MBC Practice Test

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Practice Questions

ICD-10-CM

1. How is a valid ICD-10-CM code structured?

A. 3 to 5 characters, and the first character is always a number
B. Exactly 7 characters, all alphanumeric
C. 4 to 6 characters, beginning with either a letter or a number
D. 3 to 7 characters, and the first character is always a letter

2. An injury code requires a 7th character, but the base code contains only five characters. What must the coder do?

A. Report the five-character code and omit the 7th character entirely
B. Insert placeholder "X" in the empty sixth position, then add the 7th character
C. Repeat the fifth character in the sixth position so the code reaches seven characters
D. Report the code with the 7th character placed directly in the sixth position

3. A note under a code category reads "Excludes2" followed by another condition. What does this instruct the coder to do?

A. Query the provider before assigning either of the codes
B. Both codes may be reported together when the patient has both conditions
C. Replace this code with the code for the excluded condition
D. The two conditions cannot occur together, so the codes are mutually exclusive

4. A 68-year-old patient has documented hypertension and stage 2 chronic kidney disease. No heart disease is documented. Which codes are correct?

A. I10, N18.2
B. I13.10, N18.2
C. I12.9, with no additional code
D. I12.9, N18.2

5. A patient presents with productive cough and fever and is diagnosed with community-acquired pneumonia. How should the encounter be coded?

A. Cough and fever only, since they are the presenting symptoms
B. Pneumonia plus fever, since fever is systemic
C. Pneumonia only
D. Pneumonia, cough, and fever, each as separate codes

6. The provider's note states only "urosepsis." What should the coder do?

A. Query the provider for clarification
B. Code unspecified sepsis
C. Code a urinary tract infection as the definitive diagnosis
D. Code sepsis with a urinary tract infection as the source

7. A patient is 27 weeks and 6 days pregnant. For ICD-10-CM coding, which trimester is she in?

A. The trimester cannot be determined from weeks of gestation
B. Third trimester

C. First trimester
D. Second trimester

8. A patient with a healing wrist fracture returns for a scheduled cast check. The fracture is healing normally. Which 7th character applies?

A. X — placeholder
B. D — subsequent encounter
C. A — initial encounter
D. S — sequela

9. An average-risk, asymptomatic 50-year-old has a screening colonoscopy. No abnormalities are found. What is the first-listed diagnosis code?

A. A signs-and-symptoms code
B. No diagnosis code is needed for a normal screening
C. A personal-history-of-cancer code
D. Z12.11, encounter for screening for malignant neoplasm of colon

10. A patient with an existing breast primary malignancy is treated this admission only for a vertebral metastasis. How are the neoplasm codes sequenced?

A. The primary breast malignancy is sequenced first, with the metastasis additional
B. A Z51 encounter code is sequenced first, followed by both neoplasm codes
C. The metastatic site is sequenced first, with the primary coded as an additional diagnosis
D. The primary malignancy is reported for this admission, without a metastasis code

11. Which statement about external cause codes (V00–Y99) is true?

A. They are never reported as the principal or first-listed diagnosis
B. They are required on every claim
C. They may be reported as the principal diagnosis when the injury is severe
D. They replace the injury code

12. The provider documents a detailed, specific type of a condition, but no ICD-10-CM code exists for that exact type. Which abbreviation identifies the code the coder should assign?

A. UHDDS
B. NEC — not elsewhere classifiable
C. NOS — not otherwise specified
D. PTP

13. A category note reads "Excludes1: diabetic retinopathy." What does this mean for the code above it?

A. Both codes may be reported together when the patient has both documented conditions
B. A pure Excludes1 — the two conditions cannot occur together, so the codes are not reported together
C. The excluded condition's code replaces this code entirely on the claim
D. The coder queries the provider before assigning either code

14. A patient's record documents "acute renal failure due to rhabdomyolysis." The Tabular List shows a "Code first underlying condition" note under the renal failure code. What does the coder do?

A. Sequence the renal failure first, then rhabdomyolysis as an additional code
B. Report the rhabdomyolysis code alone
C. Sequence rhabdomyolysis first, then the renal failure code
D. Report the renal failure code alone

15. A patient with type 2 diabetes has documented diabetic nephropathy and no other diabetic complication. Which code set is correct?

A. E11.9 alone, since nephropathy is assumed with any diabetes diagnosis
B. E11.21, the combination code for type 2 diabetes with diabetic nephropathy
C. E11.9 and N18.9, reported as two separate unrelated codes
D. N18.9 alone, since the kidney disease is the reason for treatment

16. A patient treated for a healed traumatic brain injury now has documented post-traumatic seizures as a late effect. How is this sequenced?

A. The seizure disorder alone, since the original injury has healed
B. The original injury with 7th character A, then the seizure disorder
C. The seizure disorder first, then the injury code with 7th character S
D. The injury code with 7th character S alone; the late effect itself is not coded

17. A trauma patient's Glasgow Coma Scale is documented as eye opening to pain, incomprehensible sounds, and abnormal flexion. Where does the coder find codes for these individual GCS components?

A. Nowhere — individual GCS components are not codeable
B. Chapter 19 injury codes, combined with the trauma code
C. A single unspecified coma code covering the combined findings
D. Category R40 coma scale codes — one code per component

18. A physician documents a patient's BMI as 32 during a visit for hypertension management. How is the BMI coded?

A. It is not coded, because a BMI value is a finding rather than a diagnosis
B. As a secondary diagnosis; BMI codes are not first-listed
C. As the principal diagnosis, since it drove part of today's visit
D. With an external cause code from Chapter 20

19. A patient had breast cancer five years ago, successfully treated with no evidence of disease since. Today's visit is unrelated. How is the resolved cancer coded?

A. With a family history code from category Z80
B. With an active malignant neoplasm code from category C50
C. With a personal history code from category Z85
D. It is not coded, since it is no longer active

20. A patient's mother had colon cancer; the patient has never had it. What code reports this fact during a screening visit?

A. No code is needed
B. A code from category Z85, personal history of malignant neoplasm
C. A code from category Z80, family history of malignant neoplasm
D. A current malignant neoplasm code

21. In the ICD-10-CM Alphabetic Index, when two conditions are linked by the word "with" in a subterm, the classification instructs the coder to:

A. Report the code for the first condition and omit the second
B. Assume the conditions are unrelated unless the provider explicitly links them in the note
C. Query the provider in each case before linking the two conditions
D. Assume a causal relationship, unless the classification or provider states the conditions are unrelated

22. A patient intentionally takes double her prescribed dose of a blood pressure medication and develops symptomatic hypotension. This is coded as:

A. Underdosing, since the drug was her own prescription
B. A therapeutic-use adverse effect with no poisoning component
C. An adverse effect, since a legitimately prescribed drug was involved
D. Poisoning, because the drug was taken in a dose greater than prescribed

23. A patient meets criteria for sepsis and, during the same encounter, develops septic shock. How are these sequenced?

A. The underlying infection alone, since shock is inherent to sepsis
B. The underlying infection first, then R65.21; septic shock is never first
C. R65.21 alone, since it captures the entire septic episode
D. The septic shock code first, then the underlying systemic infection

24. A progress note reads: "Type 2 diabetes mellitus with hyperglycemia." Which ICD-10-CM code is reported?

A. R73.9
B. E10.65
C. E11.9
D. E11.65

25. A patient returns three weeks after knee replacement surgery for a scheduled wound check with no complications. How is this encounter coded?

A. With a Z48 aftercare code for planned surgical follow-up
B. With a Z09 follow-up code for completed treatment of a disease
C. With the original knee condition code that led to the surgery
D. With an injury code and 7th character D for subsequent encounter

CPT

26. A patient was seen two years ago by another internist in the same group practice. Today she sees a different internist in that group. For E/M purposes, she is:

A. A consultation, since she was referred within the group
B. An established patient of the practice
C. A new patient, because more than one year has passed
D. A new patient to this individual physician

27. Under the current CPT E/M guidelines, how is the level selected for office and outpatient visits (99202–99215)?

A. By medical decision making OR total time on the encounter date

B. By the number and severity of diagnoses listed on the claim
C. By the extent of history, exam, and medical decision making combined
D. By total time, measured as face-to-face time in the exam room

28. A physician performs a significant, separately identifiable E/M service on the same day as a minor procedure. How is this reported?

A. Append modifier 25 to the E/M code
B. Append modifier 59 to the E/M code
C. Append modifier 25 to the procedure code
D. Report the procedure alone; the E/M is included that day

29. A surgeon performs carpal tunnel release on both wrists during the same operative session. Which modifier is appended?

A. 50 — bilateral procedure
B. 59 — distinct procedural service
C. 76 — repeat procedure
D. 51 — multiple procedures

30. A radiologist interprets and reports a chest X-ray taken on the hospital's equipment. Which modifier does the radiologist append?

A. 26 — professional component
B. No modifier; report the global service
C. TC — technical component
D. 52 — reduced services

31. Which service is NOT included in the CPT surgical package?

A. Immediate postoperative care, including writing orders and evaluating the patient in recovery
B. Local infiltration or digital block anesthesia administered by the surgeon
C. Typical, uncomplicated postoperative follow-up care during the global period
D. An E/M service for an unrelated condition during the postoperative period

32. Operative note: colonoscope advanced to the cecum; a sigmoid polyp was sampled with cold biopsy forceps and retrieved. Which CPT code is reported?

A. 45385
B. 45378
C. 45330
D. 45380

33. How is anesthesia payment calculated?

A. Time units × the procedure's relative value units
B. Base units × conversion factor, with no time component
C. A flat fee set per procedure by the payer's fee schedule
D. (Base units + time units + modifying units) × conversion factor

34. When does anesthesia time begin?

A. When the anesthesia provider arrives at the facility for the case
B. When the anesthesia provider begins preparing the patient for induction

C. When the patient is brought into the operating room suite
D. When the surgeon makes the initial incision

35. A patient has two simple lacerations repaired: 2.0 cm on the left forearm and 1.5 cm on the trunk. How is this reported?

A. 12001 for the larger of the two wounds
B. 12001 twice, once per wound
C. 12002 once, for a combined 3.5 cm repair
D. 12001 and 12002 together

36. Which CPT code reports a 2-view chest X-ray?

A. 71048
B. 71046
C. 71047
D. 71045

37. Which code reports a complete blood count (CBC), automated, WITH an automated differential WBC count?

A. 36415
B. 85027
C. 80053
D. 85025

38. Which code reports a routine venipuncture for the collection of a venous blood specimen?

A. 85025
B. 36416
C. 99000
D. 36415

39. A physician orders a troponin level repeated four hours after the first to track serial results. Which modifier goes on the repeat lab test?

A. 77
B. 76
C. 59
D. 91

40. A surgeon performs two different procedures through separate incisions during the same operative session, and no more specific modifier applies. Which modifier indicates these are distinct procedural services?

A. Modifier 25
B. Modifier 51
C. Modifier 59
D. Modifier 76

41. A patient is 10 days into the 90-day global period after abdominal surgery and is seen by the same surgeon for an unrelated new onset of chest pain. Which modifier is appended to the E/M code?

A. Modifier 25 — significant, separately identifiable E/M
B. Modifier 79 — unrelated procedure during the postoperative period
C. Modifier 57 — decision for surgery
D. Modifier 24 — unrelated E/M during a postoperative period

42. A surgeon evaluates a patient in the office and, during that same visit, makes the decision to perform major surgery the next day. Which modifier is appended to the E/M code?

A. Modifier 24 — unrelated E/M in a global period
B. Modifier 57 — decision for surgery
C. Modifier 78 — unplanned return to the operating room
D. Modifier 58 — staged or related procedure

43. A patient has a planned second-stage procedure performed by the same surgeon during the global period of the first surgery, as documented in the original operative plan. Which modifier applies to the second procedure?

A. Modifier 76 — repeat procedure by the same physician
B. Modifier 79 — unrelated procedure, same surgeon
C. Modifier 78 — unplanned return to the operating room
D. Modifier 58 — staged procedure during the postoperative period

44. A patient returns to the operating room during the global period for a complication of the original surgery, performed by the same surgeon and not planned in advance. Which modifier applies?

A. Modifier 79 — unrelated procedure during the global period
B. Modifier 58 — staged or anticipated procedure
C. Modifier 76 — repeat of the same procedure
D. Modifier 78 — unplanned return to the OR for a related procedure

45. During the global period of a knee surgery, the same surgeon performs an unrelated procedure on the patient's opposite hand. Which modifier applies to the second procedure?

A. Modifier 58 — staged procedure planned at the original surgery
B. Modifier 79 — unrelated procedure during the postoperative period
C. Modifier 78 — related procedure after return to the OR
D. Modifier 51 — multiple procedures at one session

46. An add-on code, identified in CPT with a "+" symbol, is reported:

A. In addition to a specified primary procedure code, exempt from modifier 51
B. As a stand-alone code when the primary procedure is not performed
C. With modifier 51 appended, like any additional procedure at the session
D. Once per patient per day, regardless of how many units are performed

47. A surgeon performs a procedure with no CPT code that adequately describes it. What is the correct way to report it?

A. Report the section's unlisted procedure code with a special report
B. Hold the charge — the procedure cannot be billed without a code
C. Choose the closest existing code, even if it does not fully match
D. Assign an internal tracking number in place of a CPT code

48. CPT Category III codes are best described as:

A. Tracking codes used for performance measurement
B. Permanent codes for well-established, widely performed procedures
C. Temporary codes for emerging technology, services, and procedures
D. Codes reserved for laboratory panels and pathology services

49. For a CPT time-based code with a defined typical time, when may the coder report that code based on time?

A. Time may not be used — these codes are selected by complexity
B. When documented time is at least double the code's typical time
C. Whenever any face-to-face time occurs, regardless of duration
D. When documented time meets or exceeds the midpoint of the typical time

50. A patient receives one immunization injection during a preventive visit. How is this typically reported?

A. With the administration code; the vaccine product is included
B. With the vaccine product code; administration bundles into the E/M
C. With a preventive-medicine code covering both services
D. With an administration code plus the vaccine/toxoid product code

HCPCS & Modifiers

51. HCPCS Level II "J" codes report which of the following?

A. Drugs administered other than by the oral method
B. Durable medical equipment and accessories
C. Ambulance and other transportation services
D. Temporary codes for physician professional services

52. A Medicare patient receives a CPAP device for home use. In which HCPCS Level II section is it found?

A. A codes — supplies
B. E codes — durable medical equipment
C. J codes — drugs
D. G codes — temporary procedures

53. When does a coder report a HCPCS Level II code instead of a CPT code?

A. For supplies, drugs, and equipment that CPT does not describe
B. For services provided in inpatient facility settings
C. Whenever the payer is a commercial insurer rather than Medicare
D. Whenever a modifier is needed on the claim line

54. A Medicare patient signs an Advance Beneficiary Notice (ABN) because a service is likely to be denied as not medically necessary. Which modifier is appended to the service?

A. 25
B. GZ
C. GA

D. GY

55. Which HCPCS Level II code reports a Medicare beneficiary's first Annual Wellness Visit?

A. A4550
B. G0438
C. 99397
D. G0439

56. HCPCS Level II "A" codes primarily report:

A. Vision and hearing services and devices
B. Durable medical equipment such as wheelchairs and walkers
C. Dental procedures and oral surgery services
D. Miscellaneous supplies and transportation, including ambulance

57. HCPCS Level II "Q" codes are used for:

A. Permanent codes for well-established CPT-equivalent procedures
B. Ambulance and paramedic transportation services
C. Orthotic and prosthetic devices and fittings
D. Temporary codes for drugs, biologicals, and items without another equivalent

58. A Medicare patient requires a custom power wheelchair. Which HCPCS section contains the code?

A. V codes — vision and hearing services
B. L codes — orthotic and prosthetic procedures
C. K codes — temporary codes used primarily for DME
D. Q codes — temporary drugs and biologicals

59. A patient is fitted with a custom ankle-foot orthosis. Which HCPCS section contains the code for this device?

A. A codes — medical and surgical supplies
B. E codes — durable medical equipment
C. L codes — orthotic and prosthetic procedures
D. J codes — drugs administered by injection

60. Eyeglass frames dispensed after cataract surgery are reported with a code from which HCPCS section?

A. E codes — durable medical equipment
B. G codes — temporary Medicare procedures
C. V codes — vision and hearing services
D. A codes — supplies and transportation

61. A bilateral mammogram is documented, but the payer requires each side identified separately on the claim. Which modifiers are appended to the two line items?

A. LT and RT
B. TC and 26
C. 50 and 51
D. GA and GY

62. A patient asks for a service known to be statutorily excluded from Medicare coverage, and signs a voluntary notice of that fact even though an ABN isn't required. Which modifier reports this?

A. KX — coverage criteria documentation on file
B. GZ — expected denial, no ABN on file
C. GA — ABN on file, required under payer policy
D. GX — voluntary notice of liability issued

63. A service is statutorily excluded from Medicare coverage under all circumstances (for example, a service Medicare never covers by law). Which modifier reports this, letting the claim auto-deny without an ABN?

A. GX — voluntary notice of liability issued
B. GZ — denial expected, no ABN obtained
C. GA — ABN signed and on file as required
D. GY — item or service statutorily excluded

64. A provider performs a service expected to be denied as not medically necessary but has no ABN signed by the patient. Which modifier applies, and who bears financial liability?

A. GZ; the provider is liable because no ABN was obtained
B. GA; the patient is liable because an ABN is on file
C. GY; the patient is automatically liable for the charge
D. KX; liability shifts to the payer once criteria are met

65. A supplier bills for a piece of DME and attests that documentation on file supports the payer's specific coverage criteria for medical necessity. Which modifier is appended?

A. GA
B. KX
C. GY
D. 22

66. A DME item is medically necessary but has no HCPCS code that accurately describes it, even after checking every relevant section. What does the supplier report?

A. The closest similar E code, regardless of exact fit
B. No code — the claim is held until CMS assigns one
C. E1399, miscellaneous DME, with a detailed description attached
D. An unlisted CPT procedure code with a special report

67. A provider administers 40 mg of a drug whose HCPCS J code is defined as "per 10 mg." How many units are reported on the claim line?

A. 4
B. 40
C. 1
D. 10

68. A DME supplier sells a wheelchair outright to a Medicare patient rather than renting it. Which modifier indicates the equipment is new?

A. RR — rental

B. UE — used equipment
C. NU — new equipment
D. KX

69. A capped-rental DME item is billed monthly while the patient uses it, before ownership eventually transfers. Which modifier is appended each month during that period?

A. GA — ABN on file for the item
B. UE — used equipment purchase
C. NU — new equipment purchase
D. RR — rental, billed monthly

70. Which HCPCS code reports ground ambulance transportation mileage, per statute mile?

A. G0438
B. A0428
C. A0425
D. E0601

71. Ambulance claims append a two-character modifier describing origin and destination, such as "RH." What does this type of modifier communicate?

A. The type and equipment level of the vehicle used
B. The origin and destination location types of the transport
C. Whether the transport was emergent or non-emergent
D. The level of service provided during the transport

72. A nurse practitioner serves as the first assistant during a major surgery performed by a physician. Which HCPCS modifier is appended to identify the assistant's role?

A. 62
B. AS
C. 82
D. 80

73. A physician (not a PA, NP, or CNS) serves as an assistant surgeon on a procedure where assistant surgeons are typically used. Which modifier applies?

A. 66 — full surgical team procedure
B. AS — non-physician assistant at surgery
C. 62 — co-surgeons sharing a procedure
D. 80 — assistant surgeon (physician)

74. A coder is unsure whether to report a CPT code or a HCPCS Level II code for a nebulizer medication administered in the office. Which principle resolves this?

A. Report the J code for the drug plus the administration code
B. Default to the CPT code whenever any code exists there
C. Report the administration code; the drug is bundled into it
D. Report the drug code; administration is bundled into it

75. A supply used only once during a procedure, such as a surgical tray, is most likely reported with a code from which HCPCS section — and how is it typically handled by payers?

A. A codes; often bundled into the procedure's reimbursement
B. E codes; separately reimbursed as durable equipment
C. G codes; reported for Medicare wellness services
D. J codes; billed to the payer by NDC number

Terminology & Anatomy

76. The term "nephrectomy" means:

A. Surgical repair of the kidney
B. Creation of an opening into the kidney
C. Incision into the kidney
D. Surgical removal of a kidney

77. "Bradycardia" describes:

A. An abnormally slow heart rate
B. An enlarged heart
C. An irregular heart rhythm
D. An abnormally fast heart rate

78. "Hepatomegaly" means:

A. Enlargement of the spleen
B. Inflammation of the liver
C. Enlargement of the liver
D. Disease of the liver

79. From outermost to innermost, the layers of the skin are:

A. Epidermis, dermis, subcutaneous tissue
B. Epidermis, subcutaneous tissue, dermis
C. Subcutaneous tissue, dermis, epidermis
D. Dermis, epidermis, subcutaneous tissue

80. How many thoracic vertebrae does the spine contain?

A. 7
B. 12
C. 5
D. 10

81. Which heart chamber pumps oxygenated blood into the aorta for delivery to the body?

A. Left ventricle
B. Right ventricle
C. Right atrium
D. Left atrium

82. "Appendicitis" uses which suffix, and what does it mean?

A. -itis, meaning tumor
B. -algia, meaning pain
C. -itis, meaning inflammation

D. -osis, meaning abnormal condition

83. "Arthralgia" means:

A. Inflammation of a joint
B. Stiffness of a joint
C. Surgical repair of a joint
D. Pain in a joint

84. A patient with severe ulcerative colitis undergoes surgical creation of an opening from the colon to the abdominal wall for waste elimination. What is this procedure called?

A. Colonoscopy
B. Colostomy
C. Colotomy
D. Colectomy

85. A surgeon performs a tracheotomy. What has the surgeon done?

A. Repaired the trachea
B. Made a surgical incision into the trachea
C. Removed the trachea
D. Created a permanent opening into the trachea

86. A patient's blood glucose is documented as 260 mg/dL, well above normal. What term describes this condition?

A. Hyperglycemia
B. Hyperkalemia
C. Hypoglycemia
D. Glycosuria

87. "Dyspnea" describes:

A. Complete absence of breathing
B. Abnormally rapid breathing
C. Abnormally slow breathing
D. Difficult or labored breathing

88. "Anemia" uses the suffix -emia, which means:

A. Inflammation
B. Enlargement
C. Tumor
D. Blood condition

89. "Neuropathy" means:

A. Removal of a nerve
B. Inflammation of a nerve
C. Disease or dysfunction of a nerve
D. Surgical repair of a nerve

90. "Diarrhea" uses the suffix -rrhea, which means:

A. Bursting forth
B. Flow or discharge
C. Excessive pain
D. Narrowing

91. In anatomical directional terms, "proximal" and "distal" describe:

A. Position toward versus away from the midline
B. Position toward the front versus the back of the body
C. Position above versus below another structure
D. Nearness to versus distance from the trunk or point of attachment

92. Which pair of directional terms describes front versus back position on the body?

A. Medial and lateral
B. Proximal and distal
C. Anterior and posterior
D. Superior and inferior

93. Which body plane divides the body into right and left portions?

A. Oblique plane
B. Coronal (frontal) plane
C. Sagittal plane
D. Transverse (horizontal) plane

94. A patient presents with pain localized to the right lower quadrant of the abdomen, raising suspicion for appendicitis. Which abdominal quadrant is this?

A. RUQ
B. LUQ
C. LLQ
D. RLQ

95. How many vertebrae make up the lumbar spine?

A. 4
B. 7
C. 12
D. 5

96. The pancreas performs which combination of functions?

A. Exocrine function alone, producing digestive enzymes
B. Endocrine function alone, producing insulin and glucagon
C. Neither — the pancreas stores and concentrates bile
D. Both exocrine and endocrine functions

97. What is the functional unit of the kidney, responsible for filtering blood and forming urine?

A. The nephron
B. The renal pelvis
C. The ureter
D. The bladder

98. How many pairs of cranial nerves does the human body have?

A. 8
B. 31
C. 24
D. 12

99. Which heart valve sits between the right atrium and right ventricle?

A. Tricuspid valve
B. Mitral valve
C. Pulmonary valve
D. Aortic valve

100. "Lipoma" uses the suffix -oma, which means:

A. Surgical repair
B. Inflammation
C. Tumor or mass
D. Deficiency

Compliance & HIPAA

101. Which of the following is NOT a covered entity under HIPAA?

A. A physician practice that transmits claims electronically
B. A health insurance plan
C. A patient's employer
D. A healthcare clearinghouse

102. The HIPAA "minimum necessary" standard requires that a coder:

A. Review the entire medical record in full before assigning any code
B. Share PHI with any workforce member of the same organization on request
C. Access only the protected health information needed for the coding task
D. Purge all PHI from the system once each claim has been paid

103. A breach of unsecured PHI affects 600 individuals. Under the Breach Notification Rule, the covered entity must notify:

A. HHS in an annual log submitted at the end of the calendar year
B. Its liability insurer and the state insurance regulator
C. The affected individuals alone, since fewer than 1,000 were affected
D. Affected individuals, HHS within 60 days, and prominent local media

104. A coworker with no role in the patient's care asks you to look up a local celebrity's lab results "out of curiosity." You should:

A. Look them up but not print anything
B. Look them up, since you both work for a covered entity
C. Ask the celebrity's physician first
D. Refuse — accessing PHI without a job-related need violates HIPAA

105. Reporting a higher-level E/M code than the documentation supports in order to increase reimbursement is called:

A. Balance billing
B. Downcoding
C. Upcoding
D. Unbundling

106. Reporting the individual components of a procedure separately when a single comprehensive code exists is called _____, and Medicare's _____ edits are designed to catch it.

A. Upcoding; MUE
B. Fragmenting; RBRVS
C. Unbundling; NCCI
D. Unbundling; GPCI

107. Which is an example of a compliant query to a physician?

A. "Please document sepsis so this admission qualifies for the higher-weighted DRG payment."
B. "Temperature 39.2°C, WBC 18,000, positive blood cultures — can the clinical significance of these findings be specified?"
C. "Sign below to confirm the diagnosis we added to the record on your behalf."
D. "Didn't you mean to document pneumonia rather than acute bronchitis for this stay?"

108. A billing service performs coding and claims submission on behalf of a physician practice, requiring access to PHI. Under HIPAA, this billing service is a:

A. A covered entity, directly regulated like the practice itself
B. A third-party payer under the practice's contracts
C. An entity outside HIPAA's scope entirely
D. A business associate, which must sign a BAA with the practice

109. Under HIPAA, a covered entity may use and disclose PHI without patient authorization for which purposes?

A. Approved research studies, without restriction
B. Marketing to the patient about unrelated products
C. Treatment, payment, and healthcare operations (TPO)
D. Any purpose the entity documents as beneficial

110. What is the purpose of a covered entity's Notice of Privacy Practices (NPP)?

A. To document medical necessity for billed services
B. To obtain the patient's informed consent for treatment
C. To itemize charges the patient owes for services rendered
D. To inform patients how their PHI may be used and their privacy rights

111. Under the HIPAA Privacy Rule's right of access, how quickly must a covered entity generally provide a patient with a copy of their requested medical records?

A. Within whatever timeframe the entity's policy sets
B. Within 30 days, with one permissible 30-day extension
C. Within 24 hours of receiving the request

D. Within one year of receiving the request

112. Which HIPAA-compliant method allows health information to be considered de-identified so it's no longer regulated as PHI?

A. Storing the data on a server separate from the EHR
B. Encrypting the data set with a strong algorithm
C. Removing the patient's name and address from each record
D. Safe Harbor removal of all 18 identifiers, or Expert Determination

113. The HIPAA Security Rule requires covered entities to implement which categories of safeguards for electronic PHI?

A. Physical safeguards alone, such as locked facilities
B. Administrative, physical, and technical safeguards
C. Technical safeguards alone, such as encryption
D. Financial safeguards for billing systems

114. Under the HIPAA Security Rule, encryption of electronic PHI is generally classified as which type of implementation specification?

A. Applicable to paper records rather than electronic ones
B. Optional, and not assessed during compliance reviews
C. Required — implementation is mandatory in each case
D. Addressable — implement it, an equivalent alternative, or document why not

115. The federal False Claims Act allows a private individual with knowledge of fraud against the government to file suit on the government's behalf and potentially share in the recovery. This is called:

A. A compliance audit
B. A qui tam action
C. A RAC audit
D. An OIG exclusion

116. The Anti-Kickback Statute prohibits which of the following?

A. Employing coders, billers, or other administrative staff
B. Any financial communication between a physician and a hospital
C. Remuneration intended to induce or reward federal-program referrals
D. Submitting any claim to Medicare while under investigation

117. How does the Stark Law (physician self-referral law) differ from the Anti-Kickback Statute?

A. Stark is strict liability for self-referral; Anti-Kickback requires intent
B. Stark applies to hospitals, while Anti-Kickback applies to physicians
C. Stark covers Medicaid claims, while Anti-Kickback covers Medicare
D. They are duplicate statutes enforced by different agencies

118. According to OIG guidance, an effective compliance program for a physician practice should include which of the following elements?

A. Verbal policies, to avoid creating a discoverable paper trail
B. Compliance training delivered at new-hire orientation

C. A compliance officer, with training left to each department
D. Written policies, a compliance officer, training, auditing, and response

119. How does healthcare fraud differ from healthcare abuse?

A. Fraud is intentional deception; abuse may not require proof of intent
B. Abuse applies to facilities, while fraud applies to individuals
C. They are legally identical and charged under the same statute
D. Fraud is accidental misbilling, while abuse is deliberate deception

120. An employee reports suspected billing fraud internally through the compliance hotline. Federal law generally protects that employee from which of the following?

A. Retaliation, such as termination, for a good-faith report
B. Being passed over for promotion for unrelated reasons
C. Mandatory continuing education requirements
D. Being interviewed during the resulting investigation

121. Does the HIPAA "minimum necessary" standard apply to disclosures made for treatment purposes between providers?

A. It applies when the disclosure goes to a health plan
B. It applies when the providers practice in the same group
C. Yes — it applies to disclosures of any kind, including treatment
D. No — it does not apply to disclosures for treatment

122. Which type of PHI requires a specific, separate written patient authorization before disclosure, beyond the general TPO permissions?

A. Insurance eligibility and benefits information
B. The diagnosis codes reported on a claim
C. Basic demographic and contact information
D. Psychotherapy notes and PHI used for marketing purposes

123. Under the HITECH Act, business associates are:

A. Shielded from direct liability, which rests with the covered entity
B. Directly liable for applicable HIPAA provisions, as are their subcontractors
C. Liable when the covered entity is also found liable
D. Exempt from the breach notification requirements

124. Which HIPAA Security Rule safeguard requires covered entities to regularly review system activity, such as audit logs, to detect inappropriate access to ePHI?

A. Facility access controls and validation
B. Information system activity review
C. Workstation use and security policies
D. Transmission security and integrity controls

125. Under the HIPAA right of access, a patient may direct a covered entity to send their records:

A. To the patient in person, with photo identification
B. To another covered entity, after verification
C. To the requested recipient, once a court order is obtained

D. Directly to a third party the patient designates, in the requested format

Billing & Reimbursement

126. Under the resource-based relative value scale (RBRVS), the three components of a relative value unit (RVU) are:

A. Time, complexity, and geographic location of the service
B. Base units, time units, and modifying units
C. Billed charges, operating costs, and profit margin
D. Physician work, practice expense, and malpractice expense

127. How is payment calculated under the Medicare Physician Fee Schedule?

A. MS-DRG weight multiplied by the hospital's base rate
B. RVUs adjusted by GPCI, multiplied by the conversion factor
C. A flat capitated rate per patient per calendar year
D. A set percentage of the physician's billed charges

128. The condition established after study to be chiefly responsible for occasioning the patient's admission to the hospital is the definition of:

A. The primary complaint
B. The principal diagnosis
C. The admitting diagnosis
D. A comorbidity

129. Under Medicare's Outpatient Prospective Payment System (OPPS), services are grouped for payment into:

A. Resource Utilization Groups (RUGs)
B. Home Health Resource Groups (HHRGs)
C. Ambulatory Payment Classifications (APCs)
D. Medicare Severity Diagnosis Related Groups (MS-DRGs)

130. Which claim form does a physician practice use to bill professional services?

A. UB-04 (CMS-1450)
B. CMS-1500
C. ABN
D. CMS-855

131. Which part of Medicare covers physician services and most outpatient care?

A. Part B
B. Part C
C. Part D
D. Part A

132. A Medically Unlikely Edit (MUE) defines:

A. The maximum units of a service reported per beneficiary per date of service
B. Pairs of codes that cannot be reported together on the same date
C. The annual dollar cap on a beneficiary's total submitted claims

D. Diagnoses that fail to support medical necessity for a billed service

133. Which part of Medicare covers inpatient hospital stays, skilled nursing facility care, and hospice?

A. Part A
B. Part B
C. Part D
D. Part C

134. A beneficiary enrolls in a private plan that bundles Medicare Part A and Part B coverage, often adding extra benefits. This is:

A. Medicare Part D
B. Medicare Advantage (Part C)
C. Medicaid managed care
D. A Medigap supplement policy

135. Which part of Medicare covers outpatient prescription drugs?

A. Part B
B. Part C
C. Part A
D. Part D

136. Under the inpatient prospective payment system, what two factors most directly increase an MS-DRG's relative weight for a given admission?

A. The number of outpatient visits in the 30 days before admission
B. The patient's insurance type and plan benefits
C. The hospital's geographic location and wage index
D. Documented CCs or MCCs that increase the resources required

137. A patient is covered by two health plans: their own employer plan and their spouse's employer plan. General coordination-of-benefits rules determine which plan pays first. This determination is called identifying the:

A. The capitation rate
B. Primary and secondary payer
C. The clean-claim determination
D. The allowed amount

138. A claim submitted with all required, accurate data elements needed for the payer to process it without additional documentation is called a:

A. Clean claim
B. Capitated claim
C. Crossover claim
D. Timely claim

139. A payer requires claims to be submitted within a set number of days from the date of service, or the claim will be denied regardless of validity. This requirement is called the:

A. Look-back period

B. Global period
C. Grace period
D. Timely filing limit

140. After a payer processes a claim, it sends the provider a document detailing what was paid, adjusted, or denied and why. This document is the:

A. Advance Beneficiary Notice of Noncoverage (ABN)
B. The superbill generated at checkout
C. An Explanation of Benefits (EOB) or remittance advice
D. Notice of Privacy Practices (NPP)

141. A provider's billed charge for a service is $500. The payer's contracted allowed amount is $350, which it pays in full minus the patient's $50 copay. What happens to the remaining $150 difference between billed charge and allowed amount?

A. It carries forward to the patient's next statement
B. It is written off as a contractual adjustment by the provider
C. The patient owes it in addition to the $50 copay
D. The provider resubmits the claim for the balance

142. Which term describes the fixed dollar amount a patient pays for a covered service at the time of the visit, regardless of the total charge?

A. Premium
B. Coinsurance
C. Copayment
D. Deductible

143. A patient's plan requires them to pay 20% of the allowed amount for a service after their deductible has been met, with the plan paying the remaining 80%. This 20% is the patient's:

A. Premium
B. Copayment
C. Coinsurance
D. Deductible

144. Under a capitation payment model, a primary care provider is paid:

A. A negotiated percentage of billed charges
B. The full allowed amount after the patient's deductible
C. A separate fee for each individual service rendered
D. A fixed amount per enrolled patient per period

145. How does a bundled (episode-based) payment model differ from traditional fee-for-service?

A. One payment covers all services in an episode of care
B. It applies to prescription drug spending rather than procedures
C. It removes the need for procedure coding on claims
D. It pays more for each additional service performed

146. Every healthcare provider who submits electronic claims is required to obtain which unique identifier?

A. A CLIA laboratory certificate number
B. A Social Security number on file with payers
C. A DEA controlled-substance registration
D. A National Provider Identifier (NPI)

147. A physician office wants to bill Medicare for a rapid strep test performed in-house. Which requirement must the office meet before billing for that laboratory test?

A. Enrollment as a Medicare Part D prescriber
B. A National Provider Identifier for the ordering physician
C. A CLIA certificate appropriate to the test's complexity
D. A DEA registration covering in-office testing

148. A payer requires the provider to obtain approval before performing a costly elective procedure, or the claim may be denied even if medically necessary. This requirement is called:

A. Balance billing
B. Prior authorization
C. Credentialing
D. Coordination of benefits

149. A patient is eligible for both Medicare and Medicaid. After Medicare processes the claim, the remaining balance is automatically forwarded to Medicaid without the provider submitting a separate claim. This is called a:

A. Clean claim
B. Crossover claim
C. Timely-filed claim
D. Capitated claim

150. Which two-digit code on a CMS-1500 claim tells the payer where the service was rendered, such as office versus inpatient hospital?

A. A revenue center code
B. A pricing modifier code
C. Place of service (POS) code
D. The type-of-bill code

Answer Key & Explanations

ICD-10-CM

1. How is a valid ICD-10-CM code structured?

Correct answer: 3 to 7 characters, and the first character is always a letter

ICD-10-CM codes contain 3 to 7 characters, and the first character is always a letter. A three-character code is valid only when the category is not subdivided further. Characters after the first may be letters or numbers.

2. An injury code requires a 7th character, but the base code contains only five characters. What must the coder do?

Correct answer: Insert placeholder "X" in the empty sixth position, then add the 7th character

The placeholder "X" fills unused positions so the 7th character always stays in the seventh position. A 7th character reported in the wrong position makes the code invalid, and dropping it entirely is also invalid when the category requires one.

3. A note under a code category reads "Excludes2" followed by another condition. What does this instruct the coder to do?

Correct answer: Both codes may be reported together when the patient has both conditions

Excludes2 means "not included here" — the excluded condition is not part of the code, but the patient can have both conditions at the same time, so both codes may be reported when documented. The trap is Excludes1, which means the two codes are mutually exclusive and are never reported together for the same condition.

4. A 68-year-old patient has documented hypertension and stage 2 chronic kidney disease. No heart disease is documented. Which codes are correct?

Correct answer: I12.9, N18.2

ICD-10-CM assumes a causal relationship between hypertension and chronic kidney disease, so you report the combination code I12.9 — never I10 separately — and follow the "use additional code" note by adding N18.2 for the CKD stage. I13 codes are wrong because they require documented heart disease as well.

5. A patient presents with productive cough and fever and is diagnosed with community-acquired pneumonia. How should the encounter be coded?

Correct answer: Pneumonia only

The ICD-10-CM Official Guidelines state that signs and symptoms routinely associated with a confirmed diagnosis are not coded separately. Cough and fever are integral to pneumonia, so only the pneumonia code is reported. Symptoms get their own codes only when they are unrelated to the confirmed condition.

6. The provider's note states only "urosepsis." What should the coder do?

Correct answer: Query the provider for clarification

The Official Guidelines say "urosepsis" is a nonspecific term that is not synonymous with sepsis and has no default code. The coder must query the provider to clarify whether the patient has a urinary tract infection, sepsis, or both. Assuming either answer risks coding a condition that was never established.

7. A patient is 27 weeks and 6 days pregnant. For ICD-10-CM coding, which trimester is she in?

Correct answer: Second trimester

ICD-10-CM defines the third trimester as beginning at 28 weeks 0 days, so 27 weeks 6 days still falls in the second trimester (14 weeks 0 days to less than 28 weeks). This one-day distinction is a classic exam trap — the trimester boundaries are printed at the start of Chapter 15.

8. A patient with a healing wrist fracture returns for a scheduled cast check. The fracture is healing normally. Which 7th character applies?

Correct answer: D — subsequent encounter

7th character D reports care during the routine healing phase, such as cast changes and follow-up visits. A is for active treatment of the injury (the ER visit, the surgical repair), and S is for late complications after healing ends. X is a placeholder, not an encounter type.

9. An average-risk, asymptomatic 50-year-old has a screening colonoscopy. No abnormalities are found. What is the first-listed diagnosis code?

Correct answer: Z12.11, encounter for screening for malignant neoplasm of colon

When the reason for the encounter is screening, the screening Z code is first-listed — Z12.11 for a screening colonoscopy. If a polyp had been found, it would be coded additionally after the screening code, because the encounter was still a screening. Every claim requires a diagnosis, so D is never an option.

10. A patient with an existing breast primary malignancy is treated this admission only for a vertebral metastasis. How are the neoplasm codes sequenced?

Correct answer: The metastatic site is sequenced first, with the primary coded as an additional diagnosis

When treatment is directed at the secondary site, the secondary neoplasm is the first-listed diagnosis and the still-existing primary is coded as an additional diagnosis. A Z51 encounter code goes first only when the admission is solely for chemotherapy, immunotherapy, or radiation — not the case here.

11. Which statement about external cause codes (V00–Y99) is true?

Correct answer: They are never reported as the principal or first-listed diagnosis

External cause codes describe how and where an injury happened, so they are always secondary — the injury itself is sequenced first. Unless a state or payer mandates them, they are also voluntary, which rules out B.

12. The provider documents a detailed, specific type of a condition, but no ICD-10-CM code exists for that exact type. Which abbreviation identifies the code the coder should assign?

Correct answer: NEC — not elsewhere classifiable

NEC ("other specified") is used when the documentation is specific but the classification has no matching code — the record beats the code book. NOS ("unspecified") is the opposite situation: the classification has specific codes, but the documentation isn't specific enough to pick one.

13. A category note reads "Excludes1: diabetic retinopathy." What does this mean for the code above it?

Correct answer: A pure Excludes1 — the two conditions cannot occur together, so the codes are not reported together

Excludes1 means "not coded here" — the two conditions are mutually exclusive and are never reported on the same claim for the same condition. That is the opposite of Excludes2, which allows both codes when both conditions are present.

14. A patient's record documents "acute renal failure due to rhabdomyolysis." The Tabular List shows a "Code first underlying condition" note under the renal failure code. What does the coder do?

Correct answer: Sequence rhabdomyolysis first, then the renal failure code

A "code first" note under a manifestation code means that code can never be sequenced first — the underlying condition (rhabdomyolysis) is coded first, and the manifestation (renal failure) follows as an additional code. Ignoring the note and leading with the manifestation is a common sequencing error the exam tests directly.

15. A patient with type 2 diabetes has documented diabetic nephropathy and no other diabetic complication. Which code set is correct?

Correct answer: E11.21, the combination code for type 2 diabetes with diabetic nephropathy

ICD-10-CM uses combination codes to link diabetes with its documented complications, so type 2 diabetes with diabetic nephropathy is reported with the single code E11.21 — never diabetes and nephropathy as two separate codes. This mirrors the hypertension-with-CKD combination rule tested elsewhere in this bank.

16. A patient treated for a healed traumatic brain injury now has documented post-traumatic seizures as a late effect. How is this sequenced?

Correct answer: The seizure disorder first, then the injury code with 7th character S

For sequela (late effect) coding, the residual condition — here, the seizure disorder — is sequenced first, followed by the code for the cause of the late effect with 7th character S. The S character is never used with an A (initial) or D (subsequent) encounter on the same claim.

17. A trauma patient's Glasgow Coma Scale is documented as eye opening to pain, incomprehensible sounds, and abnormal flexion. Where does the coder find codes for these individual GCS components?

Correct answer: Category R40 coma scale codes — one code per component

Category R40.2- provides separate codes for eye-opening, verbal, and motor response, allowing each documented GCS component to be captured individually, plus a code for the total score when the medical record states it. This level of granularity is unique to the coma scale category.

18. A physician documents a patient's BMI as 32 during a visit for hypertension management. How is the BMI coded?

Correct answer: As a secondary diagnosis; BMI codes are not first-listed

BMI codes (category Z68) are always reported as secondary diagnoses to provide additional information about a documented condition such as obesity or overweight; the Official Guidelines state they are never sequenced as the principal or first-listed diagnosis. The associated clinical condition, if reported, must also be documented by the provider.

19. A patient had breast cancer five years ago, successfully treated with no evidence of disease since. Today's visit is unrelated. How is the resolved cancer coded?

Correct answer: With a personal history code from category Z85

Personal history codes (Z85–Z87) report a condition the patient once had that is no longer being treated and no longer exists, but that still affects current care decisions such as screening frequency. Family history (Z80–Z84) is reserved for a relative's condition, not the patient's own resolved history.

20. A patient's mother had colon cancer; the patient has never had it. What code reports this fact during a screening visit?

Correct answer: A code from category Z80, family history of malignant neoplasm

Family history codes (Z80–Z84) capture a blood relative's condition that raises the patient's own risk — here, Z80.0 for family history of colon cancer — and often justify more frequent screening. Personal history (Z85) would be wrong because the patient never had the disease.

21. In the ICD-10-CM Alphabetic Index, when two conditions are linked by the word "with" in a subterm, the classification instructs the coder to:

Correct answer: Assume a causal relationship, unless the classification or provider states the conditions are unrelated

The "with" convention presumes a linked relationship between the two conditions listed in the index — the classic example is diabetes "with" a complication — so the coder does not need explicit documentation stating the conditions are related. The presumption breaks only when guidance says otherwise or the provider specifically documents the conditions as unrelated.

22. A patient intentionally takes double her prescribed dose of a blood pressure medication and develops symptomatic hypotension. This is coded as:

Correct answer: Poisoning, because the drug was taken in a dose greater than prescribed

Poisoning codes apply when a drug is taken in error, including taking more than the prescribed amount, taken by the wrong person, or taken with alcohol against instructions. An adverse effect is a reaction from a drug correctly prescribed and correctly taken; underdosing is the opposite error — taking less medication than directed.

23. A patient meets criteria for sepsis and, during the same encounter, develops septic shock. How are these sequenced?

Correct answer: The underlying infection first, then R65.21; septic shock is never first

The Official Guidelines require the underlying systemic infection to be sequenced first, followed by the appropriate severe sepsis code — R65.21 for severe sepsis with septic shock. Septic shock is a form of acute organ dysfunction and, per the Guidelines, is never assigned as a principal diagnosis on its own.

24. A progress note reads: "Type 2 diabetes mellitus with hyperglycemia." Which ICD-10-CM code is reported?

Correct answer: E11.65

E11.65 reports type 2 diabetes with hyperglycemia — the documented complication is captured in the combination code, per the diabetes 'with' convention in the Alphabetic Index. E11.9 is type 2 diabetes without complications, E10.65 is the type 1 equivalent, and R73.9 (hyperglycemia, unspecified) is wrong because the hyperglycemia belongs inside the diabetes combination code, not on its own.

25. A patient returns three weeks after knee replacement surgery for a scheduled wound check with no complications. How is this encounter coded?

Correct answer: With a Z48 aftercare code for planned surgical follow-up

Z48 aftercare codes (such as Z48.812, encounter for surgical aftercare following orthopedic surgery) report routine post-surgical care during healing. Z09 follow-up codes are reserved for encounters after a condition — often a disease like cancer — has been fully treated and resolved, which is a different clinical scenario.

CPT

26. A patient was seen two years ago by another internist in the same group practice. Today she sees a different internist in that group. For E/M purposes, she is:

Correct answer: An established patient of the practice

A patient is established if any physician of the exact same specialty and subspecialty in the same group practice provided a face-to-face service within the past three years. The individual physician being new to the patient doesn't matter — the group and specialty do.

27. Under the current CPT E/M guidelines, how is the level selected for office and outpatient visits (99202–99215)?

Correct answer: By medical decision making OR total time on the encounter date

Since the 2021 E/M overhaul, office/outpatient visit levels are chosen using either medical decision making or total time spent on the date of the encounter — whichever benefits the provider. History and exam must still be medically appropriate but no longer score the level.

28. A physician performs a significant, separately identifiable E/M service on the same day as a minor procedure. How is this reported?

Correct answer: Append modifier 25 to the E/M code

Modifier 25 goes on the E/M code to show it was significant and separately identifiable from the same-day minor procedure. Without it, the visit bundles into the procedure's global package and the E/M line denies. Modifier 59 is for distinct procedures, never for E/M services.

29. A surgeon performs carpal tunnel release on both wrists during the same operative session. Which modifier is appended?

Correct answer: 50 — bilateral procedure

Modifier 50 reports the same procedure performed on both sides of the body at the same session. Modifier 51 is for different procedures at one session, 59 for procedures that would otherwise bundle, and 76 for repeating the same procedure on the same day.

30. A radiologist interprets and reports a chest X-ray taken on the hospital's equipment. Which modifier does the radiologist append?

Correct answer: 26 — professional component

Modifier 26 reports only the professional component — the interpretation and report. The hospital owns the equipment, so it bills the technical component with modifier TC. The global (unmodified) code is correct only when one entity provides both components.

31. Which service is NOT included in the CPT surgical package?

Correct answer: An E/M service for an unrelated condition during the postoperative period

The surgical package bundles the procedure with local anesthesia, same-day related E/M after the decision for surgery, and typical postoperative care. Treating an unrelated condition during the global period is separately billable — append modifier 24 to that E/M service.

32. Operative note: colonoscope advanced to the cecum; a sigmoid polyp was sampled with cold biopsy forceps and retrieved. Which CPT code is reported?

Correct answer: 45380

45380 reports colonoscopy with biopsy, single or multiple. 45378 is a diagnostic colonoscopy without intervention, 45385 requires snare-technique removal of the lesion, and 45330 is a flexible sigmoidoscopy — this scope reached the cecum, which defines a full colonoscopy.

33. How is anesthesia payment calculated?

Correct answer: (Base units + time units + modifying units) × conversion factor

Anesthesia payment adds the procedure's base units, time units, and any modifying units (physical status, qualifying circumstances), then multiplies the total by the anesthesia conversion factor. This formula is unique to anesthesia — no other CPT section pays on time units this way.

34. When does anesthesia time begin?

Correct answer: When the anesthesia provider begins preparing the patient for induction

Anesthesia time starts when the provider begins preparing the patient for the induction of anesthesia and ends when the provider is no longer in personal attendance and the patient is safely under postoperative supervision. Incision time and room-entry time are distractors — preparation for induction is the trigger.

35. A patient has two simple lacerations repaired: 2.0 cm on the left forearm and 1.5 cm on the trunk. How is this reported?

Correct answer: 12002 once, for a combined 3.5 cm repair

When multiple wounds share the same repair classification (simple) and the same anatomic grouping in the code descriptor — and trunk and extremities are grouped together in 12001–12007 — you add the lengths and report one code. A 3.5 cm total simple repair falls in 12002 (2.6 to 7.5 cm).

36. Which CPT code reports a 2-view chest X-ray?

Correct answer: 71046

The chest X-ray codes are counted by views: 71045 for a single view, 71046 for 2 views, 71047 for 3 views, and 71048 for 4 or more. The standard PA-and-lateral chest X-ray is 2 views — 71046.

37. Which code reports a complete blood count (CBC), automated, WITH an automated differential WBC count?

Correct answer: 85025

85025 is the automated CBC with automated differential; 85027 is the CBC without the differential. 80053 is the comprehensive metabolic panel and 36415 is the blood draw itself — neither is a CBC.

38. Which code reports a routine venipuncture for the collection of a venous blood specimen?

Correct answer: 36415

36415 reports the routine venipuncture (the stick that fills the tube). 36416 is a capillary specimen such as a fingerstick or heelstick. The lab tests performed on the specimen are always coded separately.

39. A physician orders a troponin level repeated four hours after the first to track serial results. Which modifier goes on the repeat lab test?

Correct answer: 91

Modifier 91 reports a clinical diagnostic lab test repeated on the same day to obtain subsequent, medically necessary results — exactly the serial-troponin scenario. Modifiers 76 and 77 apply to repeated procedures/services by physicians, and 59 is for distinct procedures, not repeat labs.

40. A surgeon performs two different procedures through separate incisions during the same operative session, and no more specific modifier applies. Which modifier indicates these are distinct procedural services?

Correct answer: Modifier 59

Modifier 59 identifies a procedure or service as distinct or independent from other services performed the same day, used when code edits would otherwise bundle them and no more specific modifier fits. CPT and CMS both instruct coders to consider the more specific X{EPSU} modifiers first when they apply, and to use 59 only when none of them do.

41. A patient is 10 days into the 90-day global period after abdominal surgery and is seen by the same surgeon for an unrelated new onset of chest pain. Which modifier is appended to the E/M code?

Correct answer: Modifier 24 — unrelated E/M during a postoperative period

Modifier 24 tells the payer the E/M visit is unrelated to the surgery that created the global period, so it is separately payable instead of bundling into the surgical package. Modifier 25 is for a same-day E/M with a procedure, and 79 reports an unrelated procedure (not an E/M) during the global period.

42. A surgeon evaluates a patient in the office and, during that same visit, makes the decision to perform major surgery the next day. Which modifier is appended to the E/M code?

Correct answer: Modifier 57 — decision for surgery

Modifier 57 identifies an E/M service that resulted in the initial decision to perform major surgery, on the day of or day before that surgery, so the visit is not bundled into the global surgical package. This differs from modifier 25, which covers a same-day E/M distinct from a minor procedure already planned.

43. A patient has a planned second-stage procedure performed by the same surgeon during the global period of the first surgery, as documented in the original operative plan. Which modifier applies to the second procedure?

Correct answer: Modifier 58 — staged procedure during the postoperative period

Modifier 58 reports a procedure that was planned prospectively, is more extensive than the original, or represents therapy following a diagnostic procedure, all performed by the same physician during the first procedure's global period. It starts a new global period for the staged procedure.

44. A patient returns to the operating room during the global period for a complication of the original surgery, performed by the same surgeon and not planned in advance. Which modifier applies?

Correct answer: Modifier 78 — unplanned return to the OR for a related procedure

Modifier 78 reports an unplanned return to the OR for a complication related to the original procedure, by the same physician, during the global period — and unlike modifier 58, it does not start a new global period of its own. Modifier 79 is reserved for an unrelated procedure during that same window.

45. During the global period of a knee surgery, the same surgeon performs an unrelated procedure on the patient's opposite hand. Which modifier applies to the second procedure?

Correct answer: Modifier 79 — unrelated procedure during the postoperative period

Modifier 79 signals that the second procedure is clinically unrelated to the first surgery, so it starts its own new global period and is not bundled into the original surgery's postoperative package. The key distinguishing fact from 78 is that the second procedure is unrelated, not a complication of the first.

46. An add-on code, identified in CPT with a "+" symbol, is reported:

Correct answer: In addition to a specified primary procedure code, exempt from modifier 51

Add-on codes describe an additional service performed with a primary procedure and can never be billed alone. Because they already represent incremental work, CPT exempts them from modifier 51 and the multiple-procedure payment reduction that would otherwise apply.

47. A surgeon performs a procedure with no CPT code that adequately describes it. What is the correct way to report it?

Correct answer: Report the section's unlisted procedure code with a special report

When no CPT code accurately describes a service, the coder reports the section's unlisted procedure code along with a special report — an operative note or letter describing the procedure, its complexity, and time — so the payer can determine appropriate reimbursement. Selecting a similar but inaccurate code instead is considered upcoding or miscoding.

48. CPT Category III codes are best described as:

Correct answer: Temporary codes for emerging technology, services, and procedures

Category III codes track new and emerging technology; when a Category III code exists for a service, it must be reported instead of an unlisted Category I code, because it gives more specific data to payers and CMS. A Category III code that isn't converted to a permanent Category I code sunsets after a period of use if it isn't extended.

49. For a CPT time-based code with a defined typical time, when may the coder report that code based on time?

Correct answer: When documented time meets or exceeds the midpoint of the typical time

CPT's general rule for time-based codes is that the service can be reported when the documented time reaches at least the midpoint of the stated typical time for that code — for example, a 30-minute code can be reported once at least 16 minutes have elapsed. Falling short of the midpoint means the lower time-based code, if one exists, should be reported instead.

50. A patient receives one immunization injection during a preventive visit. How is this typically reported?

Correct answer: With an administration code plus the vaccine/toxoid product code

CPT reports the vaccine product (a code from the 90476–90759 range) and the administration of that vaccine (90460–90474) as two separate codes, because the product and the act of giving it are distinct services. Omitting either code under-reports the encounter.

HCPCS & Modifiers

51. HCPCS Level II "J" codes report which of the following?

Correct answer: Drugs administered other than by the oral method

J codes report drugs that are not self-administered orally — injections, infusions, and some inhalation drugs — along with their dosage units. DME lives in the E codes and ambulance transport in the A codes.

52. A Medicare patient receives a CPAP device for home use. In which HCPCS Level II section is it found?

Correct answer: E codes — durable medical equipment

A CPAP machine is durable medical equipment, reported with an E code (E0601). DME is equipment that withstands repeated use in the home — the defining test that separates E codes from the disposable supplies in the A codes.

53. When does a coder report a HCPCS Level II code instead of a CPT code?

Correct answer: For supplies, drugs, and equipment that CPT does not describe

HCPCS Level II exists to fill CPT's gaps — drugs, DME, supplies, ambulance, and certain services Medicare and Medicaid require reported with national codes. It applies in every setting, and both CPT and HCPCS codes accept modifiers.

54. A Medicare patient signs an Advance Beneficiary Notice (ABN) because a service is likely to be denied as not medically necessary. Which modifier is appended to the service?

Correct answer: GA

GA tells Medicare a required ABN is on file, which shifts financial liability to the patient if the claim denies. GZ means the provider expects denial but has no ABN (provider eats the cost), and GY marks services statutorily excluded from Medicare — no ABN applies.

55. Which HCPCS Level II code reports a Medicare beneficiary's first Annual Wellness Visit?

Correct answer: G0438

G0438 reports the initial Medicare Annual Wellness Visit; the subsequent, lower-paying annual visit is G0439. 99397 is a CPT preventive exam code, not the Medicare wellness visit, and Medicare does not cover it the same way.

56. HCPCS Level II "A" codes primarily report:

Correct answer: Miscellaneous supplies and transportation, including ambulance

The A-code section covers a broad mix of supplies (dressings, catheters) and transportation services, including the ambulance codes. DME lives in the E codes, dental in the D codes, and vision/hearing in the V codes — each HCPCS letter section groups a distinct service category.

57. HCPCS Level II "Q" codes are used for:

Correct answer: Temporary codes for drugs, biologicals, and items without another equivalent

Q codes are temporary national codes CMS assigns to items — often certain drugs, supplies, or services — that need a code before a permanent one exists elsewhere in CPT or HCPCS. Like G codes, they fill a gap until the coding system catches up.

58. A Medicare patient requires a custom power wheelchair. Which HCPCS section contains the code?

Correct answer: K codes — temporary codes used primarily for DME

K codes are temporary HCPCS codes issued by the DME Medicare Administrative Contractors, historically used heavily for wheelchairs and related mobility equipment before some migrate to permanent E codes. L codes are reserved for orthotics and prosthetics, a different equipment category.

59. A patient is fitted with a custom ankle-foot orthosis. Which HCPCS section contains the code for this device?

Correct answer: L codes — orthotic and prosthetic procedures

L codes report orthotic devices (braces that support a body part) and prosthetic devices (that replace a missing body part). This is distinct from E codes, which cover durable medical equipment like wheelchairs and hospital beds.

60. Eyeglass frames dispensed after cataract surgery are reported with a code from which HCPCS section?

Correct answer: V codes — vision and hearing services

V codes report vision services (frames, lenses, contact lenses) and hearing services (hearing aids). They're a distinct national code section separate from the DME and supply codes used for most other equipment.

61. A bilateral mammogram is documented, but the payer requires each side identified separately on the claim. Which modifiers are appended to the two line items?

Correct answer: LT and RT

Modifiers LT (left side) and RT (right side) identify which side of a paired organ or structure a service was performed on, which some payers require instead of modifier 50 for certain codes. Always check the specific payer's policy for which convention it wants — CMS and commercial payers don't always agree.

62. A patient asks for a service known to be statutorily excluded from Medicare coverage, and signs a voluntary notice of that fact even though an ABN isn't required. Which modifier reports this?

Correct answer: GX — voluntary notice of liability issued

GX reports a voluntary Advance Beneficiary Notice given for a service the provider knows is statutorily excluded or otherwise never covered — even though Medicare doesn't require the notice for excluded services. This differs from GA, which reports a required ABN for a service expected to be denied as not medically necessary.

63. A service is statutorily excluded from Medicare coverage under all circumstances (for example, a service Medicare never covers by law). Which modifier reports this, letting the claim auto-deny without an ABN?

Correct answer: GY — item or service statutorily excluded

GY marks a service as statutorily excluded from the Medicare benefit — no ABN is required or even relevant, because Medicare never covers this category of service. The claim denies automatically, and patient liability is straightforward.

64. A provider performs a service expected to be denied as not medically necessary but has no ABN signed by the patient. Which modifier applies, and who bears financial liability?

Correct answer: GZ; the provider is liable because no ABN was obtained

GZ reports that the provider expects the service to be denied for medical necessity but failed to get a signed ABN — the claim is expected to deny, and the provider (not the patient) absorbs the cost. Modifier GA is the correct choice only when a valid ABN was actually obtained beforehand.

65. A supplier bills for a piece of DME and attests that documentation on file supports the payer's specific coverage criteria for medical necessity. Which modifier is appended?

Correct answer: KX

Modifier KX attests that the supplier or provider has documentation on file proving the item or service meets the payer's specific medical-necessity policy — commonly used for DME and therapy services approaching a coverage threshold. Appending it without the supporting documentation actually on file is considered a false claim.

66. A DME item is medically necessary but has no HCPCS code that accurately describes it, even after checking every relevant section. What does the supplier report?

Correct answer: E1399, miscellaneous DME, with a detailed description attached

E1399 (durable medical equipment, miscellaneous) is used only when no specific HCPCS code exists for the item; the claim must include a clear written description, and payers typically require prior documentation or authorization because the code carries no built-in definition of the item.

67. A provider administers 40 mg of a drug whose HCPCS J code is defined as "per 10 mg." How many units are reported on the claim line?

Correct answer: 4

Units are billed against the code's defined dose: 40 mg ÷ 10 mg per unit = 4 units. Reporting 1 unit underbills the drug by 30 mg, and reporting 40 would claim 400 mg — a common trigger for Medically Unlikely Edit denials. Always check the J code's "per" amount before entering units.

68. A DME supplier sells a wheelchair outright to a Medicare patient rather than renting it. Which modifier indicates the equipment is new?

Correct answer: NU — new equipment

NU reports a purchase of new DME. RR reports an ongoing rental (common for capped-rental items billed monthly), and UE reports a purchase of used, refurbished equipment at a reduced allowable amount.

69. A capped-rental DME item is billed monthly while the patient uses it, before ownership eventually transfers. Which modifier is appended each month during that period?

Correct answer: RR — rental, billed monthly

RR reports a DME rental; certain high-cost items are "capped rental," billed with RR monthly for up to 13 months, after which the supplier must transfer ownership to the beneficiary. Billing NU during the rental period instead of RR misrepresents the transaction.

70. Which HCPCS code reports ground ambulance transportation mileage, per statute mile?

Correct answer: A0425

A0425 reports ground ambulance mileage, billed per statute mile traveled, in addition to the base transport code for the level of service provided (such as basic life support). Mileage and the base service are reported as separate line items.

71. Ambulance claims append a two-character modifier describing origin and destination, such as "RH." What does this type of modifier communicate?

Correct answer: The origin and destination location types of the transport

Ambulance origin-destination modifiers use single letters (R for residence, H for hospital, N for skilled nursing facility, and so on) combined into a two-letter modifier — the first letter is the origin, the second the destination — which payers use to validate medical necessity and set the mileage rate.

72. A nurse practitioner serves as the first assistant during a major surgery performed by a physician. Which HCPCS modifier is appended to identify the assistant's role?

Correct answer: AS

Modifier AS identifies a physician assistant, nurse practitioner, or clinical nurse specialist acting as the assistant at surgery — distinct from modifiers 80/81/82, which report a physician acting as the assistant surgeon. Payers typically reimburse non-physician assistant-at-surgery services at a lower percentage of the fee schedule than physician assistants at surgery.

73. A physician (not a PA, NP, or CNS) serves as an assistant surgeon on a procedure where assistant surgeons are typically used. Which modifier applies?

Correct answer: 80 — assistant surgeon (physician)

Modifier 80 reports a physician serving as assistant surgeon. Modifier 62 is for two surgeons of different specialties each performing a distinct part of the same procedure as primary surgeons — a very different working relationship from an assistant role.

74. A coder is unsure whether to report a CPT code or a HCPCS Level II code for a nebulizer medication administered in the office. Which principle resolves this?

Correct answer: Report the J code for the drug plus the administration code

Injectable and inhalation drugs are reported with their own J code identifying the specific drug and dosage, separate from the CPT or HCPCS code describing the administration itself (the nebulizer treatment or injection). Bundling the two into one code under-reports the resources used.

75. A supply used only once during a procedure, such as a surgical tray, is most likely reported with a code from which HCPCS section — and how is it typically handled by payers?

Correct answer: A codes; often bundled into the procedure's reimbursement

Single-use procedural supplies generally fall in the A-code section, but many payers, including Medicare, bundle routine supplies into the procedure's payment rather than reimbursing them as a separate line — a detail worth confirming per payer before expecting separate payment.

Terminology & Anatomy

76. The term "nephrectomy" means:

Correct answer: Surgical removal of a kidney

Nephr- means kidney and -ectomy means surgical removal. The distractors are the other three surgical suffixes worth memorizing: -otomy (incision into), -ostomy (creating an opening), and -plasty (surgical repair).

77. "Bradycardia" describes:

Correct answer: An abnormally slow heart rate

Brady- means slow and -cardia refers to the heart, so bradycardia is a slow heart rate (typically under 60 beats per minute). Its opposite is tachycardia (tachy- = fast); an irregular rhythm is an arrhythmia, and an enlarged heart is cardiomegaly.

78. "Hepatomegaly" means:

Correct answer: Enlargement of the liver

Hepat- means liver and -megaly means enlargement. Inflammation of the liver is hepatitis (-itis), an enlarged spleen is splenomegaly, and general liver disease is hepatopathy.

79. From outermost to innermost, the layers of the skin are:

Correct answer: Epidermis, dermis, subcutaneous tissue

The epidermis is the outer protective layer, the dermis beneath it holds vessels, nerves, and glands, and the subcutaneous (fatty) tissue lies deepest. Integumentary anatomy matters directly in CPT — repair depth separates simple, intermediate, and complex wound closures.

80. How many thoracic vertebrae does the spine contain?

Correct answer: 12

The spine has 7 cervical, 12 thoracic, and 5 lumbar vertebrae, plus the sacrum and coccyx. The thoracic count matches the 12 pairs of ribs — a handy memory anchor for spinal coding and fracture levels.

81. Which heart chamber pumps oxygenated blood into the aorta for delivery to the body?

Correct answer: Left ventricle

The left ventricle drives systemic circulation, pumping oxygenated blood through the aorta to the body — which is why its wall is the thickest. The right ventricle pumps to the lungs, and the atria are receiving chambers.

82. "Appendicitis" uses which suffix, and what does it mean?

Correct answer: -itis, meaning inflammation

The suffix -itis means inflammation, so appendicitis is inflammation of the appendix. It's one of the most common suffixes in diagnosis coding, appearing across nearly every body system (gastritis, dermatitis, arthritis).

83. "Arthralgia" means:

Correct answer: Pain in a joint

The suffix -algia means pain, so arthralgia is joint pain. It's a distinct, less specific diagnosis than arthritis (arthr- + -itis, joint inflammation) — an important distinction when the documentation doesn't confirm inflammation.

84. A patient with severe ulcerative colitis undergoes surgical creation of an opening from the colon to the abdominal wall for waste elimination. What is this procedure called?

Correct answer: Colostomy

The suffix -ostomy means the surgical creation of a new opening, so colostomy is an opening created from the colon to the body surface. This differs from -otomy (a simple incision into an organ) and -ectomy (surgical removal), both

common exam distractors.

85. A surgeon performs a tracheotomy. What has the surgeon done?

Correct answer: Made a surgical incision into the trachea

The suffix -otomy means incision into, so a tracheotomy is a cut made into the trachea, often to establish an emergency airway. A tracheostomy (-ostomy) instead creates a more permanent opening — the two terms describe related but distinct procedures.

86. A patient's blood glucose is documented as 260 mg/dL, well above normal. What term describes this condition?

Correct answer: Hyperglycemia

The prefix hyper- means excessive or above normal, and -glycemia refers to blood sugar, so hyperglycemia is high blood sugar. Its opposite, hypoglycemia (hypo- = deficient, below normal), describes low blood sugar — the two prefixes are a frequent exam trap.

87. "Dyspnea" describes:

Correct answer: Difficult or labored breathing

The prefix dys- means difficult, painful, or abnormal, and -pnea refers to breathing, so dyspnea is difficult or labored breathing. It's a common presenting symptom documented across cardiac and respiratory chart notes.

88. "Anemia" uses the suffix -emia, which means:

Correct answer: Blood condition

The suffix -emia refers to a condition of the blood. An-, meaning without or deficient, combines with -emia to describe a deficiency of red blood cells or hemoglobin — anemia.

89. "Neuropathy" means:

Correct answer: Disease or dysfunction of a nerve

The suffix -pathy means disease, so neuropathy is any disease or dysfunction of the nervous system's peripheral nerves — commonly seen in diabetic patients (diabetic neuropathy). Inflammation of a nerve specifically would instead use the suffix -itis, as in neuritis.

90. "Diarrhea" uses the suffix -rrhea, which means:

Correct answer: Flow or discharge

The suffix -rrhea means flow or discharge, so diarrhea (dia- = through) describes an abnormally frequent, watery flow through the bowel. Related suffixes worth distinguishing are -rrhagia (excessive bleeding/bursting forth) and -rrhaphy (suturing).

91. In anatomical directional terms, "proximal" and "distal" describe:

Correct answer: Nearness to versus distance from the trunk or point of attachment

Proximal means closer to the point of origin or the trunk, and distal means farther away from it — most often used to describe locations along a limb, such as the proximal versus distal end of the femur. These terms directly affect fracture-site coding, which specifies the exact bone segment involved.

92. Which pair of directional terms describes front versus back position on the body?

Correct answer: Anterior and posterior

Anterior (or ventral) refers to the front of the body, and posterior (or dorsal) refers to the back. Superior/inferior describe above/below, and medial/lateral describe toward/away from the body's midline — a full set of directional terms coders should be able to distinguish on sight.

93. Which body plane divides the body into right and left portions?

Correct answer: Sagittal plane

The sagittal plane divides the body into right and left sections; a midsagittal plane divides it into equal halves. The coronal plane divides front from back, and the transverse plane divides top from bottom — imaging orders and operative reports routinely reference these planes.

94. A patient presents with pain localized to the right lower quadrant of the abdomen, raising suspicion for appendicitis. Which abdominal quadrant is this?

Correct answer: RLQ

The abdomen is commonly divided into four quadrants — RUQ, LUQ, RLQ, LLQ — around the umbilicus. The appendix sits in the right lower quadrant (RLQ), which is why RLQ pain is a classic presenting complaint for appendicitis in chart-note scenarios.

95. How many vertebrae make up the lumbar spine?

Correct answer: 5

The spine has 5 lumbar vertebrae, positioned below the 12 thoracic vertebrae and above the sacrum. Knowing the count for each region (7 cervical, 12 thoracic, 5 lumbar) helps confirm the correct spinal level on operative reports and imaging orders.

96. The pancreas performs which combination of functions?

Correct answer: Both exocrine and endocrine functions

The pancreas is both an exocrine gland, secreting digestive enzymes into the small intestine, and an endocrine gland, secreting insulin and glucagon directly into the bloodstream to regulate blood sugar. This dual function explains why pancreatic disease can affect digestion, blood sugar control, or both.

97. What is the functional unit of the kidney, responsible for filtering blood and forming urine?

Correct answer: The nephron

The nephron is the kidney's microscopic functional unit, containing the glomerulus and tubules that filter blood and form urine. Each kidney contains roughly a million nephrons — the ureter simply carries the finished urine to the bladder.

98. How many pairs of cranial nerves does the human body have?

Correct answer: 12

There are 12 pairs of cranial nerves, numbered I through XII, that arise directly from the brain rather than the spinal cord. This is distinct from the 31 pairs of spinal nerves, which branch from the spinal cord along its length.

99. Which heart valve sits between the right atrium and right ventricle?

Correct answer: Tricuspid valve

The tricuspid valve, named for its three cusps, separates the right atrium from the right ventricle. The mitral (bicuspid) valve performs the equivalent role on the left side, between the left atrium and left ventricle.

100. "Lipoma" uses the suffix -oma, which means:

Correct answer: Tumor or mass

The suffix -oma means tumor or mass, so lipoma is a benign fatty tumor (lip/o- = fat). This differs from -itis (inflammation) and -osis (abnormal condition), two suffixes it's frequently confused with on exam distractor lists.

Compliance & HIPAA

101. Which of the following is NOT a covered entity under HIPAA?

Correct answer: A patient's employer

HIPAA's covered entities are health plans, healthcare clearinghouses, and providers who transmit health information electronically. An employer acting as an employer is not a covered entity — even one that sponsors a health plan is only covered with respect to the plan itself.

102. The HIPAA "minimum necessary" standard requires that a coder:

Correct answer: Access only the protected health information needed for the coding task

Minimum necessary means using, accessing, and disclosing only the PHI required for the task at hand. Coders legitimately need clinical documentation to code — but browsing records beyond the job's need, even inside the organization, violates the standard.

103. A breach of unsecured PHI affects 600 individuals. Under the Breach Notification Rule, the covered entity must notify:

Correct answer: Affected individuals, HHS within 60 days, and prominent local media

Breaches affecting 500 or more individuals trigger the full notification set: the individuals and HHS without unreasonable delay (no later than 60 days), plus prominent media serving the state or jurisdiction. Breaches under 500 may be logged and reported to HHS annually instead.

104. A coworker with no role in the patient's care asks you to look up a local celebrity's lab results "out of curiosity." You should:

Correct answer: Refuse — accessing PHI without a job-related need violates HIPAA

Working for a covered entity does not authorize access — every access must serve treatment, payment, operations, or another permitted purpose. Curiosity snooping is one of the most commonly disciplined HIPAA violations, and audit trails make it easy to detect.

105. Reporting a higher-level E/M code than the documentation supports in order to increase reimbursement is called:

Correct answer: Upcoding

Upcoding is billing a higher-paying code than the service documented — fraud under the False Claims Act when done knowingly. Unbundling splits a comprehensive code into parts, and downcoding is the reverse error, under-reporting the level provided.

106. Reporting the individual components of a procedure separately when a single comprehensive code exists is called _____, and Medicare's _____ edits are designed to catch it.

Correct answer: Unbundling; NCCI

Unbundling fragments one comprehensive service into multiple component codes for higher payment. The National Correct Coding Initiative (NCCI) procedure-to-procedure edits identify code pairs that should not be reported together. GPCI and RBRVS are payment-calculation concepts, not edits.

107. Which is an example of a compliant query to a physician?

Correct answer: "Temperature 39.2°C, WBC 18,000, positive blood cultures — can the clinical significance of these findings be specified?"

A compliant query presents the clinical indicators from the record and asks an open, non-leading question. It never suggests a specific diagnosis, mentions reimbursement impact, or pressures the provider — options A, C, and D each fail at least one of those tests.

108. A billing service performs coding and claims submission on behalf of a physician practice, requiring access to PHI. Under HIPAA, this billing service is a:

Correct answer: A business associate, which must sign a BAA with the practice

A business associate is a person or entity that performs functions involving PHI on behalf of a covered entity, such as billing or coding services. HIPAA requires a written business associate agreement spelling out how that PHI will be protected before access is granted.

109. Under HIPAA, a covered entity may use and disclose PHI without patient authorization for which purposes?

Correct answer: Treatment, payment, and healthcare operations (TPO)

HIPAA permits PHI to be used and disclosed without specific patient authorization for treatment, payment, and healthcare operations — the routine functions that keep care and billing running. Most other uses, including marketing, require the patient's written authorization first.

110. What is the purpose of a covered entity's Notice of Privacy Practices (NPP)?

Correct answer: To inform patients how their PHI may be used and their privacy rights

The NPP is a required HIPAA document that explains to patients how their health information may be used and disclosed and lays out their privacy rights, including the right to request restrictions and to file a complaint. Covered entities must provide it at the first service delivery and post it prominently.

111. Under the HIPAA Privacy Rule's right of access, how quickly must a covered entity generally provide a patient with a copy of their requested medical records?

Correct answer: Within 30 days, with one permissible 30-day extension

Patients have the right to access and obtain a copy of their own PHI, and covered entities generally must comply within 30 days, with one 30-day extension allowed if they notify the patient in writing of the reason. Charging more than a reasonable, cost-based fee for the copy can itself violate the rule.

112. Which HIPAA-compliant method allows health information to be considered de-identified so it's no longer regulated as PHI?

Correct answer: Safe Harbor removal of all 18 identifiers, or Expert Determination

De-identification under HIPAA can be achieved by Safe Harbor, stripping all 18 listed identifiers (name, dates, geographic detail smaller than a state, and so on), or by Expert Determination, where a qualified statistician certifies the re-identification risk is very small. Removing only the name does not meet either standard.

113. The HIPAA Security Rule requires covered entities to implement which categories of safeguards for electronic PHI?

Correct answer: Administrative, physical, and technical safeguards

The Security Rule organizes required protections for electronic PHI into three categories: administrative (policies, training, risk assessments), physical (facility access controls, workstation security), and technical (access controls, audit logs, encryption). All three categories work together to protect ePHI.

114. Under the HIPAA Security Rule, encryption of electronic PHI is generally classified as which type of implementation specification?

Correct answer: Addressable — implement it, an equivalent alternative, or document why not

Most encryption requirements under the Security Rule are "addressable," meaning the covered entity must assess whether the safeguard is reasonable and appropriate, implement it or an equivalent alternative measure, or document the justification for not implementing it — addressable does not mean optional.

115. The federal False Claims Act allows a private individual with knowledge of fraud against the government to file suit on the government's behalf and potentially share in the recovery. This is called:

Correct answer: A qui tam action

A qui tam action lets a whistleblower (relator) sue on behalf of the government under the False Claims Act and, if the case succeeds, receive a percentage of the funds recovered. Many major healthcare fraud settlements originate from qui tam suits filed by employees who spotted the billing pattern.

116. The Anti-Kickback Statute prohibits which of the following?

Correct answer: Remuneration intended to induce or reward federal-program referrals

The Anti-Kickback Statute makes it a crime to exchange anything of value intended to induce or reward referrals of federally reimbursable business — a free EMR system in exchange for referrals is a textbook violation. It requires intent, unlike the Stark Law, which imposes strict liability regardless of intent.

117. How does the Stark Law (physician self-referral law) differ from the Anti-Kickback Statute?

Correct answer: Stark is strict liability for self-referral; Anti-Kickback requires intent

The Stark Law bars a physician from referring Medicare patients for certain designated health services to an entity with which the physician (or an immediate family member) has a financial relationship, unless an exception applies — and it is strict liability, meaning intent to defraud doesn't need to be proven. The Anti-Kickback Statute, by contrast, requires proof of intent to induce referrals.

118. According to OIG guidance, an effective compliance program for a physician practice should include which of the following elements?

Correct answer: Written policies, a compliance officer, training, auditing, and response

OIG's compliance program guidance for physician practices outlines core elements including written standards, a compliance officer, ongoing education, internal monitoring and auditing, open lines of communication for reporting concerns, and consistent enforcement with corrective action when problems are found.

119. How does healthcare fraud differ from healthcare abuse?

Correct answer: Fraud is intentional deception; abuse may not require proof of intent

Fraud requires proving intentional deception — knowingly billing for services not rendered, for example — while abuse describes practices that result in unnecessary costs or payments, such as overusing services, without necessarily proving deliberate intent. Both are targeted by compliance programs, but they carry different legal consequences.

120. An employee reports suspected billing fraud internally through the compliance hotline. Federal law generally protects that employee from which of the following?

Correct answer: Retaliation, such as termination, for a good-faith report

Whistleblower protections, including provisions under the False Claims Act, prohibit an employer from retaliating against an employee for making a good-faith report of suspected fraud. This protection is part of why a strong internal reporting culture and clear anti-retaliation policy matter for a compliance program.

121. Does the HIPAA "minimum necessary" standard apply to disclosures made for treatment purposes between providers?

Correct answer: No — it does not apply to disclosures for treatment

HIPAA specifically excludes treatment-related disclosures from the minimum necessary standard, recognizing that a treating provider may legitimately need the full record to safely care for a patient. Minimum necessary still applies to most payment and operations disclosures, and to a coder's own routine access to records.

122. Which type of PHI requires a specific, separate written patient authorization before disclosure, beyond the general TPO permissions?

Correct answer: Psychotherapy notes and PHI used for marketing purposes

Psychotherapy notes and most uses of PHI for marketing require a specific written authorization from the patient beyond the general treatment/payment/operations permissions — these categories carry heightened protection under the Privacy Rule because of their sensitivity or the risk of misuse.

123. Under the HITECH Act, business associates are:

Correct answer: Directly liable for applicable HIPAA provisions, as are their subcontractors

HITECH extended direct legal liability for HIPAA compliance to business associates, not just covered entities, and business associates must also ensure their own subcontractors meet the same requirements through downstream agreements. Before HITECH, a business associate's obligations existed only through contract, not through direct statutory liability.

124. Which HIPAA Security Rule safeguard requires covered entities to regularly review system activity, such as audit logs, to detect inappropriate access to ePHI?

Correct answer: Information system activity review

Regular review of information system activity — audit logs, access reports, and security incident tracking — is an administrative safeguard under the Security Rule, and it's exactly the kind of review that catches incidents like a coworker snooping on a celebrity's chart. Facility access and workstation controls are physical safeguards, a different category.

125. Under the HIPAA right of access, a patient may direct a covered entity to send their records:

Correct answer: Directly to a third party the patient designates, in the requested format

The HIPAA right of access lets a patient direct the covered entity to transmit a copy of their PHI directly to a person or entity they name, in the format they request if it's readily producible — the same 30-day (plus one 30-day extension) timeline and reasonable cost-based fee limits apply as for a request made by the patient themselves.

Billing & Reimbursement

126. Under the resource-based relative value scale (RBRVS), the three components of a relative value unit (RVU) are:

Correct answer: Physician work, practice expense, and malpractice expense

Every RVU is built from physician work, practice expense, and malpractice (professional liability) expense. Base/time/modifying units are the anesthesia formula — a favorite distractor. Geography enters later through the GPCI adjustment, not as an RVU component.

127. How is payment calculated under the Medicare Physician Fee Schedule?

Correct answer: RVUs adjusted by GPCI, multiplied by the conversion factor

Each code's RVU components are adjusted for locality using the GPCIs, summed, and multiplied by the annual conversion factor to produce the fee. Percentage-of-charges is how some commercial contracts work, and MS-DRG math pays hospitals, not physicians.

128. The condition established after study to be chiefly responsible for occasioning the patient's admission to the hospital is the definition of:

Correct answer: The principal diagnosis

That is the UHDDS definition of principal diagnosis, word for word — and "after study" is the phrase to anchor on: it can differ from the admitting diagnosis, which is only what was suspected at admission. The principal diagnosis

drives MS-DRG assignment for inpatient payment.

129. Under Medicare's Outpatient Prospective Payment System (OPPS), services are grouped for payment into:

Correct answer: Ambulatory Payment Classifications (APCs)

OPPS pays hospital outpatient services through APCs. MS-DRGs pay inpatient stays under IPPS, while RUGs/PDPM apply to skilled nursing facilities and HHRGs to home health — each payment system pairs with its own setting.

130. Which claim form does a physician practice use to bill professional services?

Correct answer: CMS-1500

Professional (physician and supplier) claims go on the CMS-1500; institutional claims from hospitals and facilities go on the UB-04, also called the CMS-1450. The CMS-855 is a provider enrollment form and the ABN is a beneficiary notice, not a claim.

131. Which part of Medicare covers physician services and most outpatient care?

Correct answer: Part B

Part B covers physician services, outpatient care, and DME. Part A covers inpatient hospital, SNF, and hospice; Part C (Medicare Advantage) is the private-plan alternative bundling A and B; Part D covers prescription drugs.

132. A Medically Unlikely Edit (MUE) defines:

Correct answer: The maximum units of a service reported per beneficiary per date of service

An MUE is the maximum number of units of a single code one provider would report for one patient on one day under normal circumstances — for example, more than one unit of an appendectomy fails the edit. Code-pair restrictions are NCCI procedure-to-procedure edits, a separate mechanism.

133. Which part of Medicare covers inpatient hospital stays, skilled nursing facility care, and hospice?

Correct answer: Part A

Part A covers inpatient hospital, skilled nursing facility (following a qualifying hospital stay), and hospice care. Part B covers physician services and most outpatient care, and most beneficiaries pay no premium for Part A if they or a spouse paid Medicare payroll taxes long enough.

134. A beneficiary enrolls in a private plan that bundles Medicare Part A and Part B coverage, often adding extra benefits. This is:

Correct answer: Medicare Advantage (Part C)

Medicare Part C, branded as Medicare Advantage, is the private-plan alternative to Original Medicare, bundling Part A and Part B (and often Part D) coverage, frequently with additional benefits like vision or dental. It's distinct from Medigap, which is supplemental insurance that works alongside Original Medicare, not a replacement for it.

135. Which part of Medicare covers outpatient prescription drugs?

Correct answer: Part D

Part D covers outpatient prescription drugs, offered through private plans that contract with Medicare. Part B does cover certain drugs administered in a clinical setting, such as injectable chemotherapy, but retail prescription drugs are a Part D benefit.

136. Under the inpatient prospective payment system, what two factors most directly increase an MS-DRG's relative weight for a given admission?

Correct answer: Documented CCs or MCCs that increase the resources required

A documented CC or MCC — a secondary diagnosis that reflects added severity and resource use, such as acute respiratory failure as an MCC — shifts the case into a higher-weighted MS-DRG, increasing the hospital's payment for that stay. This is why complete, specific secondary diagnosis documentation matters so much for inpatient coding accuracy.

137. A patient is covered by two health plans: their own employer plan and their spouse's employer plan. General coordination-of-benefits rules determine which plan pays first. This determination is called identifying the:

Correct answer: Primary and secondary payer

Coordination of benefits rules establish which plan is the primary payer (pays first, up to its benefit limits) and which is secondary (pays some or all of the remaining balance). For dependent children covered by both parents' plans, the common tiebreaker is the "birthday rule": the parent whose birthday falls earlier in the calendar year holds the primary plan.

138. A claim submitted with all required, accurate data elements needed for the payer to process it without additional documentation is called a:

Correct answer: Clean claim

A clean claim contains all the correct, complete information the payer needs to adjudicate it without requesting more documentation or clarification — errors or missing data instead trigger a rejection or request for information, delaying payment.

139. A payer requires claims to be submitted within a set number of days from the date of service, or the claim will be denied regardless of validity. This requirement is called the:

Correct answer: Timely filing limit

The timely filing limit is the payer-specific deadline for submitting a claim; missing it typically results in an automatic denial that isn't appealable on the merits, which is why tracking filing deadlines is a core revenue-cycle function.

140. After a payer processes a claim, it sends the provider a document detailing what was paid, adjusted, or denied and why. This document is the:

Correct answer: An Explanation of Benefits (EOB) or remittance advice

The EOB (sent to the patient) and ERA (sent electronically to the provider) both detail how a claim was adjudicated — what was billed, allowed, paid, and the patient's responsibility. They are the documents billing staff reconcile against posted payments to catch underpayments or denials.

141. A provider's billed charge for a service is $500. The payer's contracted allowed amount is $350, which it pays in full minus the patient's $50 copay. What happens to the remaining $150 difference between billed charge and allowed amount?

Correct answer: It is written off as a contractual adjustment by the provider

In a network contract, the provider agrees to accept the payer's allowed amount as payment in full for covered services, so the difference between the higher billed charge and the lower allowed amount is written off as a contractual adjustment — not billed to the patient (except through non-network balance billing, where allowed).

142. Which term describes the fixed dollar amount a patient pays for a covered service at the time of the visit, regardless of the total charge?

Correct answer: Copayment

A copayment is a flat, fixed amount (such as $30 for an office visit) paid at the time of service. A deductible is the amount the patient must pay out of pocket before the plan starts paying, and coinsurance is a percentage split of

costs after the deductible is met — three distinct patient-responsibility concepts that are easy to mix up.

143. A patient's plan requires them to pay 20% of the allowed amount for a service after their deductible has been met, with the plan paying the remaining 80%. This 20% is the patient's:

Correct answer: Coinsurance

Coinsurance is the percentage split of cost-sharing between the patient and the plan after the deductible is satisfied — commonly 80/20 or 70/30. It differs from a copayment, which is a flat dollar amount rather than a percentage.

144. Under a capitation payment model, a primary care provider is paid:

Correct answer: A fixed amount per enrolled patient per period

Capitation pays a provider a set amount per assigned patient per month (or other period), regardless of how much or how little care that patient actually uses, shifting financial risk toward the provider. This contrasts with fee-for-service, which pays for each individual service delivered.

145. How does a bundled (episode-based) payment model differ from traditional fee-for-service?

Correct answer: One payment covers all services in an episode of care

Bundled payment covers an entire episode of care — such as a hip replacement and its related pre- and post-operative services — with one payment, incentivizing efficient, coordinated care. Fee-for-service, by contrast, pays separately for each individual service, which can reward volume over efficiency.

146. Every healthcare provider who submits electronic claims is required to obtain which unique identifier?

Correct answer: A National Provider Identifier (NPI)

The National Provider Identifier is a unique 10-digit number assigned to healthcare providers and used on all HIPAA-covered electronic transactions, including claims. A DEA number is specific to prescribing controlled substances, and CLIA certification is specific to performing laboratory testing — different identifiers for different purposes.

147. A physician office wants to bill Medicare for a rapid strep test performed in-house. Which requirement must the office meet before billing for that laboratory test?

Correct answer: A CLIA certificate appropriate to the test's complexity

The Clinical Laboratory Improvement Amendments (CLIA) require any facility performing even simple in-house lab testing to hold a CLIA certificate matching the complexity of the tests performed; billing for lab work without one risks denial and compliance exposure.

148. A payer requires the provider to obtain approval before performing a costly elective procedure, or the claim may be denied even if medically necessary. This requirement is called:

Correct answer: Prior authorization

Prior authorization requires the provider to get the payer's approval before performing certain services, confirming in advance that the plan will consider them covered. Skipping this step, even for a medically necessary service, is a common and preventable cause of claim denial.

149. A patient is eligible for both Medicare and Medicaid. After Medicare processes the claim, the remaining balance is automatically forwarded to Medicaid without the provider submitting a separate claim. This is called a:

Correct answer: Crossover claim

A crossover claim automatically transfers Medicare's adjudication data to Medicaid (or a supplemental payer) for dual-eligible beneficiaries, so the provider doesn't have to file a separate claim with the secondary payer. This

coordination reduces administrative burden for practices serving dual-eligible patients.

150. Which two-digit code on a CMS-1500 claim tells the payer where the service was rendered, such as office versus inpatient hospital?

Correct answer: Place of service (POS) code

The place of service code (for example, POS 11 for office, POS 21 for inpatient hospital) tells the payer the setting where a service occurred, which affects payment because many codes are reimbursed differently in a facility versus a non-facility setting. Revenue codes and type-of-bill codes are used on the institutional UB-04 claim, not the professional CMS-1500.