported because the documented infarction is an acute ST-elevation myocardial infarction involving the inferolateral wall, and the return encounter is only three weeks after the June 15 event. ICD-10-CM treats an acute myocardial infarction as acute for four weeks (28 days) from onset. The I21 category is used throughout that acute period, including subsequent care and evaluation related to the same infarction. “Inferolateral wall” is not assigned to a distinct named-wall code in the I21 STEMI subcategories; it is classified as a STEMI involving other sites, which is represented by I21.29. The patient’s symptoms and inpatient evaluation do not, by themselves, document a new or subsequent myocardial infarction. Therefore, the established acute inferolateral STEMI remains the reportable diagnosis for this encounter. The ICD-10-CM Official Guidelines state that an acute MI is classified to category I21 for four weeks and direct coders to use the subsequent-MI category only when a new MI occurs during that time. See the ICD-10-CM Official Guidelines for Coding and Reporting and the CMS ICD-10-CM code set resources.

QUESTION NO: 16

(A 32-year-old is in the outpatient clinic for anesophagoscopydue to increased difficulty swallowing with hiseosinophilic esophagitis. The flexible scope is inserted into the esophagus. Examination notes narrowing in the distal esophagus. Following an injection of Kenalog, atransendoscopic balloon dilationis performed in the area of stenosis, eventually reaching 18 mm. What CPT® coding is reported for this procedure?)

A. 43220, 43204

B. 43214, 43201

C. 43220, 43201

D. 43220, 43200-59

ANSWER: C

Explanation:

The correct reporting is **43220, 43201**. CPT® code 43220 describes flexible, transoral esophagoscopy with transendoscopic balloon dilation of the esophagus when the dilation is less than 30 mm in diameter. The documented procedure used a flexible esophagoscope and a balloon to dilate the distal esophageal stenosis to 18 mm, which meets this code’s stated diameter criterion. The therapeutic dilation is therefore captured by 43220. See the code’s descriptor at AAPC CPT® code 43220.

The Kenalog administration is a directed injection delivered endoscopically to the stenotic esophageal area. CPT® code 43201 reports flexible, transoral esophagoscopy with directed submucosal injection of any substance. Kenalog is a triamcinolone corticosteroid, and its endoscopic injection is separately identified by this code when documented as a distinct therapeutic service in addition to the balloon dilation. The scope work is inherent in the therapeutic esophagoscopy codes, while the dilation and directed injection describe the two documented treatments. The applicable injection code descriptor is available at AAPC CPT® code 43201.

QUESTION NO: 17

A patient has hypertension, chronic diastolic heart failure, and chronic kidney disease stage 3a. The provider does not document that either the heart failure or chronic kidney disease is unrelated to the hypertension.

What ICD-10-CM codes are reported?

A. I13.0, I50.32, N18.31

B. I11.0, I50.32, N18.31

C. I12.9, I50.32, N18.31

D. I10, I50.32, N18.31

ANSWER: A

Explanation:

I13.0, I50.32, N18.31 is correct. ICD-10-CM presumes a causal relationship between hypertension and both heart disease and chronic kidney disease when they are documented together, unless the provider documents that the conditions are unrelated. Category I13 is used when hypertension, heart failure, and chronic kidney disease are all present.

Code I13.0 reports hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease. An additional code from category I50.- is required to identify the type of heart failure, and I50.32 identifies chronic diastolic heart failure. Code N18.31 identifies chronic kidney disease stage 3a. Reporting I10 separately would not accurately capture the documented hypertensive heart and kidney disease combination.

QUESTION NO: 18

Two weeks after removal of a 4 cm subcutaneous lipoma, the patient presents with extensive internal wound dehiscence requiring multi-layer closure in the OR.

What CPT® coding is reported by the surgeon?

A. 13160-78

B. 13160-58

C. 13101-78

D. 13101-58

ANSWER: A

Explanation:

13160-78 is reported because CPT® 13160 specifically describes secondary closure of a surgical wound or dehiscence when the closure is extensive or complicated. The documented extensive internal wound separation and required multilayer closure support reporting the dedicated dehiscence-repair code rather than a routine wound-closure code. The fact that the repair is performed two weeks after the lipoma excision means it occurs during the postoperative global period of the original procedure. Because the patient must return to the operating room for an unplanned procedure to treat a complication related to that original surgery, modifier 78 appropriately identifies an unplanned return to the operating/procedure room for a related procedure during the postoperative period. Modifier 78 allows the payer to recognize that the dehiscence repair is separately reportable while preserving its relationship to the prior surgical service and its global package. CMS defines modifier 78 as an unplanned return to the operating or procedure room by the same physician or other qualified health care professional following an initial procedure for a related procedure during the postoperative period. See the CMS Physician Fee Schedule resources and the AMA CPT® overview for authoritative coding-framework information.

QUESTION NO: 19

A 1-year-old is with his mom to have his scheduled vaccinations. The physician provides counseling for routine immunizations and carries out measles, mumps, rubella and varicella (MMRV)

subcutaneously and dose 3 of Hepatitis B intramuscularly without difficulty.

What CPT® codes are reported?

A. 90471, 90472 x 4, 90707, 90746

B. 90460, 90461, 90710, 90744

C. 90460 x 2, 90461 x 3, 90710, 90744

D. 90471, 90472, 90707, 90746

ANSWER: C

Explanation:

90460 x 2, 90461 x 3, 90710, 90744 is correct because the child is younger than 18 years and the physician personally provides immunization counseling. Under the CPT immunization-administration guidelines, 90460 is reported for the first or only component of each vaccine administered with qualifying physician or other qualified health care professional counseling. Two distinct vaccines are given, so 90460 is reported twice: once for the MMRV vaccine and once for the hepatitis B vaccine.

MMRV is a combination vaccine with four antigen components: measles, mumps, rubella, and varicella. After reporting the initial component with 90460, each of its remaining three components is reported with 90461, resulting in 90461 x 3. Hepatitis B is a single-component vaccine, so it does not generate an additional-component administration code. CPT 90710 identifies the MMRV vaccine for subcutaneous use, and 90744 identifies the pediatric/adolescent hepatitis B vaccine, three-dose schedule, for intramuscular administration. The dose number does not alter the appropriate product code in this scenario. See the AAPC code information for 90460 and the AAPC code information for 90710.

QUESTION NO: 20

A couple presents to the freestanding fertility clinic to start in vitro fertilization. Under radiologic guidance, an aspiration needle is inserted (by aid of a superimposed guiding-line) puncturing the ovary and preovulatory follicle and withdrawing fluid from the follicle containing the egg.

What is the correct CPT® code for this procedure?

A. 58976

B. 58974

C. 58999

D. 58970

ANSWER: D

Explanation:

58970 is the correct CPT® code because the documented service is follicle puncture to retrieve oocytes. The procedure describes placement of an aspiration needle into the ovary and a preovulatory follicle, followed by aspiration of follicular fluid containing the egg. This is the oocyte-retrieval step of an in vitro fertilization cycle. CPT® code 58970 specifically reports “follicle puncture for oocyte retrieval, any method,” so it encompasses retrieval performed with radiologic or ultrasound guidance as part of the puncture procedure. The phrase “any method” is important: the approach used to guide the needle does not alter the fundamental service being coded, which is aspiration of ovarian follicles for egg retrieval. Code selection should be based on the service actually performed and documented rather than the broader IVF treatment plan. The current CPT® code descriptor can be verified through the American Medical Association CPT® overview. For coding principles requiring complete and accurate documentation of services rendered, see the CMS National Correct Coding Initiative.

QUESTION NO: 21

Miranda is in her provider ' s office for follow up of her diabetes. Her blood sugars remain at goal with continuing her prescribed medications.

When referring to the MDM Table in the CPT® code book for number and complexity of problems addressed at the encounter, what type of problem is this considered?

A. Acute, uncomplicated illness or injury

B. Minimal problem

C. Stable, chronic illness

D. Stable, acute illness

ANSWER: C

Explanation:

Stable, chronic illness is correct because diabetes is a long-term condition that requires ongoing clinical management rather than a condition expected to resolve quickly. In this encounter, Miranda's blood sugars remain at goal while she continues her prescribed medication regimen. This indicates that the diabetes is stable: the provider is following an established chronic condition and its current management is maintaining the intended treatment outcome. Under the CPT office or other outpatient evaluation and management medical decision-making table, a stable chronic illness is specifically included in the problem element for low-level MDM when one stable chronic illness is addressed. The condition must be evaluated or managed during the visit, not merely listed in the history. A follow-up visit assessing glycemic control and continuing treatment reflects active management of the chronic diabetes. The CPT framework focuses on the status and complexity of the problem as addressed at that encounter; diabetes controlled at goal with continued therapy fits the definition of a stable chronic illness. See the AMA's overview of office/outpatient E/M coding at https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management and CMS guidance on office/outpatient E/M visit coding at https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/medicare-telehealth-services.

QUESTION NO: 22

A 42-year-old male is diagnosed with a left renal mass. Patient is placed under general anesthesia and in prone position. A periumbilical incision is made and a trocar inserted. A laparoscope is inserted and advanced to the operative site. The left kidney is removed, along with part of the left ureter. What CPTÂ® code is reported for this procedure?

A. 50220

B. 50548

C. 50543

D. 50546

ANSWER: D

Explanation:

50546 is reported because the operative note documents a surgical laparoscopic nephrectomy with removal of part of the ureter. The laparoscope and trocar access establish that the procedure was performed laparoscopically rather than through an open incision. The code descriptor for 50546 is laparoscopic nephrectomy, including partial ureterectomy, which directly captures removal of the entire kidney together with a portion of the ureter. "Including" indicates that the partial ureterectomy is integral to the reported nephrectomy service and is not separately coded. The diagnosis of a renal mass does not, by itself, establish that a radical nephrectomy or a total ureterectomy was performed; coding must follow the documented surgical work. Here, the documented removal of the kidney and only part of the ureter supports laparoscopic nephrectomy including partial ureterectomy. CPT code details can be reviewed through AAPC's 50546 code listing. For general guidance on using the current CPT code set and its descriptors, see the American Medical Association CPT overview.

QUESTION NO: 23

A patient presents with fever, cough, SOB, and a recent history of COVID-19. A PCR test was positive for COVID-19. The provider documents a final diagnosis of "pneumonia with history of COVID-19."

What ICD-10-CM coding is reported?

A. J18.9, Z86.16

B. J18.9, U09.9

C. U07.1, J20.9

D. U07.1, J22

E. U07.1, J18.9

ANSWER: E

Explanation:

U07.1, J18.9 is the appropriate coding because a documented positive COVID-19 PCR test supports assignment of U07.1, COVID-19, as a confirmed current infection under the ICD-10-CM Official Guidelines. A positive test result is sufficient confirmation for code assignment even when the diagnostic wording includes a history of COVID-19. U07.1 is sequenced first when COVID-19 is the reason for the encounter or is associated with the condition being treated.

The provider's final diagnosis also establishes pneumonia, but does not specify an organism or explicitly document that the pneumonia is due to COVID-19. Therefore, J18.9, Pneumonia, unspecified organism, is reported as the additional diagnosis. A causal relationship should not be assumed merely from concurrent COVID-19 positivity; documentation such as "COVID-19 pneumonia" or "pneumonia due to COVID-19" would be needed to report J12.82. The history code is not reported with a current confirmed COVID-19 infection, because a personal-history code represents a resolved condition without current disease. See the ICD-10-CM Official Guidelines for Coding and Reporting and the CDC ICD-10-CM resources.

QUESTION NO: 24

What modifier is appended to indicate when a service is performed because it was mandated by a third-party payer, government agency, or other regulatory requirement?

A. 23

B. 32

C. 76

D. 24

ANSWER: B

Explanation:

Modifier 32 is appended to a CPT code when the reported service was performed because it was required by an entity outside the treating clinician's independent clinical judgment. CPT describes this modifier as identifying a "mandated service." The mandate may come from a third-party payer, government agency, legal authority, employer, or other regulatory body. Its purpose is to communicate that the reason for performing the service was an external requirement, which can be important for claim processing and for accurately documenting the circumstances surrounding the encounter or procedure.

For example, a patient may need an examination, evaluation, or testing to satisfy a workers' compensation requirement, an insurance-related determination, an employer requirement, or a government or legal directive. When the circumstances meet the CPT definition, appending modifier 32 clearly identifies that the service was mandated. Coders should still ensure the underlying CPT code accurately represents the service actually performed and that documentation identifies the source and nature of the mandate. The official CPT modifier listing is maintained by the American Medical Association; see the AMA CPT modifier resource. AAPC also provides coding education and modifier guidance through its Coding News & Education resources.

QUESTION NO: 25

A patient comes in complaining of pain in the lower left back, which is accompanied by a numbing sensation that extends into the leg. Attempts to alleviate the pain with home treatments have been unsuccessful. The provider orders an MRI of the lumbar spine initially without, and then with, contrast material. The images are interpreted by the physician, the final diagnosis is left-sided low back pain with sciatica.

What CPT® and ICD-10-CM codes are reported?

A. 72158,M54.42

B. 72148,72149, M54.42

C. 72148,72149, M54.42. M54.50

D. 72158,M54.42,M54.50

ANSWER: A

Explanation:

72158, M54.42 is correct because CPT® code 72158 describes magnetic resonance imaging of the lumbar spine performed without contrast material and subsequently with contrast material. This code represents the complete contrast sequence documented in the encounter: initial noncontrast imaging followed by contrast-enhanced imaging of the same lumbar-spine study. It is reported as one comprehensive MRI service rather than as separate without-contrast and with-contrast procedures. The fact that the physician interpreted the images supports reporting the diagnostic imaging service in the context presented, subject to any applicable professional or technical component circumstances in actual billing.

The documented final diagnosis is low back pain with sciatica affecting the left side. ICD-10-CM code M54.42 specifically captures lumbago/low back pain with left-sided sciatica, matching both the anatomic symptom location and the radiating leg symptoms described. The diagnosis is reported as documented, without separately assigning an additional unspecified low-back-pain code. CPT® coding details for this MRI service are available from AAPC's CPT® code listing for 72158, and the diagnosis descriptor can be reviewed in AAPC's ICD-10-CM listing for M54.42.

QUESTION NO: 26

A patient is admitted with acute on chronic systolic congestive heart failure. The provider does not document any additional type of heart failure.

What ICD-10-CM code is reported?

A. I50.21

B. I50.22

C. I50.23

D. I50.43

ANSWER: C

Explanation:

I50.23 is correct because the provider documents acute on chronic systolic congestive heart failure. ICD-10-CM code I50.23 specifically identifies acute on chronic systolic heart failure.

Code I50.21 represents acute systolic heart failure without documentation that the condition is chronic. Code I50.22 represents chronic systolic heart failure without an acute exacerbation. Code I50.43 is for acute on chronic combined systolic and diastolic heart failure, which is not documented.

QUESTION NO: 27

(What CPT® coding is reported for the insertion ofHeyman capsulesfor clinical brachytherapy?)

A. 55875

B. 55920

C. 57155

D. 58346

ANSWER: D

Explanation:

The correct code is 58346, which specifically describes insertion of Heyman capsules for clinical brachytherapy. Heyman capsules are an intracavitary applicator system used in gynecologic radiation treatment, particularly for uterine brachytherapy. The procedure involves placing the capsules within the uterine cavity so a radiation source can be positioned to deliver localized internal radiation therapy. Because CPT code selection must reflect the precise procedure actually performed, the named Heyman capsule insertion is reported with its dedicated CPT code rather than a general radiation-treatment service or a code for another type of brachytherapy applicator. In the CPT code set, this service is classified within the female genital system procedures, consistent with the gynecologic use and uterine placement of the device. Accurate reporting also requires coding any separately documented radiation oncology planning, source loading, and treatment-delivery services according to the applicable CPT guidance and payer requirements; however, the insertion procedure itself is represented by 58346. The Centers for Medicare & Medicaid Services lists CPT 58346 as “Insertion of Heyman capsules for clinical brachytherapy” in its physician fee schedule data. See the CMS Physician Fee Schedule Search and the American Medical Association CPT overview.

QUESTION NO: 28

The documentation states:

“A punch is placed and pushed downward to obtain a tissue sample for a biopsy of the lunula.”

What anatomical structure is being biopsied?

A. Brain

B. Nail

C. Eye

D. Skin

ANSWER: B

Explanation:

The correct answer is **Nail**. The lunula is the visible, pale crescent-shaped area at the proximal base of a fingernail or toenail. It is a component of the nail unit and represents the visible portion of the distal nail matrix, the specialized tissue responsible for producing the nail plate. Therefore, documentation describing a biopsy of the lunula identifies the procedure as involving a nail structure. Although a punch instrument may pass through surrounding tissue to obtain the specimen, the documented anatomic target is the lunula, which is classified as part of the nail apparatus. Accurate identification of the anatomic site is important when interpreting procedure documentation and selecting the appropriate procedural code family, particularly because nail-unit services are distinguished from biopsies of ordinary skin lesions. The National Cancer Institute’s definition describes the lunula as the whitish, half-moon-shaped area at the base of a fingernail or toenail. DermNet also explains that the nail matrix lies beneath the proximal nail fold and produces the nail plate, supporting the lunula’s relationship to nail anatomy. See the National Cancer Institute definition of lunula and DermNet’s nail matrix biopsy overview.

QUESTION NO: 29

Preoperative diagnosis: Right thigh benign congenital hairy nevus. *1

Postoperative diagnosis: Right thigh benign congenital hairy 0 nevus.

Operation performed: Excision of right thigh benign congenital > 1

nevus, excision size with margins 4.5 cm and closure size 5 cm.

Anesthesia: General.0

Intraoperative antibiotics: Ancef.0

Indications: The patient is a 5-year-old girl who presented with her parents for evaluation of her right thigh congenital nevus. It has been followed by pediatrics and thought to have changed over the past year. Family requested excision. They understood the risks involved, which included but were not limited to risks of general

anesthesia, infection, bleeding, wound dehiscence, and poor scar formation. They understood the scar would likely widen as the child grows because of the location of it and because of the age of the patient. They consented to proceed.

Description of procedure: The patient was seen preoperatively in > I the holding area, identified, and then brought to the operating room. Once adequate general anesthesia had been induced, the patient ' s right thigh was prepped and draped in standard surgical fashion. An elliptical excision measuring 6 x 1.8 cm had been marked. This was injected with Lidocaine with epinephrine, total of 6 cc of 1% with 1:100,000. After an adequate amount of time, a #15 blade was used to sharply excise this full thickness.

This was passed to pathology for review. The wound required □ limited undermining in the deep subcutaneous plane on both sides for approximately 1.5 cm in order to allow mobilization of the skin for closure. The skin was then closed in a layered fashion using 3-0 Vicryl on the dermis and then 4-0 Monocryl running subcuticular in the skin, the wound was cleaned and dressed with Dermabond and Steri-Strips.

The patient was then cleaned and turned over to anesthesia for S extubation.

She was extubated successfully in the operating room and taken S to the recovery room in stable condition. There were no complications.

What CPT® coding is reported?

A. 12002, 11406-51

B. 12002, 11606-51

C. 12032, 11406-51

D. 12032, 11606-51

ANSWER: C

Explanation:

12032, 11406-51 is reported because the documented lesion is a benign congenital nevus on the thigh, which is classified within the trunk, arms, or legs anatomic grouping for skin-lesion excision coding. Excision coding is based on the greatest clinical diameter of the lesion plus the narrowest margins required for complete excision—not on the final elliptical incision length. The operative report expressly gives an excised size including margins of 4.5 cm. That measurement falls in the 4.1 cm to 5.0 cm size range for excision of a benign lesion of the trunk, arms, or legs, supporting 11406.

Although simple closure is included in the excision code, the closure here was intermediate. The surgeon performed limited undermining in the deep subcutaneous plane to mobilize skin and documented layered closure with dermal Vicryl sutures and a subcuticular Monocryl skin closure. Intermediate repair is therefore separately reportable. The repaired wound length was 5 cm, which is within the 2.6 cm to 7.5 cm range for intermediate repair of the scalp, axillae, trunk, and/or extremities, supporting 12032. Modifier 51 identifies the additional reportable procedure when required by the payer. See the CMS guidance on lesion excision measurement and the CMS guidance on repair coding.

QUESTION NO: 30

A child returns for stage 2 surgical repair of double outlet right ventricle, including removal of pulmonary artery band, arterial switch repair, and ECMO cannulation.

What CPT® codes are reported?

A. 33778-78, 33953-78, 33985-78

B. 33779-78, 33953-78, 33985-78

C. 33778-58, 33955-58, 33985-58

D. 33779-58, 33955-58, 33985-58

ANSWER: D

Explanation:

33779-58, 33955-58, 33985-58 is correct because the definitive second-stage repair of double outlet right ventricle includes an arterial switch operation with ventricular septal defect closure, reported with CPT® 33779. The prior pulmonary artery band is part of the staged surgical history, and its removal is integral to completing this definitive repair rather than separately reported. Open central cannulation for extracorporeal membrane oxygenation is reported with CPT® 33955, while CPT® 33985 reports the applicable ECMO management service. Modifier 58 is appropriate because the return for the definitive stage is a planned or anticipated, related staged procedure performed during the postoperative period of the earlier operation. Modifier 58 distinguishes a staged service from an unplanned return to the operating room and begins a new global surgical period for the staged procedure. The same staged-procedure modifier is appended to the separately reportable services performed as part of this planned return. See the AAPC description of modifier 58 and CMS guidance on Physician Fee Schedule coding and payment resources.

QUESTION NO: 31

A patient with coronary artery disease due to lipid-rich plaque undergoes coronary artery bypass grafting. The surgeon performs a left internal mammary artery graft to the left anterior descending artery. Then performs saphenous vein grafts to the obtuse marginal artery, ramus intermedius, and posterior descending artery. An endoscopic saphenous vein harvest is performed.

What CPT® coding is reported for the surgical procedure?

A. 33536,33512

B. 33533, 33512, 33508

C. 33536,33519

D. 33533,33519,33508

ANSWER: D

Explanation:

33533, 33519, 33508 correctly represents the coronary artery bypass grafting procedure. CPT® 33533 reports a single arterial coronary bypass graft, which applies to the left internal mammary artery graft placed to the left anterior descending coronary artery. The three saphenous vein graft distal anastomoses—to the obtuse marginal artery, ramus intermedius, and posterior descending artery—are reported with 33519, the code for three venous coronary artery bypass grafts. CABG code selection is based on the type of conduit used and the number of coronary venous or arterial grafts constructed, rather than simply the total number of vessels named in the operative report.

In addition, 33508 is reported for the endoscopic harvesting of the saphenous vein. This is an add-on code and is separately reportable when the vein is obtained through an endoscopic technique, as documented here. The arterial and venous bypass codes are reported together because they describe distinct conduit types used during the same CABG operation. For CPT® code descriptors and coding guidance, see the American Medical Association CPT® overview and the CMS guidance addressing cardiac surgery coding.

QUESTION NO: 32

An abdominal X-ray includes decubitus, supine, and erect views.

What CPT® code is reported?

A. 74021-26

B. 74018-26

C. 74022-26

D. 74019-26

ANSWER: A

Explanation:

74021-26 is reported because CPT® code 74021 describes a complete radiologic examination of the abdomen consisting of three or more views. The documented decubitus, supine, and erect projections total three abdominal views, meeting the code's "three or more views" requirement. Each projection is a distinct radiographic view used to evaluate abdominal anatomy and, depending on the clinical indication, may help demonstrate bowel gas patterns, air-fluid levels, calcifications, or free intraperitoneal air.

The **-26**AAPC's CPT® 74021 listing, and CMS explains professional-component billing with modifier 26 in its Physician Fee Schedule resources.

QUESTION NO: 33

(A 3-year-old is seen by his primary care physician for anannual exam. His last exam with the primary care physician wastwo years ago. He has no complaints. What CPT® code is reported?)

A. 99383

B. 99393

C. 99394

D. 99382

E. 99392

ANSWER: E

Explanation:

99392 is reported for a periodic comprehensive preventive medicine evaluation and management service for an *established* patient age 1 through 4 years. The child is 3 years old, placing the service in the 1–4-year preventive medicine age range. The annual examination is preventive in nature because it is a routine health-maintenance visit and the child has no complaint requiring a problem-oriented evaluation.

The patient is established because he was previously seen by the same primary care physician within the preceding three years. CPT's established-patient concept is based on prior professional services from the same physician or another physician of the same specialty in the same group practice during that three-year period; it does not require that the prior visit have occurred within one year. Therefore, the established-patient preventive medicine code for the applicable age range is 99392. The preventive medicine service includes an age- and gender-appropriate history, examination, counseling/anticipatory guidance, risk-factor reduction interventions, and ordering of laboratory or diagnostic procedures when appropriate. See the AAPC CPT code listing for 99392 and CMS's Evaluation and Management Services Guide for the established-patient three-year standard.

QUESTION NO: 34

The Medicare program has multiple parts covering different services. Which part provides coverage for outpatient physician charges?

A. Part C

B. Part B

C. Part A

D. Part D

ANSWER: B

Explanation:

Part B is correct because it is the component of Original Medicare that covers medically necessary outpatient medical services and preventive services. This includes services furnished by physicians and other qualified health care professionals in office, clinic, hospital outpatient, and other ambulatory settings. Accordingly, outpatient physician charges are generally submitted to and paid under Medicare Part B, subject to applicable deductibles, coinsurance, coverage requirements, and assignment rules. Part B also covers a broad range of related outpatient items and services, such as diagnostic testing, laboratory services, outpatient therapy, durable medical equipment, ambulance services when coverage criteria are met, and specified preventive screenings. For coding and billing purposes, recognizing that professional services provided to a Medicare beneficiary in an outpatient setting are ordinarily Part B benefits helps establish the appropriate Medicare coverage context. The Centers for Medicare & Medicaid Services describes Part B as medical insurance covering doctors' services, outpatient care, medical supplies, and preventive services. Medicare's official overview likewise identifies doctor and other provider services and outpatient care as Part B-covered services. See Medicare.gov: Parts of Medicare and CMS: Medicare General Information.

QUESTION NO: 35

(Full Case:Location:ABC Outpatient Clinic.Patient:60-year-old menopausal female.Independent radiologist (not employed by hospital):Dr. Q.Chief complaint:Uterine cramping.Procedure:Transvaginal ultrasound.Findings:Ovaries normal; measurements given (note: left ovary listed twice with different dimensions); uterus 5.2 × 5.1 × 4.0; endometrial stripe 0.8 cm; uterus without focal hypoechoic mass; ovoid anechoic foci in lower uterus/cervix due to Nabothian cysts; no adnexal fluid or mass; cervix thickness/length normal; true sagittal thickest portion measured.Question:What CPT® and ICD-10-CM codes are reported for the independent radiologist that provided the interpretation of the ultrasound?)

A. 76830-26, N94.89

B. 76817, N94.89

C. 76817-26, N94.9

D. 76830, N94.9

ANSWER: A

Explanation:

76830-26, N94.89 is correct because the documented examination is a nonobstetric transvaginal pelvic ultrasound. CPT® code 76830 describes ultrasound of the pelvic organs performed through the transvaginal approach. The imaging findings include assessment and measurement of the uterus, endometrium, ovaries, cervix, and adnexal regions, supporting this transvaginal pelvic ultrasound service. The independent radiologist supplied the interpretation and report but was not the provider furnishing the technical component, such as the equipment, technologist, and image acquisition. Modifier 26 therefore correctly identifies that the radiologist is billing only the professional component of 76830. CMS describes modifier 26 as identifying the professional component when a service has distinct professional and technical portions. See the CMS HCPCS modifiers guidance. For the reason for the study, uterine cramping is indexed as an other specified condition associated with the female genital organs and menstrual cycle, reported with ICD-10-CM code N94.89. The documented Nabothian cysts are imaging findings and do not replace the symptom-based reason for the examination when the encounter is supported by uterine cramping. CPT® code details are available through AAPC's 76830 code reference.

QUESTION NO: 36

A surgeon performs laparoscopic cholecystectomy. The operative report documents cholangiography performed during the same procedure, with interpretation of the cholangiogram by the surgeon.

What CPT® code is reported?

A. 47562

B. 47563

C. 47564

D. 47600

ANSWER: B

Explanation:

47563 is correct because this code reports laparoscopic cholecystectomy with cholangiography. The documented intraoperative cholangiogram and the surgeon's interpretation are included in this comprehensive code.

Code 47562 reports laparoscopic cholecystectomy without cholangiography. Code 47564 includes exploration of the common duct, which is not documented. The cholangiography is not separately reported with an additional radiology code when it is performed as part of the service described by 47563.

QUESTION NO: 37

A 42-year-old male is diagnosed with a left renal mass. Patient is placed under general anesthesia and in prone position. A periumbilical incision is made and a trocar inserted. A laparoscope is inserted and advanced to the operative site. The left kidney is removed, along with part of the left ureter. What CPT® code is reported for this procedure?

A. 50220

B. 50548

C. 50543

D. 50546

ANSWER: D

Explanation:

50546 is reported because the documented procedure is a surgical laparoscopic nephrectomy that includes removal of only a portion of the ureter. The operative description establishes the laparoscopic approach through trocar placement and insertion of a laparoscope, followed by removal of the entire left kidney. It also specifically documents removal of part of the left ureter. This matches the CPT descriptor for 50546, “Laparoscopy, surgical; nephrectomy, including partial ureterectomy.”

Code selection depends on the extent of ureter removal as well as the extent of kidney removal. Here, the kidney is removed and the ureterectomy is partial, with no documentation that the complete ureter was excised. There is also no documentation of radical-nephrectomy components, such as removal of adjacent structures or regional lymphadenectomy, that would support a radical procedure code. The diagnosis of a renal mass does not by itself establish that a radical nephrectomy was performed; coding follows the procedure documented in the operative report.

For the current CPT listing and descriptor, see AAPC Codify: CPT® 50546. General CPT code-set information is available from the American Medical Association CPT® overview.

QUESTION NO: 38

Preoperative diagnosis: Right thigh benign congenital hairy nevus. *1

Postoperative diagnosis: Right thigh benign congenital hairy 0 nevus.

Operation performed: Excision of right thigh benign congenital > 1

nevus, excision size with margins 4.5 cm and closure size 5 cm.

Anesthesia: General.0

Intraoperative antibiotics: Ancef.0

Indications: The patient is a 5-year-old girl who presented with her parents for evaluation of her right thigh congenital nevus. It has been followed by pediatrics and thought to have changed over the past year. Family requested excision. They understood the risks involved, which included but were not limited to risks of general

anesthesia, infection, bleeding, wound dehiscence, and poor scar formation. They understood the scar would likely widen as the child grows because of the location of it and because of the age of the patient. They consented to proceed.

Description of procedure: The patient was seen preoperatively in > I the holding area, identified, and then brought to the operating room. Once adequate general anesthesia had been induced, the patient ' s right thigh was prepped and draped in standard surgical fashion. An elliptical excision measuring 6 x 1.8 cm had been marked. This was injected with Lidocaine with epinephrine, total of 6 cc of 1% with 1:100,000. After an adequate amount of time, a #15 blade was used to sharply excise this full thickness.

This was passed to pathology for review. The wound required ? limited undermining in the deep subcutaneous plane on both sides for approximately 1.5 cm in order to allow mobilization of the skin for closure. The skin was then closed in a layered fashion using 3-0 Vicryl on the dermis and then 4-0 Monocryl running subcuticular in the skin, the wound was cleaned and dressed with Dermabond and Steri-Strips.

The patient was then cleaned and turned over to anesthesia for S extubation.

She was extubated successfully in the operating room and taken S to the recovery room in stable condition. There were no complications.

What CPT® coding is reported?

A. 52353-RT, 52332-RT

B. 52356-RT

C. 52320-RT, 52332-RT

D. 52356-RT, 52332-RT

E. 11406, 12032

ANSWER: E

Explanation:

The appropriate coding is **11406, 12032**. The documented diagnosis is a benign congenital hairy nevus on the thigh, which is coded from the benign lesion excision family for the trunk, arms, or legs. Excision coding is based on the greatest clinical diameter of the lesion plus the narrowest margins required for complete excision. The operative report specifically documents an excision size with margins of 4.5 cm. That measurement falls within the 4.1 cm to 5.0 cm range represented by CPT® 11406. See the CPT® code descriptor summary at AAPC CPT® 11406.

Simple closure is included in lesion excision, but this closure is separately reportable because the surgeon performed limited undermining in the deep subcutaneous plane and a layered closure with dermal and subcuticular sutures. Those documented actions support an intermediate repair. The repair measured 5 cm and was performed on the thigh, an extremity site other than the hands or feet; this supports CPT® 12032, which covers intermediate repair of 2.6 cm to 7.5 cm in that anatomic grouping. Refer to AAPC CPT® 12032. No laterality modifier is assigned to these CPT® codes because their code descriptors do not distinguish right from left.

QUESTION NO: 39

A 7-year-old boy is brought to the pediatric clinic by his mother. She reported that her son is complaining of discomfort in both ears and loss of hearing in the left ear for the past two days. The pediatrician diagnosis is impacted cerumen. Pediatrician with the mother ' s consent removes impacted cerumen using water irrigation In the right ear. For the left ear the cerumen impaction is removed using instrumentation.

What CPT® coding is reported '

A. 69209-LT.69210-RT

B. 69210-50

C. 69209-RT.69210-LT

D. 69209-50

ANSWER: C

Explanation:

69209-RT.69210-LT correctly reports two separately performed cerumen-removal services, identifying the distinct technique and ear for each service. CPT® code 69209 describes removal of impacted cerumen using irrigation/lavage, unilateral, and the documentation states that water irrigation was performed in the right ear. The RT modifier identifies that right-sided service. CPT® code 69210 describes removal of impacted cerumen requiring instrumentation, unilateral, and the documentation specifically supports instrumentation in the left ear. The LT modifier identifies that left-sided service.

Because the ears were treated with different removal methods, each method is represented by its own CPT® code rather than applying a bilateral modifier to one code. The diagnosis of impacted cerumen supports the medical necessity for the removal procedures, while the procedure note supplies the essential coding details: impaction, method of removal, and laterality. CPT® descriptors and coding guidance for these services distinguish lavage from instrumentation and characterize each code as unilateral. See the AAPC CPT® 69209 code page and the AAPC CPT® 69210 code page.

QUESTION NO: 40

What does the prefix â€œsub-â€□ signify in medical terminology?

A. Outside

B. Above

C. Within

D. Below

ANSWER: D

Explanation:

Below is correct because the medical prefix *sub-* denotes a position beneath, under, or below another structure. Medical terminology combines a prefix with a root word to communicate anatomy, location, route, or relationship precisely. For example, *subcutaneous* describes tissue or an injection route beneath the skin, while *sublingual* describes medication administered under the tongue. Similarly, *subclavian* identifies a structure located beneath the clavicle. Recognizing this prefix helps coders accurately interpret provider documentation, understand anatomical terminology, and distinguish the location involved in a service, diagnosis, or procedure. In coding practice, the documented word should always be interpreted in its full clinical context, but the prefix consistently supplies the positional meaning of under or below. This foundational terminology knowledge supports correct reading of terms encountered throughout anatomy, pathology, evaluation and management documentation, and procedure descriptions. The National Cancer Institute's definition of subcutaneous specifically uses "under the skin," illustrating this standard usage. For additional terminology context, see the National Cancer Institute Dictionary of Cancer Terms and OpenStax Anatomy and Physiology: Anatomical Terminology.

QUESTION NO: 41

A patient undergoes cystourethroscopy with pyeloscopy and manipulation to remove a ureteral calculus. No stent is inserted.

What CPT® coding is reported?

A. 52352

B. 52352, 52351-51

C. 52353

D. 52356

ANSWER: A

Explanation:

52352 is reported because the documented service includes cystourethroscopy with upper-tract endoscopy (pyeloscopy) and removal or manipulation of a ureteral calculus. The CPT descriptor for 52352 encompasses cystourethroscopy with ureteroscopy and/or pyeloscopy when a calculus is removed or manipulated, including basket extraction. The key reportable therapeutic work is the manipulation and removal of the stone; the cystoscopic and pyeloscopic access necessary to perform that work is included in the single comprehensive code. No separate diagnostic endoscopy code should be assigned for the same operative session because it is integral to the definitive stone-removal procedure. The record also expressly states that no stent was inserted, so the selected code appropriately reflects the service actually performed without including ureteral stent placement. Accurate CPT assignment depends on matching the operative technique documented—stone manipulation/removal without lithotripsy and without stent insertion—to the code descriptor. See the CPT code summary at AAPC CPT® 52352 and the general coding guidance in the CMS Physician Fee Schedule resources.

QUESTION NO: 42

A patient receives 30 mg of ketorolac tromethamine by intramuscular injection in the office. The physician supplies and administers the medication.

What HCPCS Level II and CPT® coding is reported?

A. J1885, 96372

B. J1885 ×2, 90471

C. J1885 ×2, 96372

D. J1885 ×30, 96372

ANSWER: C

Explanation:

J1885 ×2, 96372 is correct. HCPCS Level II code J1885 represents ketorolac tromethamine per 15 mg. A 30-mg dose requires two units. Code 96372 reports therapeutic, prophylactic, or diagnostic injection by subcutaneous or intramuscular route.

Code 90471 is for vaccine administration and is not appropriate for a therapeutic medication injection. Reporting one unit of J1885 would represent only 15 mg rather than the documented 30-mg dose.

QUESTION NO: 43

A surgeon performed Mohs micrographic surgery on a lesion on the right arm. This required one stage with six tissue blocks.

What CPT@ codes are reported for the Mohs surgery?

A. 17313, 17314, 17315

B. 17311, 17315

C. 17313, 17315

D. 17311, 17312, 17315

E. 85B2-335

ANSWER: C

Explanation:

17313, 17315 is reported because the right arm is classified with the trunk, arms, or legs anatomic group for Mohs micrographic surgery coding. Code 17313 describes the first stage of Mohs surgery in this anatomic group and includes up to five tissue blocks. The documented service involved one stage, so only the first-stage code is needed; there is no separate additional-stage service to report. However, six tissue blocks were processed during that stage. Because the base first-stage service includes five blocks, one block is in excess of the included number. Add-on code 17315 reports each additional block beyond the first five blocks within a stage. Therefore, reporting 17313 for the first stage and 17315 once for the sixth block accurately reflects both the location and the documented tissue-block count. Mohs codes include the surgeon's histopathologic examination of the tissue, so the coding is based on the specified stage and block rules rather than separately reporting routine pathology for these blocks. CMS identifies Mohs surgery services within its physician-fee-schedule code information, and its National Correct Coding Initiative materials provide coding-policy context for surgical services. See the CMS Physician Fee Schedule and the CMS National Correct Coding Initiative.

QUESTION NO: 44

(Preoperative diagnoses:Bradycardia.

Postoperative diagnosis:Bradycardia.

Procedure performed:Dual-chamber pacemaker implantation.

Brief history:77-year-old female with recurrent syncope; evaluation revealed first-degree AV block, sinus bradycardia, bundle-branch block; bradyarrhythmia suspected; after discussion with her sister, dual-chamber pacemaker recommended; risks explained; consent obtained.

Procedure details:Taken to cardiac catheterization lab; positioned on cath table; prepped/draped standard; procedure challenging due to agitation despite adequate sedation; left infraclavicular area anesthetized with 0.5 cc Xylocaine; pacemaker pocket created; hemostasis with cautery; 9-French peel-away sheath used to introduce an atrial and a ventricular lead; leads positioned with excellent thresholds; secured with O-silk sutures over sleeves; pulse generator connected; pocket flushed with antibiotic solution; pacemaker/leads placed in pocket; incision closed in two layers; performed under fluoroscopic guidance.

Complication:None.

Plan:Return to recovery; discharge later this evening to nursing home with routine post-pacemaker care.

Question:What CPTÂ® coding is reported for this procedure?)

A. 33208

B. 33206

C. 33207

D. 33206, 33207

ANSWER: A

Explanation:

33208 is reported because the operative note documents the initial insertion of a complete permanent dual-lead pacemaker system. The physician created a generator pocket in the left infraclavicular region, introduced and positioned two

transvenous pacing leads, tested the leads with satisfactory thresholds, secured them, connected them to the pulse generator, and placed the generator in the pocket. The documentation specifically identifies one atrial lead and one ventricular lead, which establishes a dual-chamber system. The code descriptor for 33208 encompasses insertion or replacement of a permanent pacemaker with transvenous electrode(s), including the pulse generator, for an atrial and ventricular system. It is therefore the single comprehensive CPT® code for the work performed during this encounter. Routine elements integral to the implantation, such as pocket formation, fluoroscopic lead placement, threshold testing, lead fixation, generator connection, wound irrigation, and closure, are included in reporting the system insertion. The procedure was performed as a new implantation rather than a generator-only change or a lead revision. The CPT code listing is available through AAPC's CPT® code reference for 33208; Medicare's coverage resources for cardiac pacemakers are also available at CMS National Coverage Determination 20.8.3.

QUESTION NO: 45

Which circumstance supports medical necessity for a payment by the insurance company?

A. Speech therapy for a lisp.

B. Tummy tuck after a pregnancy.

C. Second rhinoplasty for a smaller nose.

D. Removing excess skin in losing weight from a gastric bypass.

ANSWER: D

Explanation:

Removal of excess skin following weight loss from gastric bypass surgery supports medical necessity when the redundant skin causes documented functional or medical problems rather than being removed solely to improve appearance. Following massive weight loss, an overhanging abdominal pannus can produce recurrent intertrigo, skin breakdown, ulceration, infections, hygiene difficulties, or interference with ambulation and activities of daily living. In those circumstances, surgical removal may be needed to treat the condition and prevent ongoing complications. The record should clearly connect the patient's symptoms and failed conservative treatment, when required by the payer, to the planned procedure. It should also document the extent of weight loss, stable weight when applicable, relevant physical findings, and the functional impact of the excess tissue. Medicare guidance distinguishes cosmetic surgery, which is performed to improve appearance, from surgery that is reasonable and necessary to improve function or treat illness or injury. Payer-specific medical policies commonly use similar clinical criteria for panniculectomy after substantial weight loss. See the CMS Medicare Benefit Policy Manual, Chapter 16, for the distinction between cosmetic and medically necessary surgery: CMS Benefit Policy Manual. Additional clinical policy criteria are illustrated by the American Society of Plastic Surgeons' panniculectomy insurance coverage recommendations.

QUESTION NO: 46

A comatose patient is seen in the ER. The patient has a history of depression. Drug testing confirm she overdosed on tricyclic antidepressant drugs doxepin, amoxapine, and clomipramine.

What CPT® code is reported?

A. 80366

B. 80335

C. 80332

D. 80338

ANSWER: A

Explanation:

80366 is reported because it represents definitive drug testing for three to five tricyclic and other cyclic antidepressant analytes. The documented testing identifies three drugs in this category: doxepin, amoxapine, and clomipramine. Therefore, the quantity of analytes tested falls within the three-to-five range specified by this CPT® code. The patient's coma, emergency department setting, history of depression, and overdose circumstance establish the clinical context and medical necessity for testing, but they do not alter selection of the laboratory drug-testing code. Code selection is based on the drug class tested and the number of relevant analytes reported. Tricyclic and other cyclic antidepressants are specifically represented by the applicable definitive-testing family, and three identified antidepressants support reporting 80366. The current code descriptor and coding details can be reviewed through AAPC's CPT® code reference for 80366. CMS also provides laboratory-payment resources, including its Clinical Laboratory Fee Schedule, for laboratory coding and payment reference.

QUESTION NO: 47

View MR 001394

MR 001394

Operative Report

Procedure: Excision of 11 cm back lesion with rotation flap repair.

Preoperative Diagnosis: Basal cell carcinoma

Postoperative Diagnosis: Same

Anesthesia: 1% Xylocaine solution with epinephrine warmed and buffered and injected slowly through a 30-gauge needle for the patient ' s comfort.

Location: Back

Size of Excision: 11 cm

Estimated Blood Loss: Minimal

Complications: None

Specimen: Sent to the lab in saline for frozen section margin control.

Procedure: The patient was taken to our surgical suite, placed in a comfortable position, prepped and draped, and locally anesthetized in the usual sterile fashion. A #15 scalpel blade was used to excise the basal cell carcinoma plus a margin of normal skin in a circular fashion in the natural relaxed skin tension lines as much as possible The lesion was removed full thickness including epidermis, dermis, and partial thickness subcutaneous tissues. The wound was then spot electro desiccated for hemorrhage control. The specimen was sent to the lab on saline for frozen section.

Rotation flap repair of defect created by foil thickness frozen section excision of basal cell carcinoma of the back. We were able to devise a 12 sq cm flap and advance it using rotation flap closure technique. This will prevent infection, dehiscence, and help reconstruct the area to approximate the situation as it was prior to surgical excision diminishing the risk of significant pain and distortion of the anatomy in the area. This was advanced medially to close the defect with 5 0 Vicryl and 6-0 Prolene stitches.

What CPTÂ® coding is reported for this case?

A. 14001

B. 15271

C. 14001, 11606-51, 12034-51

D. 14001, 11606-51

ANSWER: A

Explanation:

14001 is reported for the rotation flap repair on the back. This procedure is an adjacent tissue transfer or rearrangement: tissue next to the surgical defect is elevated, rotated, and advanced medially to cover the defect. The operative note explicitly documents a rotation flap measuring 12 square centimeters. For adjacent tissue transfer/rearrangement of the trunk, including the back, CPT® 14001 applies when the defect size is 10.1 square centimeters through 30.0 square centimeters. The documented 12-square-centimeter flap therefore falls squarely within this code's size range.

The lesion excision and the layered closure are integral to performing the adjacent tissue transfer at the same operative site and are not separately reported. The National Correct Coding Initiative policy manual states that excision of a lesion is included in an adjacent tissue transfer/rearrangement when performed at the same site. The flap code represents the work of creating and moving local tissue to reconstruct the post-excision defect, rather than merely closing it. See the CMS National Correct Coding Initiative edits and AAPC's CPT® 14001 code information.

QUESTION NO: 48

(Full Case:Procedure:Excision of6.0 cm malignant lesionof theright forearmwithadjacent tissue transferusing arotation flap.Pre/Post-op Dx:Basal cell carcinoma, right forearm.Anesthesia:local (1% Xylocaine with epi).Defect size:8 sq cm.Specimen:sent forfrozen section margin control; margins confirmed clear.Closure:rotation flap from adjacent healthy tissue,total area 8 sq cm, secured with layered closure (5-0 Vicryl/6-0 Prolene).Question:What CPT® coding is reported?)

A. 14020, 11606-51

B. 14020

C. 14040

D. 14040, 11606-51

ANSWER: B

Explanation:

14020 is reported because the repair is an adjacent tissue transfer/rearrangement performed on the forearm, which falls within the CPT anatomic grouping for the scalp, arms, and legs. The operative note specifically identifies a rotation flap created from adjacent healthy tissue and documents a total flap/defect area of 8 sq cm. This falls within the "defect 10 sq cm or less" size range represented by 14020. For adjacent tissue transfer coding, the measured area includes the primary defect plus the secondary defect created to develop and move the flap, so the documented total area is the relevant measurement for code selection. The excision of the basal cell carcinoma is integral to creating the surgical defect that is closed by the adjacent tissue transfer; accordingly, the adjacent tissue transfer code represents the reportable primary procedure in this circumstance. Layered closure is likewise included in the flap service. Frozen-section margin assessment confirms margin status but does not alter selection of the adjacent tissue transfer code for the surgeon's reconstruction. CMS's NCCI Policy Manual explains the inclusive nature of repair services when performed as part of a more extensive procedure; see CMS NCCI Policy Manual. CPT code details are also available through AAPC's CPT 14020 reference.

QUESTION NO: 49

A 3-day-old died in her sleep. The pediatrician determined this was the result of crib death syndrome. The parents give permission to refer the newborn for a necropsy. The pathologist receives the newborn with her brain and performs a gross and microscopic examination. The physician issues the findings and reports they are consistent with a normal female newborn.

What CPT® code is reported?

A. 88028

B. 88012

C. 88029

D. 88014

ANSWER: A

Explanation:

88028 is reported because the documented service is a necropsy (autopsy) of a newborn that includes both gross and microscopic examination and includes examination of the brain. The patient was 3 days old, so the stillborn-or-newborn category applies. The pathology narrative specifically states that the pathologist received the newborn with her brain and performed gross and microscopic examination; these are the defining service elements represented by CPT® 88028. The fact that the final findings are consistent with a normal female newborn does not alter procedure-code selection. CPT® reporting is based on the service performed and documented, rather than whether a pathologic abnormality is identified. Likewise, parental permission and the pediatrician's suspected cause of death provide clinical context but do not change the code for the pathologist's completed postmortem examination. CPT® is maintained by the American Medical Association; its role and code-set governance are described by the AMA CPT® overview. Code-specific descriptor information is also available through AAPC's CPT® code reference for 88028.

QUESTION NO: 50

A CRNA independently administers MAC anesthesia for ICD replacement.

What CPT® and ICD-10-CM codes are reported?

A. 00520-QY, I48.91

B. 00520-QZ-QS, I49.01

C. 00534-QZ-QS, I49.01

D. 00534-QY, I48.91

ANSWER: C

Explanation:

00534-QZ-QS, I49.01 is correct. CPT® code 00534 reports anesthesia for procedures involving the insertion or replacement of a permanent implantable defibrillator system, including the associated transvenous leads. An ICD replacement is therefore assigned to this anesthesia code. Because the CRNA performed the anesthesia independently, without medical direction by an anesthesiologist, modifier QZ is appended to identify CRNA service without medical direction. Modifier QS identifies that monitored anesthesia care (MAC) was provided. Medicare recognizes QS as an informational modifier used to distinguish MAC services, while the applicable anesthesia provider modifier communicates the CRNA's independent status. The diagnosis code I49.01 identifies ventricular fibrillation, the documented dysrhythmia supporting the ICD-related service in this scenario. Report the anesthesia CPT® code with both applicable modifiers, followed by the ICD-10-CM diagnosis code. CMS provides anesthesia modifier and payment-policy guidance in its Anesthesiologists Center; the current diagnosis-code structure is available through the CDC's ICD-10-CM resources.

QUESTION NO: 51

The CPT® code book provides full descriptions of medical procedures, although some descriptions require the use of a semicolon (;) to distinguish among closely related procedures.

What is the full description of CPT® code 69644?

A. Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed canal wall, with ossicular chain reconstruction

B. Without ossicular chain reconstruction with intact or reconstructed canal wall, with ossicular chain reconstruction

C. With intact or reconstructed canal wall with ossicular chain reconstruction

D. Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction with intact or reconstructed canal wall, with ossicular chain reconstruction

ANSWER: A

Explanation:

Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed canal wall, with ossicular chain reconstruction is the complete descriptor for CPT® 69644. The semicolon is important because it separates the common base procedure—tympanoplasty with mastoidectomy and its included work—from the qualifying surgical details that define this specific code. The base language identifies that canalplasty, middle-ear surgery, and tympanic-membrane repair are included in the tympanoplasty/mastoidectomy service. The text following the semicolon specifies that the procedure is performed using an intact or reconstructed canal wall and includes reconstruction of the ossicular chain. Ossicular chain reconstruction addresses the middle-ear sound-conduction mechanism and is a defining component of the service reported by CPT® 69644. Accurate use of the full descriptor is essential because CPT® code selection depends on the documented surgical technique and included reconstruction, not merely on the general fact that a tympanoplasty or mastoidectomy was performed. CPT® is maintained by the American Medical Association; consult the current CPT® Professional code set and applicable instructions for authoritative reporting guidance. See the AMA CPT® overview and CMS Medicare payment-code resources.

QUESTION NO: 52

A patient is diagnosed with a healing pressure ulcer on her left heel that is currently being treated.

What ICD-10-CM coding is reported?

A. L89.609

B. L89.624

C. L89.626

D. L89.629

ANSWER: D

Explanation:

L89.629 is the appropriate code because the documented site is the patient's left heel, but no pressure-ulcer stage is provided. ICD-10-CM pressure-ulcer codes require both the anatomic location and, when documented, the stage or severity. The term "healing" describes the ulcer's clinical course but does not independently establish a reportable stage. A healing ulcer may have been any stage initially, and coding professionals must not infer a stage from the fact that treatment is ongoing or that healing is mentioned. Therefore, when the record identifies a pressure ulcer of the left heel without documentation of stage, the unspecified-stage code for that site is reported: L89.629, Pressure ulcer of left heel, unspecified stage. If the provider later documents the ulcer's stage, coding should be updated to the code matching that documented stage. The ICD-10-CM Official Guidelines direct coders to base pressure-ulcer stage assignment on the medical-record documentation and to use an unspecified-stage code when the stage is not documented. See the ICD-10-CM Official Guidelines for Coding and Reporting and the CMS ICD-10-CM resources.

QUESTION NO: 53

(A patient with age-related osteoporosis is hospitalized after a slip and fall resulting in fractures to both hips. The physician ordersthree-view imaging of both hips and the pelvis, interpreted by the hospital radiologist. Later the same day, the patient falls from bed and the doctor ordersthree additional viewsof both hips and pelvis, interpreted by thesame radiologist. What CPT® coding is reported?)

A. 73522, 73522-76

B. 73522-76, 73522-51

C. 73523, 73523-77

D. 73523-76, 73523-51

E. 73523, 73523-76

ANSWER: E

Explanation:

73523, 73523-76 is the appropriate reporting. CPT® code 73523 describes a radiologic examination of bilateral hips with pelvis, when performed, involving three to four views. The initial three-view examination of both hips and the pelvis is therefore reported with 73523. Because the patient experiences a distinct subsequent fall later that day, the physician orders another medically necessary examination of the same anatomic area. This is not merely an additional view performed as part of the original imaging encounter; it is a new, repeated diagnostic service prompted by a new clinical event.

The second examination is interpreted by the same hospital radiologist who interpreted the first study. Modifier 76 identifies a repeat procedure or service performed by the same physician or other qualified health care professional. It is appended to the code for the repeated imaging service, while the first service remains unmodified. Thus, report 73523 for the initial examination and 73523-76 for the subsequent examination. AAPC's modifier guidance describes modifier 76 as applying when the same provider repeats a procedure after the original service. See AAPC Modifier 76 information and the CMS guidance on repeat procedure modifiers.

QUESTION NO: 54

(A patient is seen by her podiatrist to treat a painfulleft ingrown toenailon the big toe. The podiatrist performs awedge excisionof the skin of the nail fold at the lateral margin. Local anesthetic is administered, and an elliptical incision is made through subcutaneous tissue of the affected nail groove. A wedge-shaped piece of soft tissue from the nail margins is removed. What CPT® code is reported?)

A. 11755-TA

B. 11730-TA

C. 11750-TA

D. 11765-TA

ANSWER: D

Explanation:

11765-TA is reported because the documented service is a wedge excision of the skin of the nail fold for an ingrown nail. The procedure description specifically identifies an elliptical incision through subcutaneous tissue in the affected nail groove and removal of a wedge-shaped portion of soft tissue at the nail margin. Those elements support the CPT procedure described as wedge excision of skin of the nail fold, rather than a service limited to removal of the nail plate. The documentation's focus is the lateral nail fold and adjacent soft tissue, which is the defining procedural work captured by 11765.

The **TA** modifier supplies the required anatomic specificity for the left great toe. Laterality and toe identification are important for claim clarity and payer processing when services involve toes. The treatment of an ingrown nail does not alter the fundamental code selection; it is the documented wedge excision technique that establishes the reported CPT code. For CPT code information, see AAPC's CPT 11765 listing. For official modifier guidance, see the CMS HCPCS modifier resources.

QUESTION NO: 55

A 30-year-old patient with a scalp defect is having plastic surgery to insert tissue expanders. The provider inserts the implants, closes the skin, and increases the volume of the expanders by injecting saline solution. Tissue is expanded until a satisfactory aesthetic outcome is obtained to repair the scalp defect.

What CPT® code is reported?

A. 11960

B. 11970

C. 15777

D. 19357

ANSWER: A

Explanation:

11960 is reported because it describes insertion of a tissue expander for a site other than the breast, with subsequent expansion included in the service. In this case, the surgeon places the expander beneath the scalp tissue and closes the incision. The expander is then progressively filled with saline over time to stretch adjacent scalp tissue, creating sufficient tissue for later repair or coverage of the scalp defect. The scalp is a non-breast anatomic site, so the code's "other than breast" designation directly fits the documented procedure. Importantly, the gradual saline injections used to enlarge the expander are integral to the tissue-expansion treatment described by this code rather than being separately reported as individual expansion procedures. Coding is based on the placement of the non-breast tissue expander and the included subsequent expansion service, regardless of the fact that the final defect repair may occur at a later operative encounter. See the CPT code summary in AAPC Codify for CPT® 11960 and Medicare's Physician Fee Schedule resources for coding and payment-reference context.