Final CPC Mock Exam

100-question comprehensive practice exam

Name: _____ Date: _____

Score (instructor): _____ / 100 Practice time: 4 hours

Choose the best answer for each question. Mark one choice per question. Each question is worth 1 point.

1. The suffix “-ectomy” means:

[ ] A. Surgical repair
[ ] B. Surgical removal
[ ] C. Incision into
[ ] D. Visual examination

2. The prefix “brady-” means:

[ ] A. Fast
[ ] B. Slow
[ ] C. Above
[ ] D. Around

3. Proximal describes a structure that is:

[ ] A. Farther from the point of attachment
[ ] B. Nearer the point of attachment
[ ] C. Toward the back
[ ] D. Toward the midline only

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

[ ] A. Coronal
[ ] B. Transverse
[ ] C. Sagittal
[ ] D. Oblique

5. What is the outermost layer of the skin?

[ ] A. Dermis
[ ] B. Epidermis
[ ] C. Fascia
[ ] D. Periosteum

6. Which bone is the longest in the human body?

[ ] A. Humerus
[ ] B. Tibia
[ ] C. Femur
[ ] D. Radius

7. The mitral valve lies between the:

[ ] A. Right atrium and right ventricle
[ ] B. Left atrium and left ventricle
[ ] C. Left ventricle and aorta
[ ] D. Right ventricle and pulmonary artery

8. The functional unit of the kidney is the:

[ ] A. Alveolus
[ ] B. Neuron
[ ] C. Nephron
[ ] D. Osteon

9. Which structure is part of the small intestine?

[ ] A. Sigmoid colon
[ ] B. Cecum
[ ] C. Ileum
[ ] D. Rectum

10. Which organ has both endocrine and exocrine functions?

[ ] A. Spleen
[ ] B. Pancreas
[ ] C. Gallbladder
[ ] D. Appendix

11. In outpatient coding, a diagnosis documented as “rule out pneumonia” is reported as:

[ ] A. Pneumonia
[ ] B. The signs and symptoms
[ ] C. A history code
[ ] D. No diagnosis

12. The first-listed diagnosis in an outpatient encounter is generally the condition:

[ ] A. With the highest reimbursement
[ ] B. Chiefly responsible for the services provided
[ ] C. Listed last in the note
[ ] D. With the shortest code

13. An Excludes1 note generally indicates that:

[ ] A. The excluded condition is always coded first
[ ] B. The two conditions should not be coded together
[ ] C. The code requires a 7th character
[ ] D. The code is exempt from POA

14. A “code first” note directs the coder to:

[ ] A. Sequence the underlying condition before the manifestation
[ ] B. Use only a symptom code
[ ] C. Add an external cause code first
[ ] D. Ignore the Tabular List

15. For most injury codes, 7th character D identifies:

[ ] A. Initial active treatment
[ ] B. Subsequent encounter for routine healing
[ ] C. Sequela
[ ] D. Screening

16. The letter X is used in some ICD-10-CM codes as a:

[ ] A. Decimal
[ ] B. Placeholder
[ ] C. Laterality marker
[ ] D. POA indicator

17. For a sequela of an injury, which is generally sequenced first?

[ ] A. The original acute injury code
[ ] B. The residual condition
[ ] C. An external cause status code
[ ] D. A screening code

18. When laterality is documented and available in the code set, the coder should:

[ ] A. Use an unspecified-side code
[ ] B. Assign the side-specific code
[ ] C. Report both sides automatically
[ ] D. Omit the diagnosis

19. Can a Z code be first-listed?

[ ] A. Never
[ ] B. Yes, when the circumstances of the encounter support it
[ ] C. Only for inpatients
[ ] D. Only with modifier 25

20. External cause codes:

[ ] A. Replace the injury diagnosis
[ ] B. Provide details about how an injury occurred
[ ] C. Are CPT procedure codes
[ ] D. Establish medical necessity alone

21. A diabetes combination code may capture:

[ ] A. Diabetes and a documented complication
[ ] B. Only insulin use
[ ] C. Only family history
[ ] D. A surgical procedure

22. When hypertension and chronic kidney disease are both documented, ICD-10-CM generally:

[ ] A. Requires the physician to explicitly link them in every case
[ ] B. Presumes a causal relationship unless documented otherwise
[ ] C. Prohibits coding both
[ ] D. Uses only a symptom code

23. When acute and chronic forms of the same condition are documented and separate codes exist, the coder generally reports:

[ ] A. Only the chronic code
[ ] B. Both, with the acute code sequenced first
[ ] C. Only the symptom
[ ] D. An unspecified code

24. For an inpatient admission, the principal diagnosis is the condition established after study to be:

[ ] A. Present for the longest time
[ ] B. Chiefly responsible for the admission
[ ] C. Most expensive to treat
[ ] D. Listed first in the history

25. Outpatient diagnosis coding is based on:

[ ] A. Possible conditions only
[ ] B. The highest degree of certainty known for that encounter
[ ] C. DRG assignment
[ ] D. The surgeon's preference

26. A symptom routinely associated with a confirmed diagnosis is generally:

[ ] A. Always separately reported
[ ] B. Not separately reported unless instructed
[ ] C. Sequenced first
[ ] D. Reported as an external cause

27. Words in parentheses in the Alphabetic Index are:

[ ] A. Mandatory fifth characters
[ ] B. Nonessential modifiers
[ ] C. Excludes notes
[ ] D. Placeholders

28. NEC means:

[ ] A. No established code
[ ] B. Not elsewhere classified
[ ] C. New encounter code
[ ] D. Not enough characters

29. NOS means:

[ ] A. Not otherwise specified
[ ] B. No outpatient service
[ ] C. New-onset symptom
[ ] D. Not on system

30. A manifestation code with “in diseases classified elsewhere” is generally:

[ ] A. Sequenced first
[ ] B. Not permitted as principal or first-listed
[ ] C. Used without the underlying disease
[ ] D. A procedure code

31. A screening encounter is performed when a person:

[ ] A. Has signs of the disease
[ ] B. Has no signs or symptoms and is tested for early detection
[ ] C. Is receiving treatment
[ ] D. Has completed treatment and is checked for recurrence

32. A follow-up code is appropriate when:

[ ] A. Treatment is complete and surveillance is occurring
[ ] B. The disease is actively treated
[ ] C. A symptom is undiagnosed
[ ] D. An injury receives active treatment

33. A personal history code indicates that the condition:

[ ] A. Is currently active
[ ] B. No longer exists but may affect care
[ ] C. Is only suspected
[ ] D. Is congenital

34. For a preoperative evaluation, the coder commonly reports the preprocedural examination code and:

[ ] A. Nothing else
[ ] B. The condition or reason for the surgery
[ ] C. Only an external cause code
[ ] D. A sequela code

35. A fracture patient returning for routine healing during the recovery phase generally uses 7th character:

[ ] A. A
[ ] B. D
[ ] C. S
[ ] D. X

36. When no specific CPT code accurately describes a service, report:

[ ] A. The closest higher-paying code
[ ] B. An appropriate unlisted code
[ ] C. No code
[ ] D. A diagnosis code instead

37. An add-on code:

[ ] A. May be reported alone
[ ] B. Is reported with an appropriate primary code
[ ] C. Always requires modifier 51
[ ] D. Is a diagnosis code

38. A procedure designated “separate procedure” is usually:

[ ] A. Always separately reported
[ ] B. Bundled when integral to a more extensive related service
[ ] C. Exempt from documentation
[ ] D. A HCPCS Level II code

39. Modifier 25 is appended to:

[ ] A. A significant, separately identifiable E/M service on the same day as another service
[ ] B. A bilateral surgery
[ ] C. A technical component
[ ] D. An assistant surgeon service

40. Modifier 59 indicates:

[ ] A. A staged procedure
[ ] B. A distinct procedural service when supported
[ ] C. A reduced service
[ ] D. A professional component

41. Modifier 51 is associated with:

[ ] A. Multiple procedures
[ ] B. Anesthesia physical status
[ ] C. A repeat lab test
[ ] D. A left-sided service

42. Modifier 50 reports:

[ ] A. A bilateral procedure
[ ] B. A repeat procedure
[ ] C. A discontinued procedure
[ ] D. An unrelated postoperative service

43. Which modifier identifies the right side?

[ ] A. LT
[ ] B. RT
[ ] C. TC
[ ] D. 26

44. A new patient generally has not received professional services from the same physician/QHP, or same specialty in the same group, within:

[ ] A. 12 months
[ ] B. 24 months
[ ] C. 36 months
[ ] D. 60 months

45. Office/outpatient E/M medical decision making requires meeting:

[ ] A. One of three elements
[ ] B. Two of three elements
[ ] C. All three elements
[ ] D. Time only

46. When office/outpatient E/M is selected by time, the relevant time is generally:

[ ] A. Only face-to-face time
[ ] B. Total physician/QHP time on the date of the encounter
[ ] C. Staff time for the week
[ ] D. Travel time

47. Emergency department E/M categories distinguish patients as:

[ ] A. New or established
[ ] B. They do not use the new/established distinction
[ ] C. Inpatient only
[ ] D. Preventive only

48. Critical care is based primarily on:

[ ] A. Room location alone
[ ] B. Critical illness/injury, high-complexity decision making, and time
[ ] C. Patient age only
[ ] D. A specific diagnosis list only

49. Anesthesia reimbursement calculations commonly include:

[ ] A. Base units and time units
[ ] B. Only room charges
[ ] C. Only supplies
[ ] D. DRG weight only

50. Physical-status modifier P3 describes a patient with:

[ ] A. Normal health
[ ] B. Mild systemic disease
[ ] C. Severe systemic disease
[ ] D. A declared brain death

51. Qualifying-circumstance anesthesia codes are generally:

[ ] A. Primary stand-alone services
[ ] B. Add-on codes
[ ] C. Diagnosis codes
[ ] D. E/M codes

52. The excised diameter of a skin lesion is based on:

[ ] A. Lesion size only
[ ] B. Lesion diameter plus the narrowest margins
[ ] C. Incision length
[ ] D. Pathology size after shrinkage

53. A layered closure of subcutaneous tissue and skin is generally classified as:

[ ] A. Simple
[ ] B. Intermediate
[ ] C. Always complex
[ ] D. Unlisted

54. Debridement code selection is driven primarily by:

[ ] A. Wound color
[ ] B. Deepest tissue removed and total surface area
[ ] C. Patient age
[ ] D. Anesthesia type

55. A biopsy followed by complete excision of the same lesion at the same session is generally:

[ ] A. Reported as both services
[ ] B. Reported as the definitive excision only
[ ] C. Never coded
[ ] D. Reported with modifier 50

56. Routine postoperative care included in the global surgical package is:

[ ] A. Separately reported with every visit
[ ] B. Included in the procedure payment
[ ] C. Reported with modifier 59
[ ] D. A diagnosis-only service

57. Closed treatment of a fracture means:

[ ] A. The fracture site is surgically opened
[ ] B. The fracture is treated without surgically exposing the fracture site
[ ] C. No manipulation may occur
[ ] D. No immobilization is used

58. A surgical arthroscopy generally includes:

[ ] A. The diagnostic arthroscopy
[ ] B. Every unrelated open procedure
[ ] C. Postoperative physical therapy
[ ] D. Anesthesia by another provider

59. When the same physician provides definitive fracture care, the initial cast application is generally:

[ ] A. Included
[ ] B. Always separately reported
[ ] C. Reported as DME
[ ] D. Reported with modifier 26

60. A bronchoscopy examines the:

[ ] A. Colon
[ ] B. Airways
[ ] C. Bladder
[ ] D. Uterus

61. Modifier 26 identifies the:

[ ] A. Technical component
[ ] B. Professional component
[ ] C. Bilateral component
[ ] D. Repeat component

62. A pacemaker system includes a pulse generator and:

[ ] A. One or more leads
[ ] B. A coronary bypass graft
[ ] C. A prosthetic valve only
[ ] D. An external splint

63. A surgical endoscopy generally includes:

[ ] A. The related diagnostic endoscopy
[ ] B. An unrelated E/M service
[ ] C. All pathology services
[ ] D. All future surveillance

64. A colonoscopy advanced to the cecum is generally considered:

[ ] A. Complete
[ ] B. A sigmoidoscopy
[ ] C. An EGD
[ ] D. Incomplete

65. EGD examines the esophagus, stomach, and:

[ ] A. Duodenum
[ ] B. Colon
[ ] C. Rectum
[ ] D. Bladder

66. Cystoscopy is an endoscopic examination of the:

[ ] A. Bladder
[ ] B. Stomach
[ ] C. Lung
[ ] D. Knee

67. A global obstetric package may include:

[ ] A. Antepartum, delivery, and postpartum services
[ ] B. Newborn care only
[ ] C. Anesthesia only
[ ] D. Laboratory services only

68. A decompression procedure is intended to:

[ ] A. Relieve pressure on a neural structure
[ ] B. Replace a lens
[ ] C. Remove the appendix
[ ] D. Measure pulmonary function

69. Cataract surgery addresses the eye's:

[ ] A. Clouded lens
[ ] B. Optic nerve only
[ ] C. Lacrimal gland only
[ ] D. Retinal vessel only

70. Modifier TC identifies the:

[ ] A. Professional component
[ ] B. Technical component
[ ] C. Team surgery
[ ] D. Transfer of care

71. When one provider supplies both the equipment and interpretation for a radiology service, it may report:

[ ] A. Only modifier 26
[ ] B. Only modifier TC
[ ] C. The global service when payer rules allow
[ ] D. An anesthesia code

72. Radiologic guidance that is bundled into a procedure should be:

[ ] A. Separately reported anyway
[ ] B. Not separately reported
[ ] C. Reported with modifier 25
[ ] D. Replaced by a diagnosis code

73. A CPT laboratory panel is reported when:

[ ] A. At least one listed test is performed
[ ] B. All tests required by the panel descriptor are performed
[ ] C. The patient requests it
[ ] D. No order exists

74. Modifier 91 is used for:

[ ] A. A repeat clinical diagnostic laboratory test
[ ] B. A bilateral procedure
[ ] C. An unrelated postoperative service
[ ] D. A technical component

75. Vaccine administration is generally:

[ ] A. Included in the vaccine product code
[ ] B. Reported separately from the vaccine product
[ ] C. Never reported
[ ] D. A diagnosis code

76. A global ECG service includes:

[ ] A. Tracing only
[ ] B. Interpretation only
[ ] C. Tracing plus interpretation and report
[ ] D. Only supplies

77. For timed therapy codes, units are based on:

[ ] A. Documented qualifying treatment time
[ ] B. Appointment length only
[ ] C. Patient age
[ ] D. Diagnosis count

78. Hydration is not separately reported when it is performed only to:

[ ] A. Treat dehydration
[ ] B. Facilitate administration of another drug
[ ] C. Provide medically necessary fluid replacement
[ ] D. Treat fluid loss

79. A diagnostic test interpretation requires:

[ ] A. A separate, complete report when required
[ ] B. Only a signature
[ ] C. A diagnosis code only
[ ] D. No documentation

80. HCPCS Level II commonly identifies:

[ ] A. Diagnoses
[ ] B. Drugs, supplies, DME, and ambulance services
[ ] C. Hospital DRGs
[ ] D. Anatomy terms

81. To calculate drug billing units, compare the administered dose with:

[ ] A. The diagnosis code
[ ] B. The amount in the HCPCS descriptor
[ ] C. The patient's age only
[ ] D. The NCCI table only

82. DME stands for:

[ ] A. Direct medical examination
[ ] B. Durable medical equipment
[ ] C. Diagnostic management edit
[ ] D. Drug measurement equivalent

83. An Advance Beneficiary Notice is used in applicable Medicare situations to:

[ ] A. Notify the patient of expected noncoverage before the service
[ ] B. Guarantee payment
[ ] C. Replace documentation
[ ] D. Authorize fraud

84. NCCI edits primarily help prevent:

[ ] A. Improper code combinations and unbundling
[ ] B. Diagnosis sequencing
[ ] C. Credentialing delays
[ ] D. Book updates

85. The False Claims Act addresses:

[ ] A. Knowingly submitting false claims to the government
[ ] B. Only appointment scheduling
[ ] C. Anatomy education
[ ] D. Code-book publishing

86. HIPAA's minimum necessary principle generally requires:

[ ] A. Using or disclosing only the PHI reasonably needed
[ ] B. Sharing the entire chart every time
[ ] C. Never sharing PHI for treatment
[ ] D. Deleting all documentation

87. Medical necessity means a service is:

[ ] A. Appropriate and supported for the patient's condition
[ ] B. Always covered if coded
[ ] C. Selected for higher payment
[ ] D. Unrelated to documentation

88. An MUE is a payer edit concerning:

[ ] A. The likely maximum units of service for a code
[ ] B. Diagnosis laterality
[ ] C. Provider licensure
[ ] D. Medical terminology

89. An LCD is issued by a:

[ ] A. Medicare Administrative Contractor
[ ] B. Patient
[ ] C. Medical dictionary publisher
[ ] D. State licensing board only

90. If documentation does not support a higher service level, the coder should:

[ ] A. Report it anyway
[ ] B. Query when appropriate or code only what is supported
[ ] C. Change the note
[ ] D. Choose the most expensive code

91. An established office patient has a separately identifiable E/M service and a minor procedure on the same date. Which modifier may apply to the E/M code?

[ ] A. 25
[ ] B. 50
[ ] C. TC
[ ] D. 91

92. A physician interprets an x-ray performed on equipment owned by another entity. Which modifier belongs on the radiology code?

[ ] A. TC
[ ] B. 26
[ ] C. 59
[ ] D. 51

93. A lesion measures 1.0 cm and is excised with 0.2-cm margins on each side. What is the excised diameter?

[ ] A. 1.0 cm
[ ] B. 1.2 cm
[ ] C. 1.4 cm
[ ] D. 2.0 cm

94. A patient returns during fracture healing for a cast check with no new active treatment. Which injury 7th character generally applies?

[ ] A. A
[ ] B. D
[ ] C. S
[ ] D. X

95. The physician documents “probable influenza” in an urgent-care outpatient note. The patient has fever and cough. What is coded?

[ ] A. Influenza as confirmed
[ ] B. The fever and cough
[ ] C. No diagnosis
[ ] D. A history of influenza

96. A laboratory repeats the same medically necessary glucose test later the same day to monitor the patient. Which modifier may apply?

[ ] A. 91
[ ] B. 25
[ ] C. 50
[ ] D. RT

97. A bilateral eligible procedure is performed on paired organs during the same session. Which modifier may be appropriate?

[ ] A. 26
[ ] B. 50
[ ] C. 52
[ ] D. 79

98. The patient receives 20 mg of a drug whose HCPCS descriptor represents 10 mg per unit. How many units are reported?

[ ] A. 1
[ ] B. 2
[ ] C. 10
[ ] D. 20

99. A surgeon performs a diagnostic arthroscopy and then a surgical arthroscopy in the same joint. How is the diagnostic scope handled?

[ ] A. Reported separately with modifier 59
[ ] B. Included in the surgical arthroscopy
[ ] C. Reported as an E/M service
[ ] D. Reported with modifier 50

100. All tests listed in a CPT organ/disease-oriented panel are performed. The most appropriate reporting is generally:

[ ] A. The panel code
[ ] B. Every component plus the panel
[ ] C. Only the highest-priced test
[ ] D. An unlisted code