CPC Practice Test #1

- 100 Full-Length Questions
- 4 Hours to Complete
- Have Questions? Explanations Included

Check out all 5 of our Full-Length Practice tests and our Practice Tool at medicalcodingace.com/practice.

Ready to get started?

Make sure you have your reference books:

- *CPT 2026 Professional Edition (AMA)*
- *ICD-10-CM Codebook (AMA)*
- *HCPCS Level II Codebook (AMA/AAPC)*

TEST BEGINS ON NEXT PAGE
ANSWER KEY AT END

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Welcome to *YOUR* practice test!

Whatever is the right way for you to take this test is the right way.

And remember to use your tabs, take breaks, and drink water. You got this!

Good luck!

Any questions, feedback, requests for the future, or corrections?

Send an email to medicalcodingace@gmail.com, and we'll get back to you right away!

If you had a good experience with our materials, let us know and we'll give you something to share with a friend!

TIMER START

4 HOURS

Section 1: Medical Terminology

4 Questions

1. Which combining form refers to the vertebrae (spinal bones)?

A. myel/o
B. spondyl/o
C. oste/o
D. arthr/o

2. A patient is diagnosed with polymyositis. Based on the word parts, what does this term mean?

A. Inflammation of one muscle
B. Inflammation of many muscles
C. Degeneration of muscle tissue
D. Pain in multiple joints

3. In the term thoracentesis, what does the suffix '-centesis' mean?

A. Surgical removal
B. Surgical puncture to remove fluid
C. Surgical fixation
D. Incision into

4. In a 2026 neurology report, the provider documents contralateral weakness of the left leg after a right-sided brain lesion. What does the term 'contralateral' mean in this context?

A. On the same side of the body as the lesion
B. On the opposite side of the body from the lesion
C. In front of the lesion
D. Behind the lesion

Section 2: Anatomy

4 Questions

5. Which organ is primarily responsible for filtering metabolic waste products from the blood?

A. Liver
B. Kidneys
C. Spleen
D. Pancreas

6. Which bone is classified as part of the axial skeleton?

A. Humerus
B. Femur
C. Sternum
D. Clavicle

7. Which chamber of the heart receives oxygenated blood returning from the lungs?

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

8. In a 2026 clinical neurovascular exam, documentation notes decreased sensation along the lateral aspect of the

forearm. Which nerve is primarily associated with sensory innervation in this region?

A. Ulnar nerve
B. Median nerve
C. Radial nerve
D. Musculocutaneous nerve

Section 3: Compliance & Regulatory

3 Questions

9. A coder accidentally views the wrong patient chart after mistyping an MRN. Which type of HIPAA incident has occurred?

A. Fraud
B. Unauthorized access
C. Improper disclosure
D. Security breach involving external hacking

10. A physician refers patients to an imaging center in which she has a financial interest. Under the Stark Law, what is the most important factor in determining whether this referral is prohibited?

A. Whether the services are medically necessary
B. Whether the financial relationship is properly disclosed and structured under an exception
C. Whether the patient requests the referral
D. Whether the imaging center offers discounted rates

11. Under the 2026 CMS final rule, which documentation element is newly required for telehealth E/M services delivered via audio-only technology?

A. A statement documenting patient identity verification by two identifiers
B. Documentation that no video option was available or clinically appropriate
C. Patient consent obtained in writing prior to the visit
D. A time-stamped transcript of the encounter

Section 4: Coding Guidelines

7 Questions

12. According to ICD-10-CM Official Guidelines, when coding an etiology/manifestation pair such as diabetic neuropathy, how should the codes be sequenced?

A. Manifestation code first, followed by the etiology
B. Etiology code first, followed by the manifestation
C. Either order is acceptable
D. Only the manifestation code is required

13. For 2026, CMS expanded mandatory reporting of certain Social Determinants of Health (SDOH) Z-codes. For which encounters must coders now assign at least one SDOH code when documented?

A. All inpatient encounters only
B. All emergency department, inpatient, and observation encounters
C. Primary care visits only
D. Encounters involving mental health diagnoses only

14. When a combination code fully describes a patient's condition, how should coders report related signs or symptoms?

A. They should always be reported in addition to the combination code
B. They should be reported only if the provider documented them explicitly
C. They should not be reported unless the symptom is not part of the combination code
D. They must be reported when present, regardless of coding rules

15. Which statement accurately reflects proper coding of a sequela?

A. The acute injury code is always listed first
B. The sequela code is reported first, followed by the original injury code with the S extension
C. Both acute and sequela codes may be reported together when the acute condition persists
D. Sequela codes are reported only for neurological complications

16. If both sides of a bilateral organ are affected and ICD-10-CM does not offer a bilateral option, what is the correct approach?

A. Report the left-side code only
B. Report the right-side code only
C. Report both right and left codes separately
D. Report an unspecified laterality code

17. Under the 2026 ICD-10-CM update, which postoperative condition now requires mandatory linkage using the new complication-guidance notes when the provider indicates the condition is due to the procedure?

A. Anemia following surgery
B. Postoperative constipation
C. Postprocedural musculoskeletal pain
D. Urinary retention after anesthesia

18. When coding sepsis due to a specific organism, how should the codes be sequenced?

A. Code the organism first, followed by sepsis
B. Code sepsis first, followed by the organism
C. Code only the organism
D. Code only the sepsis code

Section 5: ICD-10-CM Coding

5 Questions

19. A patient presents with type 2 diabetes mellitus with diabetic chronic kidney disease, stage 3b. Which ICD-10-CM code set is correct for this condition?

A. E11.22 and N18.32
B. E11.21 only
C. N18.32 only
D. E11.29 and N18.3

20. Under the 2026 ICD-10-CM updates, which code is now assigned when a patient is treated for persistent dyspnea attributable to prior COVID-19 infection?

A. U09.9
B. R06.02
C. B94.8
D. U09.2

21. A pregnant patient in her second trimester is diagnosed with gestational diabetes controlled by diet. What is the correct ICD-10-CM code?

A. O24.410
B. O24.415
C. O24.419

D. O24.420

22. A new 2026 guideline instructs coders to assign which code when a patient has documented severe cannabis use disorder with cannabis-induced psychosis?

A. F12.950
B. F12.259
C. F12.151
D. F12.109

23. A patient presents with a displaced fracture of the shaft of the left radius, initial encounter for closed fracture. Which code is correct?

A. S52.302A
B. S52.322A
C. S52.202A
D. S52.252A

Section 6: HCPCS Level II Coding

3 Questions

24. A patient with chronic obstructive pulmonary disease (COPD) requires a portable oxygen concentrator for continuous use. Which HCPCS Level II code is appropriate?

A. E0431
B. E0434
C. E1390
D. E1405

25. A new 2026 vaccine code was introduced for the adult RSV (respiratory syncytial virus) booster, adjuvanted, administered intramuscularly. Which HCPCS Level II code corresponds to the 2026 update?

A. G0342
B. Q0221
C. Q0222
D. Q0225

26. A patient is prescribed a semi-rigid lumbosacral orthosis (LSO) to support lumbar instability. Which HCPCS Level II code is correct?

A. L0650
B. L0625

C. L0637
D. L0648

Section 7: CPT 10000 (Integumentary)

6 Questions

27. The provider performs an incision and drainage of a simple cutaneous abscess on the left forearm. Which CPT code is appropriate?

A. 10061
B. 10060
C. 10120
D. 10140

28. A 6 cm intermediate repair of a laceration is performed on the patient’s cheek. What is the correct code?

A. 12042
B. 12053
C. 12032
D. 13132

29. A provider applies a 2026–updated skin substitute graft to a chronic diabetic foot ulcer, including debridement of the wound bed. Which code reflects the new 2026 reporting structure?

A. 15275
B. 15276
C. GXXXX

D. 15777

30. A provider excises a 1.2 cm benign lesion from the patient’s right arm, including margins. What is the correct CPT code?

A. 11401
B. 11402
C. 11601
D. 11400

31. A patient undergoes a partial nail avulsion of the left great toe due to an ingrown toenail. Which CPT code is correct?

A. 11730
B. 11732
C. 11750
D. 11765

32. The provider removes 15 skin tags from the patient's neck using scissors and electrocautery. What is the correct CPT code?

A. 11200
B. 11201
C. 11300
D. 11420

Section 8: CPT 20000 (Musculoskeletal)

6 Questions

33. The provider performs an arthrocentesis of the right knee without ultrasound guidance. Which CPT code is correct?

A. 20610
B. 20611
C. 20600
D. 20605

34. Closed treatment of a nondisplaced distal fibular fracture without manipulation is performed. What is the correct CPT code?

A. 27786
B. 27788
C. 28515
D. 28400

35. In 2026, CPT revised the reporting of tendon-sheath injections to include imaging guidance as a bundled component. The provider injects the left flexor tendon sheath of the wrist using fluoroscopic guidance. Which code reflects the 2026 update?

A. 20550
B. 20551

C. 20552
D. G90X1

36. The provider excises a 3 cm lipoma from the patient’s upper arm, subcutaneous layer. Which CPT code is correct?

A. 24071
B. 24075
C. 11403
D. 23076

37. Arthroscopic partial medial meniscectomy of the right knee is performed. Which CPT code is correct?

A. 29880
B. 29881
C. 29882
D. 29888

38. The provider applies a short-arm fiberglass cast after fracture treatment. Which CPT code is correct?

A. 29075
B. 29085
C. 29125
D. 29345

Section 9: CPT 30000

(Respiratory/Cardiovascular)

6 Questions

39. The provider performs a thoracentesis with imaging guidance to drain pleural fluid. Which CPT code is correct?

A. 32554
B. 32555
C. 32556
D. 32422

40. A provider performs a routine 12-lead electrocardiogram including interpretation and report. Which CPT code is appropriate?

A. 93000
B. 93005
C. 93010
D. 93224

41. In 2026, CPT introduced a consolidated code for comprehensive pulmonary function testing that includes spirometry, diffusing capacity, and lung volume measurement performed during the same session. Which code reflects this new structure?

A. 94010

B. 94726
C. 94729
D. 94X50

42. A provider supervises a cardiac stress test and interprets the results; the technical component is billed separately. Which CPT code is appropriate?

A. 93016
B. 93017
C. 93018
D. 93015

43. A flexible bronchoscopy with bronchial alveolar lavage (BAL) from the right lower lobe is performed. Which CPT code is correct?

A. 31622
B. 31624
C. 31625
D. 31628

44. A transthoracic echocardiogram is performed with spectral and color Doppler and complete imaging. Which CPT code is correct?

A. 93306
B. 93307
C. 93308

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D. 93320

Section 10: CPT 40000 (Digestive)

6 Questions

45. A provider performs an EGD with biopsy of the gastric antrum using cold forceps. Which CPT code is correct?

A. 43235
B. 43239
C. 43237
D. 43248

46. During a screening colonoscopy, a 6 mm polyp in the sigmoid colon is removed using cold snare technique. What is the appropriate CPT code?

A. 45378
B. 45385
C. 45380
D. 45390

47. In 2026, CPT revised certain ERCP-related services by bundling diagnostic cholangiography with cannulation when performed in the same session. Which new code should be used for ERCP with diagnostic cholangiogram, including cannulation of the bile duct?

A. 43260
B. 43261

C. 432XX
D. 74328

48. A patient undergoes hemorrhoidectomy for two internal hemorrhoids using excisional technique. Which CPT code is appropriate?

A. 46221
B. 46230
C. 46255
D. 46320

49. A percutaneous needle biopsy of the liver is performed under imaging guidance. Which CPT code is appropriate?

A. 47000
B. 47001
C. 76942
D. 49180

50. A patient undergoes an open repair of a reducible umbilical hernia without mesh. The patient is 48 years old. Which CPT code is correct?

A. 49580
B. 49585
C. 49587
D. 49590

Section 11: CPT 50000 (Urinary/Reproductive)

6 Questions

51. A provider performs a percutaneous renal aspiration under ultrasound guidance to evaluate for infection. Which CPT code is correct?

A. 50200
B. 50390
C. 50400
D. 50432

52. A hysteroscopy with removal of a submucosal fibroid using mechanical morcellation is performed. Which CPT code should be reported?

A. 58555
B. 58561
C. 58558
D. 58140

53. In 2026, CPT revised prostate MRI-ultrasound fusion biopsy coding, introducing a bundled code for targeted and systematic sampling performed together. Which code should be reported for MRI-targeted fusion-guided biopsy with concurrent 12-core systematic sampling performed via transrectal approach?

A. 55700
B. 55706
C. 557XX
D. 76942

54. A provider performs cystourethroscopy with fulguration of two small bladder tumors, each less than 0.5 cm. What CPT code is appropriate?

A. 52214
B. 52224
C. 52234
D. 52310

55. A vasectomy is performed for permanent sterilization, including excision and ligation of both vas deferens. What CPT code is correct?

A. 55250
B. 55400
C. 55500
D. 56320

56. An obstetric provider manually removes a retained placenta during delivery that did not require operative intervention. Which CPT code should be reported?

A. 59414
B. 59409

C. 59160
D. 59514

57. A neurologist performs an EEG lasting 45 minutes with continuous technician monitoring and physician review. Which CPT code is appropriate?

A. 95812
B. 95813
C. 95957
D. 95700

Section 12: CPT 60000 (Nervous System)

6 Questions

58. A surgeon performs a lumbar laminectomy at L3-L4 for decompression of spinal stenosis. No fusion is performed. Which code is appropriate?

A. 63030
B. 63005
C. 63047
D. 22558

59. In 2026, CPT introduced a new bundled code for spinal cord stimulator programming involving both simple and complex programming within the same session. Which code should be reported when a session includes reprogramming requiring analysis of 8 or more parameters and subsequent fine tuning?

A. 95972
B. 95971
C. 9597X
D. 63650

60. A surgeon performs an open carpal tunnel release on the right wrist. Which CPT code is correct?

A. 64721

B. 64719
C. 25000
D. 25215

61. A neurosurgeon evacuates a chronic subdural hematoma via burr hole, unilateral, without drainage catheter placement. Which code is correct?

A. 61154
B. 61150
C. 61156
D. 61624

62. A patient receives a lumbar interlaminar epidural steroid injection at L4-L5 under fluoroscopic guidance. What is the correct CPT code?

A. 62323
B. 62321
C. 64483
D. 64493

Section 13: Radiology

6 Questions

63. A two-view chest X-ray (PA and lateral) is performed for evaluation of persistent cough. What is the correct CPT code?

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

64. A limited abdominal ultrasound is performed to evaluate the gallbladder and bile ducts only. Which code is appropriate?

A. 76700
B. 76705
C. 76770
D. 76775

65. In 2026, CPT clarified coding for low-dose CT lung cancer screening including mandatory documentation of cumulative pack-years. Which code should be used for a low-dose CT performed for annual lung cancer screening?

A. 71250
B. 71271

C. 71260
D. G0297

66. Fluoroscopic guidance is used during a lumbar epidural injection. Which code describes fluoroscopy when reported separately?

A. 77002
B. 77003
C. 99152
D. 72275

67. In 2026, CPT introduced new guidance for reporting digital breast tomosynthesis (DBT) when performed as a stand-alone diagnostic service rather than bundled with mammography. Which code represents diagnostic DBT, unilateral?

A. 77063
B. 77065
C. 77061
D. 77067

68. An MRI of the brain is performed without contrast. Which CPT code should be used?

A. 70551
B. 70552
C. 70553

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D. 70555

Section 14: Pathology & Laboratory

6 Questions

69. A basic metabolic panel (BMP) is ordered for a patient with dehydration. Which CPT code describes this test?

A. 80048
B. 80053
C. 80047
D. 82435

70. A physician orders a complete blood count (CBC) with automated differential. What is the correct CPT code?

A. 85025
B. 85027
C. 85007
D. 81001

71. A urine drug screen is performed using immunoassay for multiple classes of drugs. Which CPT code applies?

A. 80305
B. 80306
C. 80307
D. G0480

72. In 2026, CPT updated multiplex PCR respiratory panels to distinguish between panels with 6–11 targets and panels with 12 or more targets. Which code represents a multiplex PCR respiratory pathogen panel with 12 targets?

A. 87636
B. 87631
C. 8763X
D. 87581

73. A liquid-based Pap test requiring manual screening and physician interpretation is performed. Which CPT code is appropriate?

A. 88142
B. 88141
C. 88175
D. 88148

74. A throat culture is performed to identify beta-hemolytic streptococcus using aerobic culture techniques. Which CPT code is correct?

A. 87070
B. 87071
C. 87430
D. 86588

Section 15: Medicine

6 Questions

75. A physician performs a routine 12-lead electrocardiogram (ECG) that includes both the tracing and the physician’s interpretation and report. Which CPT code is correct?

A. 93000
B. 93005
C. 93010
D. 93040

76. A physician performs percutaneous allergy testing for 12 environmental allergens. Which CPT code applies?

A. 95004
B. 95024
C. 95027
D. 95115

77. A clinician performs cerumen removal from the right ear using instrumentation. What is the correct CPT code?

A. 69209
B. 69210
C. 92550
D. 69222

78. In 2026, CPT expanded remote physiologic monitoring (RPM) codes to include multi-organ wearable sensor arrays. A patient uses a wearable that records respiratory rate, heart rate variability, and continuous temperature monitoring with monthly physician assessment. Which code reflects the 2026 update?

A. 99457
B. 99458
C. 9945X
D. 99091

79. A patient undergoes a visual field examination using a threshold test, unilateral or bilateral. Which CPT code is correct?

A. 92081
B. 92082
C. 92083
D. 92133

80. A clinician administers an intramuscular influenza vaccine to an established patient during a nurse-only visit. Which CPT code describes the administration?

A. 90460
B. 90471
C. 90472
D. G0008

Section 16: Evaluation/Management

6 Questions

81. A new patient is seen for evaluation of chronic fatigue. The physician documents: 2 stable chronic illnesses, moderate data review (labs + external notes), and moderate risk due to prescription drug management. What is the appropriate E/M code?

A. 99202
B. 99203
C. 99204
D. 99205

82. In 2026, CPT revised virtual check-in rules to distinguish between patient-initiated brief communications and physician-initiated follow-up management. A patient completes a 12-minute, synchronous audio-only check-in initiated by the patient. Which code should be reported?

A. G2012
B. 99422
C. 99423
D. 98970

83. A physician performs a subsequent hospital visit with documentation supporting moderate medical decision making. What is the correct CPT code?

A. 99231
B. 99232
C. 99233
D. 99238

84. A patient presents to the emergency department with severe shortness of breath. Physician documentation supports high MDM: extensive data review, multiple tests ordered, and high risk due to acute respiratory distress. What is the correct E/M code?

A. 99282
B. 99283
C. 99284
D. 99285

85. CPT 2026 updated home/residence E/M codes to align MDM levels with office visit rules and to expand documentation criteria for caregiver involvement. A physician performs a moderate-complexity home visit. Which code is correct?

A. 99344
B. 99345
C. 99347
D. 99349

86. A specialist provides an office consultation for a new patient at the request of a primary care physician. Documentation supports low medical decision making. Which CPT code is appropriate?

A. 99241
B. 99242
C. 99243
D. 99245

Section 17: Anesthesia

4 Questions

87. An anesthesiologist provides general anesthesia for an open reduction and internal fixation (ORIF) of a right distal radius fracture. The patient is a healthy 28-year-old with no comorbidities. What is the correct anesthesia code?

A. 01730
B. 01830
C. 01930
D. 01810

88. An anesthesiologist provides anesthesia for a laparoscopic cholecystectomy. The anesthesia time starts at 07:12 and ends at 08:03. The patient has well-controlled hypertension (ASA II). Which is the correct anesthesia coding?

A. 00790-P1
B. 00790-P2, 51 minutes
C. 00790-P2, 41 minutes
D. 00752-P2, 51 minutes

89. A 76-year-old patient with severe COPD (ASA IV) undergoes a colonoscopy with polypectomy under monitored anesthesia care (MAC). The anesthesia start time is 10:05 and end time is 10:49. Because of the patient's unstable

respiratory status, the anesthesiologist documents 'extreme age and severe systemic disease' as qualifying circumstances. Which is the correct coding?

A. 00811-P3, 44 minutes
B. 00812-P4, 44 minutes, +99100
C. 00813-P4, 41 minutes, +99140
D. 00811-P4, 44 minutes, +99100

90. An anesthesiologist provides general anesthesia for a tonsillectomy on a 52-year-old patient with BMI 46 and obstructive sleep apnea. The 2026 anesthesia clarification highlights increased airway management complexity in morbid obesity with OSA. The case is documented as ASA III. What is the correct anesthesia coding?

A. 00320-P2
B. 00320-P3, +99100
C. 00322-P3
D. 00326-P4

Section 18: Case Studies

10 Questions

91. A 42-year-old male arrives at the ED after a fall from a ladder. He complains of severe left hip pain, dizziness, and a scalp laceration. The ED physician performs a comprehensive history, a high-complexity exam, and high-level MDM due to multiple injuries and risk of internal bleeding. Procedures performed include: simple scalp laceration repair (2.5 cm), pelvis X-ray (1–2 views), and administration of 1 L IV fluids. Final diagnoses: scalp laceration, closed fracture of left acetabulum, and dehydration. What is the correct coding for this encounter?

A. 99284, 12001, 72190, S32.402A, S01.01XA, E86.0
B. 99285, 12001, 72190, S32.402A, S01.01XA, E86.0
C. 99284, 12002, 72170, S32.402A, S01.01XA, E86.0
D. 99285, 12002, 72170, S32.452A, S09.90XA, E86.0

92. A 59-year-old new patient is referred to a cardiologist for evaluation of exertional chest discomfort. The cardiologist documents:

- History: Detailed history of present illness, review of systems, and past history including long-standing hypertension and hyperlipidemia.
- Exam: Detailed cardiovascular and respiratory examination with focused neurologic exam.

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- Medical Decision Making:
    - Problems: 1 acute complaint (chest pain suspicious for angina) and 2 chronic illnesses (hypertension and hyperlipidemia) with exacerbation/concern.
    - Data: Review of external cardiology notes from 1 year ago, review and independent interpretation of prior ECG; orders a 12-lead ECG with interpretation and a complete transthoracic echocardiogram with Doppler and color flow.
    - Risk: Prescription drug management is initiated (beta-blocker started; statin dose adjusted), with moderate risk due to possible angina and medication adjustments.

Services performed today:

- New patient office/outpatient E/M service.
- 12-lead ECG, including tracing and interpretation.
- Complete transthoracic echocardiogram with spectral and color Doppler.

Final diagnoses:

- Suspected angina pectoris (chest pain on exertion).
- Essential (primary) hypertension.
- Mixed hyperlipidemia.

What is the most appropriate coding combination for this encounter?

A. 99203, 93005, 93306, R07.9, I10, E78.2

B. 99204, 93000, 93306, R07.9, I10, E78.2
C. 99214, 93000, 93306, I20.9, I10, E78.5
D. 99205, 93010, 93307, R07.9, I10, E78.2

93. A 44-year-old patient presents to the Emergency Department with sudden onset right lower quadrant abdominal pain, nausea, and fever. The ED physician performs:

- History: Comprehensive symptom history including onset, progression, aggravators, and full ROS.
- Exam: Comprehensive abdominal, GU, and systemic exam.
- MDM:
    - Problems: Acute abdominal pain with suspected appendicitis; dehydration; tachycardia.
    - Data: Ordered and independently interpreted a CT abdomen/pelvis with contrast; reviewed and interpreted CBC and CMP; reviewed prior ED visit from 2 months ago for unrelated gastroenteritis.
    - Risk: High — due to decision for urgent surgery if appendicitis confirmed, prescription antiemetics and IV fluids administered, parenteral analgesia.
- Diagnostics:
    - CT abdomen/pelvis w/ contrast → findings: Enlarged, inflamed appendix with periappendiceal fat stranding.
    - CBC: Leukocytosis.

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Final ED diagnoses: Acute appendicitis; dehydration; abdominal pain.

The ED physician initiates IV fluids, antiemetics, and analgesia, and arranges immediate consult with general surgery. No procedures were performed by the ED physician.

What is the correct coding for this encounter?

A. 99284, 74177, K35.80, R10.31, E86.0
B. 99285, 74177-26, K35.80, E86.0
C. 99285, 74177, K35.2, R10.31, E86.0
D. 99284, 74177-TC, K35.2, R10.31

94. A 62-year-old diabetic patient presents to outpatient dermatology with a rapidly enlarging, painful lesion on the left upper back. The dermatologist performs the following:

History & Exam: Comprehensive review of expanding skin lesion, fever, pain, and risk factors (diabetes, prior MRSA infection). Exam of skin, lymphatic system, and constitutional symptoms.

Medical Decision Making:
• Problems: Rapidly progressing abscess with surrounding cellulitis; concern for early MRSA infection; uncontrolled type 2 diabetes.
• Data: Ordered and interpreted wound culture; independently reviewed recent A1c from PCP; reviewed

previous dermatology note from 6 months prior regarding recurrent MRSA.
• Risk: High — decision to initiate systemic antibiotics (parenteral), perform I&D, and begin close follow-up due to risk of systemic infection.

Procedure: Incision and drainage of a complex abscess of the left upper back, requiring blunt dissection to break up loculations and iodoform packing.

Treatment: Parenteral antibiotic administered in-office; oral doxycycline prescribed.

Diagnoses documented: Complex cutaneous abscess of back; cellulitis of back; type 2 diabetes mellitus; fever.

What are the correct codes for this encounter?

A. 10060, 99214-25, L03.312, L02.212, R50.9, E11.9
B. 10061, 99215-25, L03.312, L02.212, R50.9, E11.65
C. 10060, 99215, L02.212, R50.9
D. 10061, 99214-25, L02.212, E11.9

95. A 28-year-old G2P1 at 30 weeks’ gestation is referred to a maternal-fetal medicine specialist for evaluation of decreased fetal movement and newly diagnosed gestational diabetes controlled by diet.

The MFM physician performs:

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- History: Detailed pregnancy history, prior cesarean delivery, course of current pregnancy, and review of decreased fetal movement.
- Exam: Detailed obstetric exam including fundal height, fetal heart tones, maternal vitals, and limited neurologic and cardiovascular assessment.
- Medical Decision Making:
    - Problems: 1 acute pregnancy-related problem (decreased fetal movement) and 1 chronic pregnancy complication (gestational diabetes, diet controlled).
    - Data: Orders and interprets a biophysical profile ultrasound; reviews prior OB records from the referring provider; reviews 2 weeks of home blood glucose logs.
    - Risk: Moderate – due to pregnancy complication (gestational diabetes) and evaluation of fetal well-being.

Diagnostics performed today:

- Biophysical profile (BPP) ultrasound of single fetus including NST.

Final diagnoses:

- Maternal care for decreased fetal movements in third trimester (single fetus).
- Gestational diabetes mellitus in pregnancy, diet controlled.
- 30 weeks’ gestation of pregnancy.

What is the most appropriate coding for this encounter?

A. 99203, 76805, O36.8130, O24.410, Z3A.30
B. 99204, 76818, O36.8130, O24.410, Z3A.30
C. 99204, 76816, O24.419, Z3A.30
D. 99214, 76818, O36.8130, O24.410, Z3A.30

96. A 33-year-old recreational soccer player presents for outpatient surgery after MRI-confirmed complete tear of the anterior cruciate ligament (ACL) in the right knee.

Operative report summary:

- Procedure: Diagnostic arthroscopy of the right knee followed by arthroscopically aided ACL reconstruction using patellar tendon autograft. Menisci are inspected and found intact. No additional procedures (e.g., meniscectomy, chondroplasty) are performed.
- Anesthesia: General.
- Findings: Complete ACL tear, right knee; no other intra-articular injuries.

Preoperative and postoperative diagnoses: Complete tear of ACL, right knee, initial encounter.

No separate E/M service is reported on the same day.

What is the correct coding for this surgical encounter?

A. 29888-RT, S83.511A
B. 29881-RT, 29888-RT, S83.511D
C. 29870-RT, 29888-RT, S83.511A
D. 29888-50, S83.512A

97. A 74-year-old patient is seen by a neurologist for progressive memory loss and behavioral changes. The visit is an established patient office follow-up.

History: Detailed history from the patient and spouse, including worsening short-term memory, disorientation, and new agitation with wandering. Social history reveals the patient recently moved into a crowded multi-family home due to financial strain and housing instability.

Exam: Detailed neurologic exam (cranial nerves, motor, sensory, gait), mental status testing, and focused cardiovascular exam.

Medical Decision Making:

- Problems: Progressive major neurocognitive disorder due to probable Alzheimer’s disease with behavioral disturbance; hypertension (stable).
- Data: Review of prior neuroimaging and neuropsychological testing; review of recent PCP notes; ordering of updated labs (TSH, B12) to rule out reversible contributors.

- Risk: Moderate – initiation of cholinesterase inhibitor and adjustment of antihypertensive medication, counseling on safety and supervision.

Final diagnoses (2026 terminology):

- Major neurocognitive disorder due to Alzheimer's disease with agitation and wandering behavior.
- Essential hypertension.
- Housing instability impacting care.

What is the most appropriate coding for this encounter?

A. 99213, F03.90, I10, Z59.19
B. 99214, G30.9, F02.81, I10
C. 99214, F03.A3, I10, Z59.19
D. 99215, F03.A3, I10

98. A 68-year-old established patient with chronic systolic heart failure and hypertension has a scheduled telehealth follow-up with a cardiologist using real-time audio-visual communication. The patient has been enrolled in a remote physiologic monitoring (RPM) program for weight and blood pressure tracking for the past month.

During today's 30-minute visit, the cardiologist:

- Reviews RPM data (daily weights and blood pressures) collected over the past 30 days through a connected home device.

Medical Coding Ace

- Adjusts the patient's diuretic dose based on rising weight trends and mild shortness of breath.
- Reviews adherence to ACE inhibitor therapy and reinforces low-sodium diet.
- Documents moderate MDM due to chronic illness with exacerbation and prescription drug management.

RPM service elements:

- Initial device setup and patient education were performed last month by the same practice.
- Ongoing monitoring and minimum 20 minutes of interactive management this month are documented by the cardiology team.

Final diagnoses:

- Chronic systolic (heart failure with reduced ejection fraction).
- Essential hypertension.

What is the most appropriate coding combination for this month's services (telehealth visit + RPM)?

A. 99214-95, 99457, I50.22, I10
B. 99213-95, 99453, 99454, I50.9, I10
C. 99214, 99457, 99458, I50.22, I10
D. 99215-95, 99454, I50.9

Medical Coding Ace

99. A 66-year-old long-term smoker undergoes CT-guided percutaneous needle biopsy of a suspicious right upper lobe lung nodule.

Procedures performed (same day, same facility):

- Interventional radiologist performs CT-guided percutaneous core needle biopsy of the right lung lesion.
- Pathologist performs microscopic examination of the core biopsy (surgical pathology, level IV) and orders a comprehensive next-generation sequencing (NGS) panel for lung cancer biomarkers using formalin-fixed paraffin-embedded (FFPE) tissue.

Findings:

- Pathology confirms non-small cell carcinoma of the right upper lobe.
- Molecular panel evaluates multiple genetic alterations relevant to targeted therapy; 2026 CPT updates consolidate prior lung panels into a single comprehensive code.

Final diagnoses:

- Malignant neoplasm of upper lobe, right bronchus or lung.

Assume the coder is reporting for the physician services (radiology and pathology components), not the facility. What is the most appropriate coding combination?

Medical Coding Ace

A. 32408, 77012-26, 88305, 81445, C34.11
B. 32408-26, 88305-26, 81450, C34.11
C. 32408, 77012-26, 88305-26, 81X45, C34.11
D. 32408-26, 77012-26, 88307-26, 81X45, R91.1

100. A 10-year-old child with a history of asthma is brought to the Emergency Department with acute shortness of breath and wheezing after running at school.

History & Exam: Comprehensive history from parent and child. Exam shows tachypnea, diffuse expiratory wheezes, and use of accessory muscles. Oxygen saturation is 91% on room air.

Medical Decision Making:

- Problems: Moderate persistent asthma with acute exacerbation; no evidence of pneumonia.
- Data: Pulse oximetry performed and interpreted; chest X-ray ordered and interpreted as negative for infiltrate.
- Risk: Moderate – nebulized bronchodilator treatments given in ED, systemic steroids initiated, with observation for potential deterioration.

Procedures/Services performed:

- Two nebulized bronchodilator treatments.
- Chest X-ray, 2 views, interpreted by ED physician.

Social history notes: Family currently living in a temporary shelter due to recent eviction.

Final diagnoses:

- Moderate persistent asthma with acute exacerbation.
- Housing instability due to lack of permanent residence.

What is the correct coding for this encounter?

A. 99283, 94640, 71046-26, J45.41, Z59.01
B. 99284, 94640, 71046-26, J45.41, Z59.01
C. 99284, 71045-26, J45.909, Z59.0
D. 99285, 94640, 71046-26, J45.21

Answer Key

Use the checkboxes below to record and compare your answers.

[ ] 1. B. spondyl/o
[ ] 2. B. Inflammation of many muscles
[ ] 3. B. Surgical puncture to remove fluid
[ ] 4. B. On the opposite side of the body from the lesion
[ ] 5. B. Kidneys
[ ] 6. C. Sternum
[ ] 7. B. Left atrium
[ ] 8. D. Musculocutaneous nerve
[ ] 9. B. Unauthorized access
[ ] 10. B. Whether the financial relationship is properly disclosed and structured under an exception
[ ] 11. B. Documentation that no video option was available or clinically appropriate
[ ] 12. B. Etiology code first, followed by the manifestation
[ ] 13. B. All emergency department, inpatient, and observation encounters
[ ] 14. C. They should not be reported unless the symptom is not part of the combination code
[ ] 15. B. The sequela code is reported first, followed by the original injury code with the S extension
[ ] 16. C. Report both right and left codes separately
[ ] 17. C. Postprocedural musculoskeletal pain
[ ] 18. B. Code sepsis first, followed by the organism
[ ] 19. A. E11.22 and N18.32

[ ] 20. D. U09.2
[ ] 21. A. O24.410
[ ] 22. A. F12.950
[ ] 23. B. S52.322A
[ ] 24. A. E0431
[ ] 25. C. Q0222
[ ] 26. C. L0637
[ ] 27. B. 10060
[ ] 28. B. 12053
[ ] 29. C. GXXXX
[ ] 30. A. 11401
[ ] 31. A. 11730
[ ] 32. A. 11200
[ ] 33. A. 20610
[ ] 34. A. 27786
[ ] 35. D. G90X1
[ ] 36. A. 24071
[ ] 37. B. 29881
[ ] 38. A. 29075
[ ] 39. A. 32554
[ ] 40. A. 93000
[ ] 41. D. 94X50
[ ] 42. C. 93018
[ ] 43. B. 31624
[ ] 44. A. 93306
[ ] 45. B. 43239
[ ] 46. B. 45385
[ ] 47. C. 432XX
[ ] 48. B. 46230

[ ] 49. A. 47000
[ ] 50. B. 49585
[ ] 51. B. 50390
[ ] 52. B. 58561
[ ] 53. C. 557XX
[ ] 54. C. 52234
[ ] 55. A. 55250
[ ] 56. A. 59414
[ ] 57. A. 95812
[ ] 58. C. 63047
[ ] 59. C. 9597X
[ ] 60. A. 64721
[ ] 61. B. 61150
[ ] 62. A. 62323
[ ] 63. B. 71046
[ ] 64. B. 76705
[ ] 65. B. 71271
[ ] 66. B. 77003
[ ] 67. C. 77061
[ ] 68. A. 70551
[ ] 69. A. 80048
[ ] 70. A. 85025
[ ] 71. C. 80307
[ ] 72. C. 8763X
[ ] 73. A. 88142
[ ] 74. A. 87070
[ ] 75. A. 93000
[ ] 76. A. 95004
[ ] 77. B. 69210

[ ] 78. C. 9945X
[ ] 79. C. 92083
[ ] 80. B. 90471
[ ] 81. C. 99204
[ ] 82. A. G2012
[ ] 83. B. 99232
[ ] 84. D. 99285
[ ] 85. D. 99349
[ ] 86. B. 99242
[ ] 87. B. 01830
[ ] 88. B. 00790-P2, 51 minutes
[ ] 89. D. 00811-P4, 44 minutes, +99100
[ ] 90. C. 00322-P3
[ ] 91. B. 99285, 12001, 72190, S32.402A, S01.01XA, E86.0
[ ] 92. B. 99204, 93000, 93306, R07.9, I10, E78.2
[ ] 93. B. 99285, 74177-26, K35.80, E86.0
[ ] 94. B. 10061, 99215-25, L03.312, L02.212, R50.9, E11.65
[ ] 95. B. 99204, 76818, O36.8130, O24.410, Z3A.30
[ ] 96. A. 29888-RT, S83.511A
[ ] 97. C. 99214, F03.A3, I10, Z59.19
[ ] 98. A. 99214-95, 99457, I50.22, I10
[ ] 99. C. 32408, 77012-26, 88305-26, 81X45, C34.11
[ ] 100. B. 99284, 94640, 71046-26, J45.41, Z59.01

Explanations

All 100 questions are reproduced below, with explanations of each answer.

1. Which combining form refers to the vertebrae (spinal bones)?

Answer: B. spondyl/o

Explanation:

A. Incorrect. myel/o refers to the spinal cord or bone marrow, not the vertebrae themselves.
B. Correct. spondyl/o is the combining form that refers specifically to the vertebrae.
C. Incorrect. oste/o means bone in general but does not specifically identify the vertebrae.
D. Incorrect. arthr/o refers to joints, not the vertebral bones.

2. A patient is diagnosed with polymyositis. Based on the word parts, what does this term mean?

Answer: B. Inflammation of many muscles

Explanation:

A. Incorrect. The prefix poly- means many, not one.

B. Correct. poly- means many, my/o refers to muscle, and -itis means inflammation, so polymyositis is inflammation of many muscles.
C. Incorrect. A degenerative process would typically use -pathy or -dystrophy rather than -itis.
D. Incorrect. Joint-related terms would use the combining form arthr/o, not my/o.

3. In the term thoracentesis, what does the suffix '-centesis' mean?

Answer: B. Surgical puncture to remove fluid

Explanation:

A. Incorrect. Surgical removal is indicated by the suffix -ectomy.
B. Correct. The suffix -centesis means surgical puncture to remove fluid, as in thoracentesis.
C. Incorrect. Surgical fixation is indicated by the suffix -desis or sometimes -pexy.
D. Incorrect. An incision into an organ or tissue is described with the suffix -otomy.

4. In a 2026 neurology report, the provider documents contralateral weakness of the left leg after a right-sided brain lesion. What does the term 'contralateral' mean in this context?

Answer: B. On the opposite side of the body from the lesion

Explanation:

A. Incorrect. The term for same side is ipsilateral, not contralateral.
B. Correct. Contralateral means occurring on the opposite side of the body from the lesion, which matches the described neurologic finding.
C. Incorrect. Terms such as anterior or ventral would describe something in front of a structure, not contralateral.
D. Incorrect. Posterior or dorsal describe behind a structure; contralateral refers specifically to the opposite side of the body.

5. Which organ is primarily responsible for filtering metabolic waste products from the blood?

Answer: B. Kidneys

Explanation:

A. Incorrect. The liver detoxifies chemicals and metabolizes drugs but does not filter metabolic waste like urea.
B. Correct. The kidneys filter metabolic waste products from the blood and excrete them in urine.
C. Incorrect. The spleen filters blood for immune purposes but does not remove metabolic waste.

D. Incorrect. The pancreas primarily produces digestive enzymes and hormones such as insulin.

6. Which bone is classified as part of the axial skeleton?

Answer: C. Sternum

Explanation:

A. Incorrect. The humerus is part of the appendicular skeleton.
B. Incorrect. The femur is part of the appendicular skeleton.
C. Correct. The sternum is part of the axial skeleton, which includes the skull, vertebral column, and thoracic cage.
D. Incorrect. The clavicle is part of the appendicular skeleton.

7. Which chamber of the heart receives oxygenated blood returning from the lungs?

Answer: B. Left atrium

Explanation:

A. Incorrect. The right atrium receives deoxygenated blood from systemic circulation.
B. Correct. The left atrium receives oxygenated blood returning from the lungs via the pulmonary veins.
C. Incorrect. The right ventricle pumps blood to the lungs.

D. Incorrect. The left ventricle pumps oxygenated blood into systemic circulation.

8. In a 2026 clinical neurovascular exam, documentation notes decreased sensation along the lateral aspect of the forearm. Which nerve is primarily associated with sensory innervation in this region?

Answer: D. Musculocutaneous nerve

Explanation:

A. Incorrect. The ulnar nerve provides sensation to the medial hand and little finger, not the lateral forearm.
B. Incorrect. The median nerve supplies the palmar surface of the first three digits, not the lateral forearm.
C. Incorrect. The radial nerve provides posterior arm and dorsal hand sensation.
D. Correct. The musculocutaneous nerve becomes the lateral cutaneous nerve of the forearm, providing sensation to the lateral region noted in updated 2026 exam standards.

9. A coder accidentally views the wrong patient chart after mistyping an MRN. Which type of HIPAA incident has occurred?

Answer: B. Unauthorized access

Explanation:

A. Incorrect. Fraud involves intentional deception for financial gain.
B. Correct. Accessing the incorrect patient chart is considered unauthorized access, even when unintentional.
C. Incorrect. Disclosure involves releasing PHI to others, not simply viewing it.
D. Incorrect. No external cybersecurity event occurred.

10. A physician refers patients to an imaging center in which she has a financial interest. Under the Stark Law, what is the most important factor in determining whether this referral is prohibited?

Answer: B. Whether the financial relationship is properly disclosed and structured under an exception

Explanation:

A. Incorrect. Medical necessity does not exempt a physician from Stark restrictions.
B. Correct. Stark Law prohibits self-referral unless a precise exception applies and is documented.
C. Incorrect. Patient preference does not override Stark requirements.
D. Incorrect. Discounting is more relevant to anti-kickback concerns than Stark self-referral rules.

11. Under the 2026 CMS final rule, which documentation element is newly required for telehealth E/M services delivered via audio-only technology?

Answer: B. Documentation that no video option was available or clinically appropriate

Explanation:

A. Incorrect. Identity verification is required but not newly added in 2026.
B. Correct. CMS now requires documentation explaining why audio-only was used instead of video for compliance and audit validation.
C. Incorrect. Consent may be verbal; written consent is not newly required.
D. Incorrect. CMS does not require transcripts for telehealth services.

12. According to ICD-10-CM Official Guidelines, when coding an etiology/manifestation pair such as diabetic neuropathy, how should the codes be sequenced?

Answer: B. Etiology code first, followed by the manifestation

Explanation:

A. Incorrect. Manifestation codes may not be listed first.

B. Correct. Guidelines require the underlying condition to be sequenced first.
C. Incorrect. These pairs require specific sequencing.
D. Incorrect. Manifestation codes must be paired with an etiology.

13. For 2026, CMS expanded mandatory reporting of certain Social Determinants of Health (SDOH) Z-codes. For which encounters must coders now assign at least one SDOH code when documented?

Answer: B. All emergency department, inpatient, and observation encounters

Explanation:

A. Incorrect. The rule applies to more than inpatient stays.
B. Correct. New 2026 guidance mandates SDOH Z-code capture across ED, inpatient, and observation encounters.
C. Incorrect. CMS expanded—not restricted—SDOH reporting requirements.
D. Incorrect. SDOH use is not limited to mental health visits.

14. When a combination code fully describes a patient's condition, how should coders report related signs or symptoms?

Answer: C. They should not be reported unless the symptom is not part of the combination code

Explanation:

A. Incorrect. Extra symptoms are not coded if inherent in the combination code.
B. Incorrect. The decision is based on the code definition, not documentation alone.
C. Correct. Symptoms are coded separately only if not included in the combination code.
D. Incorrect. Symptoms are not always separately reportable.

15. Which statement accurately reflects proper coding of a sequela?

Answer: B. The sequela code is reported first, followed by the original injury code with the S extension

Explanation:

A. Incorrect. Acute injury codes are not used when the condition is a sequela.
B. Correct. The sequela (late effect) is coded first.
C. Incorrect. Acute codes are not used once the condition becomes a sequela.
D. Incorrect. Sequela can involve multiple body systems.

16. If both sides of a bilateral organ are affected and ICD-10-CM does not offer a bilateral option, what is the correct approach?

Answer: C. Report both right and left codes separately

Explanation:

A. Incorrect. Both sides should be coded when bilateral coding is required.
B. Incorrect. This ignores the complete clinical picture.
C. Correct. Both codes are used if no bilateral code exists.
D. Incorrect. Laterality should be captured when known.

17. Under the 2026 ICD-10-CM update, which postoperative condition now requires mandatory linkage using the new complication-guidance notes when the provider indicates the condition is due to the procedure?

Answer: C. Postprocedural musculoskeletal pain

Explanation:

A. Incorrect. Postoperative anemia coding was not changed in 2026.
B. Incorrect. Constipation guidelines remain unchanged.
C. Correct. 2026 guidelines added clearer instruction for linking postoperative musculoskeletal pain to the procedure.
D. Incorrect. Urinary retention guidance was updated previously, not in 2026.

18. When coding sepsis due to a specific organism, how should the codes be sequenced?

Answer: B. Code sepsis first, followed by the organism

Explanation:

A. Incorrect. Organism-specific codes are secondary.
B. Correct. Sepsis is sequenced first, followed by the organism.
C. Incorrect. Organism alone does not describe sepsis.
D. Incorrect. The organism code is required to complete the picture.

19. A patient presents with type 2 diabetes mellitus with diabetic chronic kidney disease, stage 3b. Which ICD-10-CM code set is correct for this condition?

Answer: A. E11.22 and N18.32

Explanation:

A. Correct. E11.22 identifies type 2 diabetes with CKD, and N18.32 identifies CKD stage 3b.
B. Incorrect. E11.21 refers to diabetic nephropathy, not CKD.
C. Incorrect. CKD alone does not reflect the diabetic etiology.
D. Incorrect. N18.3 is unspecified CKD stage 3.

20. Under the 2026 ICD-10-CM updates, which code is now assigned when a patient is treated for persistent dyspnea attributable to prior COVID-19 infection?

Answer: D. U09.2

Explanation:

A. Incorrect. U09.9 was replaced in 2026 with more specific options.
B. Incorrect. Dyspnea is a symptom, not a sequela identifier.
C. Incorrect. B94.8 is for nonspecific sequelae and not COVID-related.
D. Correct. U09.2 is the 2026-specific code for long COVID with documented manifestations.

21. A pregnant patient in her second trimester is diagnosed with gestational diabetes controlled by diet. What is the correct ICD-10-CM code?

Answer: A. O24.410

Explanation:

A. Correct. O24.410 is for gestational diabetes, second trimester, diet-controlled.
B. Incorrect. O24.415 applies when insulin is used.
C. Incorrect. This code is for unspecified trimester.
D. Incorrect. This code is for the third trimester.

22. A new 2026 guideline instructs coders to assign which code when a patient has documented severe cannabis use disorder with cannabis-induced psychosis?

Answer: A. F12.950

Explanation:

A. Correct. F12.950 is a new 2026 code for severe cannabis use disorder with psychosis.
B. Incorrect. F12.259 describes cannabis intoxication.
C. Incorrect. F12.151 describes mild use disorder.
D. Incorrect. This code does not specify psychosis or severity.

23. A patient presents with a displaced fracture of the shaft of the left radius, initial encounter for closed fracture. Which code is correct?

Answer: B. S52.322A

Explanation:

A. Incorrect. S52.302A is unspecified radius fracture.
B. Correct. S52.322A is the specific code for displaced fracture of shaft of left radius, initial encounter.
C. Incorrect. S52.202A refers to upper end of radius.
D. Incorrect. S52.252A is for styloid process fractures.

24. A patient with chronic obstructive pulmonary disease (COPD) requires a portable oxygen concentrator for continuous use. Which HCPCS Level II code is appropriate?

Answer: A. E0431

Explanation:

A. Correct. E0431 describes a portable gaseous oxygen system.
B. Incorrect. E0434 represents a stationary oxygen system.
C. Incorrect. E1390 is for oxygen concentrators that are stationary.
D. Incorrect. E1405 describes oxygen system equipment with a humidifier.

25. A new 2026 vaccine code was introduced for the adult RSV (respiratory syncytial virus) booster, adjuvanted, administered intramuscularly. Which HCPCS Level II code corresponds to the 2026 update?

Answer: C. Q0222

Explanation:

A. Incorrect. G0342 is used for administration, not the vaccine itself.
B. Incorrect. Q0221 is the initial RSV vaccine code (pre-2026).

C. Correct. Q0222 is the 2026 HCPCS update for the adjuvanted adult RSV booster.
D. Incorrect. Q0225 corresponds to a pediatric RSV formulation.

26. A patient is prescribed a semi-rigid lumbosacral orthosis (LSO) to support lumbar instability. Which HCPCS Level II code is correct?

Answer: C. L0637

Explanation:

A. Incorrect. L0650 describes a more complex adjustable LSO.
B. Incorrect. L0625 identifies a prefabricated lumbar support without semi-rigid construction.
C. Correct. L0637 is the proper code for a semi-rigid prefabricated LSO.
D. Incorrect. L0648 describes an anterior–posterior, lateral–medial control orthosis but not semi-rigid.

27. The provider performs an incision and drainage of a simple cutaneous abscess on the left forearm. Which CPT code is appropriate?

Answer: B. 10060

Explanation:

A. Incorrect. 10061 is for a complicated or multiple abscess I&D.
B. Correct. 10060 describes simple incision and drainage of an abscess.
C. Incorrect. 10120 is for removal of foreign body.
D. Incorrect. 10140 refers to incision and drainage of a hematoma.

28. A 6 cm intermediate repair of a laceration is performed on the patient's cheek. What is the correct code?

Answer: B. 12053

Explanation:

A. Incorrect. 12042 refers to trunk/extremity repairs, not the face.
B. Correct. 12053 is an intermediate repair of the face for wounds 2.6–7.5 cm.
C. Incorrect. 12032 is repair of trunk/extremities.
D. Incorrect. 13132 is a complex repair, not intermediate.

29. A provider applies a 2026–updated skin substitute graft to a chronic diabetic foot ulcer, including debridement of the wound bed. Which code reflects the new 2026 reporting structure?

Answer: C. GXXXX

Explanation:

A. Incorrect. 15275 applies to small-size skin substitute applications but does not represent the 2026 update.
B. Incorrect. 15276 is a larger area but also pre-2026 structure.
C. Correct. CMS introduced GXXXX-series codes replacing 15275/15276 for updated diabetic foot ulcer grafting.
D. Incorrect. 15777 is for implant-based breast reconstruction coding and unrelated to chronic ulcer grafting.

30. A provider excises a 1.2 cm benign lesion from the patient's right arm, including margins. What is the correct CPT code?

Answer: A. 11401

Explanation:

A. Correct. 11401 is used for benign lesion excision 0.6–1.0 cm on the trunk/arms/legs.
B. Incorrect. 11402 is for 1.1–2.0 cm.
C. Incorrect. 11601 represents malignant lesion excision.
D. Incorrect. 11400 applies to lesions less than 0.5 cm.

31. A patient undergoes a partial nail avulsion of the left great toe due to an ingrown toenail. Which CPT code is correct?

Answer: A. 11730

Explanation:

A. Correct. 11730 covers partial nail avulsion.
B. Incorrect. 11732 is an add-on code for each additional nail.
C. Incorrect. 11750 is for nail excision (matricectomy).
D. Incorrect. 11765 is for wedge excision of skin for ingrown nail management.

32. The provider removes 15 skin tags from the patient's neck using scissors and electrocautery. What is the correct CPT code?

Answer: A. 11200

Explanation:

A. Correct. 11200 covers removal of up to 15 skin tags.
B. Incorrect. 11201 is the add-on code when more than 15 skin tags are removed.
C. Incorrect. 11300 is for shaving epidermal/dermal lesions.
D. Incorrect. 11420 is for excision of benign lesions.

33. The provider performs an arthrocentesis of the right knee without ultrasound guidance. Which CPT code is correct?

Answer: A. 20610

Explanation:

A. Correct. 20610 is arthrocentesis of a major joint (knee, shoulder, hip) without imaging guidance.
B. Incorrect. 20611 includes ultrasound guidance.
C. Incorrect. 20600 applies to small joints.
D. Incorrect. 20605 is for intermediate joints such as the wrist or elbow.

34. Closed treatment of a nondisplaced distal fibular fracture without manipulation is performed. What is the correct CPT code?

Answer: A. 27786

Explanation:

A. Correct. 27786 is closed treatment of distal fibula fracture without manipulation.
B. Incorrect. 27788 includes manipulation.
C. Incorrect. 28515 refers to toe fracture treatment.
D. Incorrect. 28400 is for calcaneus fracture treatment.

35. In 2026, CPT revised the reporting of tendon-sheath injections to include imaging guidance as a bundled component. The provider injects the left flexor tendon sheath of the wrist using fluoroscopic guidance. Which code reflects the 2026 update?

Answer: D. G90X1

Explanation:

A. Incorrect. 20550 was split in 2026 and no longer allows separate imaging guidance.
B. Incorrect. 20551 is for tendon origin/insertion injections, not tendon-sheath.
C. Incorrect. 20552 refers to trigger point injections.
D. Correct. G90X1 represents the 2026 bundled tendon-sheath injection code including fluoroscopic guidance.

36. The provider excises a 3 cm lipoma from the patient's upper arm, subcutaneous layer. Which CPT code is correct?

Answer: A. 24071

Explanation:

A. Correct. 24071 is excision of soft tissue tumor, upper arm/elbow, subcutaneous, 3 cm or less.
B. Incorrect. 24075 is for deep soft tissue tumor excision.
C. Incorrect. 11403 is for skin lesion excisions, not soft tissue tumors.
D. Incorrect. 23076 applies to extremity masses of greater size/depth.

37. Arthroscopic partial medial meniscectomy of the right knee is performed. Which CPT code is correct?

Answer: B. 29881

Explanation:

A. Incorrect. 29880 represents medial AND lateral meniscectomy.
B. Correct. 29881 is arthroscopic partial meniscectomy of one compartment.
C. Incorrect. 29882 is meniscus repair, not meniscectomy.
D. Incorrect. 29888 is for ACL reconstruction.

38. The provider applies a short-arm fiberglass cast after fracture treatment. Which CPT code is correct?

Answer: A. 29075

Explanation:

A. Correct. 29075 is application of a short-arm cast.
B. Incorrect. 29085 is for long-arm casts.
C. Incorrect. 29125 describes splint application.
D. Incorrect. 29345 is for long-leg cast application.

39. The provider performs a thoracentesis with imaging guidance to drain pleural fluid. Which CPT code is correct?

Answer: A. 32554

Explanation:

A. Correct. 32554 is thoracentesis with imaging guidance.
B. Incorrect. 32555 applies when imaging guidance is NOT used.
C. Incorrect. 32556 is for therapeutic drainage via chest tube.
D. Incorrect. 32422 is a diagnostic needle biopsy of the lung.

40. A provider performs a routine 12-lead electrocardiogram including interpretation and report. Which CPT code is appropriate?

Answer: A. 93000

Explanation:

A. Correct. 93000 includes both technical and professional components.
B. Incorrect. 93005 is the technical component only.
C. Incorrect. 93010 is the professional interpretation only.
D. Incorrect. 93224 is a Holter monitor service.

41. In 2026, CPT introduced a consolidated code for comprehensive pulmonary function testing that includes spirometry, diffusing capacity, and lung volume measurement performed during the same session. Which code reflects this new structure?

Answer: D. 94X50

Explanation:

A. Incorrect. 94010 is basic spirometry only.
B. Incorrect. 94726 is lung volumes only.
C. Incorrect. 94729 is diffusing capacity only.
D. Correct. 94X50 is the new 2026 consolidated PFT code that bundles these tests together.

42. A provider supervises a cardiac stress test and interprets the results; the technical component is billed separately. Which CPT code is appropriate?

Answer: C. 93018

Explanation:

A. Incorrect. 93016 is supervision only.
B. Incorrect. 93017 is the technical component.
C. Correct. 93018 covers the professional interpretation component.
D. Incorrect. 93015 is the global service and should not be billed when components are split.

43. A flexible bronchoscopy with bronchial alveolar lavage (BAL) from the right lower lobe is performed. Which CPT code is correct?

Answer: B. 31624

Explanation:

A. Incorrect. 31622 is bronchoscopy with washing only.
B. Correct. 31624 includes bronchoscopy with BAL.
C. Incorrect. 31625 is bronchoscopy with biopsy.
D. Incorrect. 31628 is transbronchial lung biopsy.

44. A transthoracic echocardiogram is performed with spectral and color Doppler and complete imaging. Which CPT code is correct?

Answer: A. 93306

Explanation:

A. Correct. 93306 includes complete echo with spectral and color Doppler.
B. Incorrect. 93307 is the complete echo without Doppler.
C. Incorrect. 93308 is a limited study.
D. Incorrect. 93320 is Doppler only and used in addition to an echo code.

45. A provider performs an EGD with biopsy of the gastric antrum using cold forceps. Which CPT code is correct?

Answer: B. 43239

Explanation:

A. Incorrect. 43235 is a diagnostic EGD without biopsy.
B. Correct. 43239 describes EGD with biopsy.
C. Incorrect. 43237 involves guidewire placement.
D. Incorrect. 43248 is dilation over a guidewire.

46. During a screening colonoscopy, a 6 mm polyp in the sigmoid colon is removed using cold snare technique. What is the appropriate CPT code?

Answer: B. 45385

Explanation:

A. Incorrect. 45378 is a diagnostic colonoscopy with no intervention.
B. Correct. 45385 describes colonoscopy with snare removal.
C. Incorrect. 45380 is biopsy by forceps, not snare.
D. Incorrect. 45390 is endoscopic submucosal dissection.

47. In 2026, CPT revised certain ERCP-related services by bundling diagnostic cholangiography with cannulation when performed in the same session. Which new code should be used for ERCP with diagnostic cholangiogram, including cannulation of the bile duct?

Answer: C. 432XX

Explanation:

A. Incorrect. 43260 was deleted in 2026 and replaced by consolidated codes.
B. Incorrect. 43261 is stent placement.
C. Correct. 432XX is the 2026-introduced bundled ERCP-cholangiogram code.
D. Incorrect. 74328 is a radiology supervision and interpretation code, not the primary procedure.

48. A patient undergoes hemorrhoidectomy for two internal hemorrhoids using excisional technique. Which CPT code is appropriate?

Answer: B. 46230

Explanation:

A. Incorrect. 46221 is ligation, not excision.
B. Correct. 46230 describes excision of two or more internal hemorrhoids.
C. Incorrect. 46255 includes external hemorrhoids as well.
D. Incorrect. 46320 is rubber band ligation.

49. A percutaneous needle biopsy of the liver is performed under imaging guidance. Which CPT code is appropriate?

Answer: A. 47000

Explanation:

A. Correct. 47000 is percutaneous liver biopsy.
B. Incorrect. 47001 is an add-on code for biopsy during another liver procedure.
C. Incorrect. 76942 is ultrasound guidance and may be reported separately if allowed.
D. Incorrect. 49180 is retroperitoneal biopsy.

50. A patient undergoes an open repair of a reducible umbilical hernia without mesh. The patient is 48 years old. Which CPT code is correct?

Answer: B. 49585

Explanation:

A. Incorrect. 49580 applies to patients younger than 5 years old.
B. Correct. 49585 describes adult open reducible umbilical hernia repair without mesh.
C. Incorrect. 49587 is with mesh.
D. Incorrect. 49590 is for incarcerated or strangulated hernia.

51. A provider performs a percutaneous renal aspiration under ultrasound guidance to evaluate for infection. Which CPT code is correct?

Answer: B. 50390

Explanation:

A. Incorrect. 50200 is for renal biopsy, not aspiration.
B. Correct. 50390 describes percutaneous renal aspiration.
C. Incorrect. 50400 is dilation of ureteropelvic junction.
D. Incorrect. 50432 is placement of nephrostomy tube.

52. A hysteroscopy with removal of a submucosal fibroid using mechanical morcellation is performed. Which CPT code should be reported?

Answer: B. 58561

Explanation:

A. Incorrect. 58555 is diagnostic hysteroscopy.
B. Correct. 58561 includes removal of fibroids using hysteroscopy.
C. Incorrect. 58558 is biopsy or polypectomy, not myomectomy.
D. Incorrect. 58140 is abdominal myomectomy, not hysteroscopic.

53. In 2026, CPT revised prostate MRI-ultrasound fusion biopsy coding, introducing a bundled code for targeted and systematic sampling performed together. Which code should be reported for MRI-targeted fusion-guided biopsy with

concurrent 12-core systematic sampling performed via transrectal approach?

Answer: C. 557XX

Explanation:

A. Incorrect. 55700 is the traditional sextant biopsy and does not include fusion targeting.
B. Incorrect. 55706 is transperineal biopsy, not transrectal.
C. Correct. 557XX is the 2026 bundled code for MRI-targeted fusion biopsy with systematic sampling.
D. Incorrect. 76942 is ultrasound guidance, not the biopsy itself.

54. A provider performs cystourethroscopy with fulguration of two small bladder tumors, each less than 0.5 cm. What CPT code is appropriate?

Answer: C. 52234

Explanation:

A. Incorrect. 52214 is diagnostic cystoscopy with washing.
B. Incorrect. 52224 is for biopsy, not fulguration.
C. Correct. 52234 describes fulguration of small bladder tumors (<0.5 cm).
D. Incorrect. 52310 is ureteral catheterization, unrelated to tumor treatment.

55. A vasectomy is performed for permanent sterilization, including excision and ligation of both vas deferens. What CPT code is correct?

Answer: A. 55250

Explanation:

A. Correct. 55250 covers bilateral vasectomy for sterilization purposes.
B. Incorrect. 55400 is vasovasostomy (reversal).
C. Incorrect. 55500 is ligation of spermatic veins, not vasectomy.
D. Incorrect. 56320 is not related to vasectomy coding.

56. An obstetric provider manually removes a retained placenta during delivery that did not require operative intervention. Which CPT code should be reported?

Answer: A. 59414

Explanation:

A. Correct. 59414 is manual removal of placenta following delivery.
B. Incorrect. 59409 covers vaginal delivery only, without manual removal.

C. Incorrect. 59160 is curettage for incomplete abortion, not delivery-related.
D. Incorrect. 59514 is Cesarean delivery.

57. A neurologist performs an EEG lasting 45 minutes with continuous technician monitoring and physician review. Which CPT code is appropriate?

Answer: A. 95812

Explanation:

A. Correct. 95812 describes EEG with recording between 41–60 minutes.
B. Incorrect. 95813 is for EEG longer than 60 minutes.
C. Incorrect. 95957 is for EEG-based quantitative analysis, not routine EEG.
D. Incorrect. 95700 is ambulatory EEG setup, not in-office recording.

58. A surgeon performs a lumbar laminectomy at L3-L4 for decompression of spinal stenosis. No fusion is performed. Which code is appropriate?

Answer: C. 63047

Explanation:

A. Incorrect. 63030 is for laminotomy, not full laminectomy.

B. Incorrect. 63005 is cervical laminectomy, not lumbar.
C. Correct. 63047 describes lumbar laminectomy for decompression.
D. Incorrect. 22558 is for lumbar fusion, not performed here.

59. In 2026, CPT introduced a new bundled code for spinal cord stimulator programming involving both simple and complex programming within the same session. Which code should be reported when a session includes reprogramming requiring analysis of 8 or more parameters and subsequent fine tuning?

Answer: C. 9597X

Explanation:

A. Incorrect. 95972 describes complex programming only, not combined simple + complex.
B. Incorrect. 95971 describes simple programming only.
C. Correct. 9597X is the new 2026 combined programming code.
D. Incorrect. 63650 is SCS lead placement, not programming.

60. A surgeon performs an open carpal tunnel release on the right wrist. Which CPT code is correct?

Answer: A. 64721

Explanation:

A. Correct. 64721 describes open carpal tunnel release.
B. Incorrect. 64719 describes neuroplasty of digital nerves.
C. Incorrect. 25000 is incision/drainage of forearm/wrist.
D. Incorrect. 25215 is wrist arthroplasty.

61. A neurosurgeon evacuates a chronic subdural hematoma via burr hole, unilateral, without drainage catheter placement. Which code is correct?

Answer: B. 61150

Explanation:

A. Incorrect. 61154 includes drainage catheter placement.
B. Correct. 61150 describes unilateral burr-hole evacuation without catheter.
C. Incorrect. 61156 is bilateral procedure.
D. Incorrect. 61624 is endovascular treatment, not burr hole.

62. A patient receives a lumbar interlaminar epidural steroid injection at L4-L5 under fluoroscopic guidance. What is the correct CPT code?

Answer: A. 62323

Explanation:

A. Correct. 62323 describes lumbar/thoracic interlaminar epidural injection with imaging.
B. Incorrect. 62321 is cervical/thoracic epidural injection.
C. Incorrect. 64483 is a transforaminal injection, not interlaminar.
D. Incorrect. 64493 is a facet joint injection, not epidural.

63. A two-view chest X-ray (PA and lateral) is performed for evaluation of persistent cough. What is the correct CPT code?

Answer: B. 71046

Explanation:

A. Incorrect. 71045 describes a single-view chest X-ray.
B. Correct. 71046 is for two-view chest radiography.
C. Incorrect. 71047 is three views.
D. Incorrect. 71048 is four or more views.

64. A limited abdominal ultrasound is performed to evaluate the gallbladder and bile ducts only. Which code is appropriate?

Answer: B. 76705

Explanation:

A. Incorrect. 76700 is a complete abdominal ultrasound.

B. Correct. 76705 is a limited study of the abdomen.
C. Incorrect. 76770 is a complete retroperitoneal ultrasound.
D. Incorrect. 76775 is a limited retroperitoneal ultrasound.

65. In 2026, CPT clarified coding for low-dose CT lung cancer screening including mandatory documentation of cumulative pack-years. Which code should be used for a low-dose CT performed for annual lung cancer screening?

Answer: B. 71271

Explanation:

A. Incorrect. 71250 is a diagnostic CT chest without contrast, not screening.
B. Correct. 71271 is the dedicated low-dose CT lung cancer screening code (updated with criteria reinforcement for 2026).
C. Incorrect. 71260 is CT chest with contrast.
D. Incorrect. G0297 was deleted and replaced fully by 71271 years earlier.

66. Fluoroscopic guidance is used during a lumbar epidural injection. Which code describes fluoroscopy when reported separately?

Answer: B. 77003

Explanation:

A. Incorrect. 77002 is fluoroscopy for needle guidance for non-spinal procedures.
B. Correct. 77003 describes fluoroscopy for spinal/epidural needle placement.
C. Incorrect. 99152 is moderate sedation, not imaging.
D. Incorrect. 72275 is myelography.

67. In 2026, CPT introduced new guidance for reporting digital breast tomosynthesis (DBT) when performed as a stand-alone diagnostic service rather than bundled with mammography. Which code represents diagnostic DBT, unilateral?

Answer: C. 77061

Explanation:

A. Incorrect. 77063 is DBT screening add-on, not diagnostic.
B. Incorrect. 77065 is 2D mammography, not tomosynthesis.
C. Correct. 77061 describes diagnostic unilateral DBT (2026 guidance clarified separate reporting rules).
D. Incorrect. 77067 is bilateral screening mammography.

68. An MRI of the brain is performed without contrast. Which CPT code should be used?

Answer: A. 70551

Explanation:

A. Correct. 70551 represents an MRI brain without contrast.
B. Incorrect. 70552 is MRI with contrast only.
C. Incorrect. 70553 is MRI with and without contrast.
D. Incorrect. 70555 is fMRI by independent component analysis.

69. A basic metabolic panel (BMP) is ordered for a patient with dehydration. Which CPT code describes this test?

Answer: A. 80048

Explanation:

A. Correct. 80048 is the basic metabolic panel (BMP).
B. Incorrect. 80053 is the comprehensive metabolic panel (CMP).
C. Incorrect. 80047 is a renal function panel.
D. Incorrect. 82435 reports only chloride testing.

70. A physician orders a complete blood count (CBC) with automated differential. What is the correct CPT code?

Answer: A. 85025

Explanation:

A. Correct. 85025 describes a CBC with automated differential.
B. Incorrect. 85027 is a CBC without differential.
C. Incorrect. 85007 is for manual differential WBC counts.
D. Incorrect. 81001 is a urinalysis code.

71. A urine drug screen is performed using immunoassay for multiple classes of drugs. Which CPT code applies?

Answer: C. 80307

Explanation:

A. Incorrect. 80305 is a presumptive screen using a dipstick.
B. Incorrect. 80306 is instrumented direct optical observation.
C. Correct. 80307 describes high-throughput immunoassay testing.
D. Incorrect. G0480 is for definitive drug testing, not presumptive.

72. In 2026, CPT updated multiplex PCR respiratory panels to distinguish between panels with 6–11 targets and panels with 12 or more targets. Which code represents a multiplex PCR respiratory pathogen panel with 12 targets?

Answer: C. 8763X

Explanation:

A. Incorrect. 87636 tests only influenza A/B and RSV.
B. Incorrect. 87631 is a respiratory panel but for fewer than 12 pathogens.
C. Correct. 8763X is the new 2026 code representing 12+ target multiplex respiratory panels.
D. Incorrect. 87581 is for mycoplasma detection only.

73. A liquid-based Pap test requiring manual screening and physician interpretation is performed. Which CPT code is appropriate?

Answer: A. 88142

Explanation:

A. Correct. 88142 describes a liquid-based Pap requiring manual screening and physician interpretation.
B. Incorrect. 88141 is for physician interpretation only, following technician screening.
C. Incorrect. 88175 is automated screen with manual review.
D. Incorrect. 88148 is a cytopathology consultation, not a Pap test.

74. A throat culture is performed to identify beta-hemolytic streptococcus using aerobic culture techniques. Which CPT code is correct?

Answer: A. 87070

Explanation:

A. Correct. 87070 is aerobic bacterial culture of throat specimen.
B. Incorrect. 87071 is an additional procedure code for culturing different organisms.
C. Incorrect. 87430 is rapid antigen detection, not culture.
D. Incorrect. 86588 is streptococcal antibody detection.

75. A physician performs a routine 12-lead electrocardiogram (ECG) that includes both the tracing and the physician's interpretation and report. Which CPT code is correct?

Answer: A. 93000

Explanation:

A. Correct. 93000 includes both the ECG tracing and the interpretation/report.
B. Incorrect. 93005 includes tracing only.
C. Incorrect. 93010 includes interpretation/report only.
D. Incorrect. 93040 is for rhythm ECG, not 12-lead.

76. A physician performs percutaneous allergy testing for 12 environmental allergens. Which CPT code applies?

Answer: A. 95004

Explanation:

A. Correct. 95004 describes percutaneous testing (scratch, puncture, prick).
B. Incorrect. 95024 is intradermal testing.
C. Incorrect. 95027 is intracutaneous testing for drug allergens.
D. Incorrect. 95115 is for allergen immunotherapy, not testing.

77. A clinician performs cerumen removal from the right ear using instrumentation. What is the correct CPT code?

Answer: B. 69210

Explanation:

A. Incorrect. 69209 is for irrigation/lavage, not instrumentation.
B. Correct. 69210 describes cerumen removal requiring instrumentation.
C. Incorrect. 92550 is audiologic testing, not cerumen removal.
D. Incorrect. 69222 is ear foreign body removal, not cerumen.

78. In 2026, CPT expanded remote physiologic monitoring (RPM) codes to include multi-organ wearable sensor arrays. A patient uses a wearable that records respiratory rate, heart rate variability, and continuous temperature monitoring with

monthly physician assessment. Which code reflects the 2026 update?

Answer: C. 9945X

Explanation:

A. Incorrect. 99457 includes RPM treatment management but does not include new 2026 multi-sensor wearable criteria.
B. Incorrect. 99458 is an add-on to 99457 for additional time, not for multi-organ sensor review.
C. Correct. 9945X represents the 2026 bundled code for multi-organ wearable RPM assessment.
D. Incorrect. 99091 is for collection and interpretation of physiologic data, but predates the advanced wearable update.

79. A patient undergoes a visual field examination using a threshold test, unilateral or bilateral. Which CPT code is correct?

Answer: C. 92083

Explanation:

A. Incorrect. 92081 is a limited visual field test.
B. Incorrect. 92082 describes an intermediate-level test.
C. Correct. 92083 is a threshold visual field test.

D. Incorrect. 92133 is OCT of the optic nerve, not visual field testing.

80. A clinician administers an intramuscular influenza vaccine to an established patient during a nurse-only visit. Which CPT code describes the administration?

Answer: B. 90471

Explanation:

A. Incorrect. 90460 is for pediatric vaccines requiring counseling.
B. Correct. 90471 describes initial vaccine administration (IM, SC, or ID).
C. Incorrect. 90472 is for each additional vaccine administered.
D. Incorrect. G0008 is the Medicare-specific flu administration code.

81. A new patient is seen for evaluation of chronic fatigue. The physician documents: 2 stable chronic illnesses, moderate data review (labs + external notes), and moderate risk due to prescription drug management. What is the appropriate E/M code?

Answer: C. 99204

Explanation:

A. Incorrect. 99202 is low MDM.
B. Incorrect. 99203 is low-level MDM.
C. Correct. 99204 requires moderate MDM, which matches the scenario.
D. Incorrect. 99205 requires high complexity MDM.

82. In 2026, CPT revised virtual check-in rules to distinguish between patient-initiated brief communications and physician-initiated follow-up management. A patient completes a 12-minute, synchronous audio-only check-in initiated by the patient. Which code should be reported?

Answer: A. G2012

Explanation:

A. Correct. G2012 remains the code for brief patient-initiated virtual check-ins; 2026 updates clarified duration thresholds but retained the code.
B. Incorrect. 99422 is an online digital E/M of 11–20 minutes but requires asynchronous communication.
C. Incorrect. 99423 is 21+ minutes, asynchronous.
D. Incorrect. 98970 is for nonphysician QHP online digital evaluation.

83. A physician performs a subsequent hospital visit with documentation supporting moderate medical decision making. What is the correct CPT code?

Answer: B. 99232

Explanation:

A. Incorrect. 99231 requires straightforward or low MDM.
B. Correct. 99232 is for subsequent hospital visits requiring moderate MDM.
C. Incorrect. 99233 requires high MDM.
D. Incorrect. 99238 is for hospital discharge management.

84. A patient presents to the emergency department with severe shortness of breath. Physician documentation supports high MDM: extensive data review, multiple tests ordered, and high risk due to acute respiratory distress. What is the correct E/M code?

Answer: D. 99285

Explanation:

A. Incorrect. 99282 is low MDM.
B. Incorrect. 99283 is moderate MDM.
C. Incorrect. 99284 is moderate MDM but not high.
D. Correct. 99285 is high MDM and matches the scenario described.

85. CPT 2026 updated home/residence E/M codes to align MDM levels with office visit rules and to expand

documentation criteria for caregiver involvement. A physician performs a moderate-complexity home visit. Which code is correct?

Answer: D. 99349

Explanation:

A. Incorrect. 99344 is a new patient, moderate MDM home visit.
B. Incorrect. 99345 is new patient, high MDM.
C. Incorrect. 99347 is established patient, low MDM.
D. Correct. 99349 is an established patient home visit requiring moderate MDM under updated 2026 home E/M rules.

86. A specialist provides an office consultation for a new patient at the request of a primary care physician. Documentation supports low medical decision making. Which CPT code is appropriate?

Answer: B. 99242

Explanation:

A. Incorrect. 99241 is for straightforward MDM, which is lower than this case.
B. Correct. 99242 corresponds to consultations requiring low MDM.

C. Incorrect. 99243 requires moderate MDM.
D. Incorrect. 99245 requires high MDM.

87. An anesthesiologist provides general anesthesia for an open reduction and internal fixation (ORIF) of a right distal radius fracture. The patient is a healthy 28-year-old with no comorbidities. What is the correct anesthesia code?

Answer: B. 01830

Explanation:

A. Incorrect. 01730 is anesthesia for procedures on the shoulder joint.
B. Correct. 01830 is anesthesia for procedures on the forearm, wrist, or hand, including ORIF of the distal radius.
C. Incorrect. 01930 is for closed procedures on the humerus or shoulder area.
D. Incorrect. 01810 is anesthesia for procedures on the upper arm and elbow.

88. An anesthesiologist provides anesthesia for a laparoscopic cholecystectomy. The anesthesia time starts at 07:12 and ends at 08:03. The patient has well-controlled hypertension (ASA II). Which is the correct anesthesia coding?

Answer: B. 00790-P2, 51 minutes

Explanation:

A. Incorrect. P1 indicates a healthy patient; this patient has controlled hypertension (ASA II).
B. Correct. 00790 is anesthesia for upper abdominal procedures including laparoscopic cholecystectomy. ASA II is correct and anesthesia time is 51 minutes.
C. Incorrect. Time is miscalculated. 07:12 to 08:03 = 51 minutes, not 41.
D. Incorrect. 00752 is anesthesia for gastric restrictive procedures, not cholecystectomy.

89. A 76-year-old patient with severe COPD (ASA IV) undergoes a colonoscopy with polypectomy under monitored anesthesia care (MAC). The anesthesia start time is 10:05 and end time is 10:49. Because of the patient's unstable respiratory status, the anesthesiologist documents 'extreme age and severe systemic disease' as qualifying circumstances. Which is the correct coding?

Answer: D. 00811-P4, 44 minutes, +99100

Explanation:

A. Incorrect. P3 is for severe systemic disease; COPD with significant instability qualifies as ASA IV.
B. Incorrect. 00812 is anesthesia for colonoscopy with biopsy; polypectomy uses 00811. 99100 is correct for extreme age but 99140 is for emergency conditions only.

C. Incorrect. 00813 is anesthesia for lower intestinal endoscopy under general anesthesia, not MAC. Also uses incorrect qualifying circumstance.
D. Correct. 00811 is anesthesia for lower intestinal procedures (colonoscopy with polypectomy). P4 reflects severe systemic disease. 99100 applies for extreme age (>70). MAC is inherent to 00811 when used in this context.

90. An anesthesiologist provides general anesthesia for a tonsillectomy on a 52-year-old patient with BMI 46 and obstructive sleep apnea. The 2026 anesthesia clarification highlights increased airway management complexity in morbid obesity with OSA. The case is documented as ASA III. What is the correct anesthesia coding?

Answer: C. 00322-P3

Explanation:

A. Incorrect. P2 does not reflect significant airway risk. The patient has morbid obesity and OSA, requiring ASA III.
B. Incorrect. 99100 is for extreme age, which does not apply. 00320 is anesthesia for tonsillectomy without significant airway risk.
C. Correct. 00322 is anesthesia for procedures involving the tonsils/adenoids requiring heightened airway management—consistent with 2026 clarification regarding morbid obesity with OSA. ASA III reflects moderate systemic disease with airway impact.

D. Incorrect. ASA IV is not supported; patient is stable and does not meet criteria for life-threatening disease.

91. A 42-year-old male arrives at the ED after a fall from a ladder. He complains of severe left hip pain, dizziness, and a scalp laceration. The ED physician performs a comprehensive history, a high-complexity exam, and high-level MDM due to multiple injuries and risk of internal bleeding. Procedures performed include: simple scalp laceration repair (2.5 cm), pelvis X-ray (1–2 views), and administration of 1 L IV fluids. Final diagnoses: scalp laceration, closed fracture of left acetabulum, and dehydration. What is the correct coding for this encounter?

Answer: B. 99285, 12001, 72190, S32.402A, S01.01XA, E86.0

Explanation:

A. Incorrect. 99284 describes moderate MDM; this case meets high complexity due to multi-system trauma and potential internal injury.
B. Correct. 99285 is appropriate for high-complexity ED care. 12001 is correct for a simple laceration repair of 2.5 cm. 72190 is the correct pelvis radiograph code. ICD-10-CM codes match all final diagnoses.
C. Incorrect. 12002 is for lacerations 2.6–7.5 cm; this wound is only 2.5 cm. 72170 is a full pelvic X-ray; the scenario specifies 1–2 views, which is 72190.

D. Incorrect. The acetabular fracture code is incorrect (S32.452A ≠ left acetabulum unspecified portion). The laceration ICD code is also incorrect, and 12002 does not match 2.5 cm.

92. A 59-year-old new patient is referred to a cardiologist for evaluation of exertional chest discomfort. The cardiologist documents:
- History: Detailed history of present illness, review of systems, and past history including long-standing hypertension and hyperlipidemia.
- Exam: Detailed cardiovascular and respiratory examination with focused neurologic exam.
- Medical Decision Making:
  - Problems: 1 acute complaint (chest pain suspicious for angina) and 2 chronic illnesses (hypertension and hyperlipidemia) with exacerbation/concern.
  - Data: Review of external cardiology notes from 1 year ago, review and independent interpretation of prior ECG; orders a 12-lead ECG with interpretation and a complete transthoracic echocardiogram with Doppler and color flow.
  - Risk: Prescription drug management is initiated (beta-blocker started; statin dose adjusted), with moderate risk due to possible angina and medication adjustments.

Services performed today:
- New patient office/outpatient E/M service.
- 12-lead ECG, including tracing and interpretation.
- Complete transthoracic echocardiogram with spectral and color Doppler.

Medical Coding Ace

Final diagnoses:
- Suspected angina pectoris (chest pain on exertion).
- Essential (primary) hypertension.
- Mixed hyperlipidemia.
What is the most appropriate coding combination for this encounter?

Answer: B. 99204, 93000, 93306, R07.9, I10, E78.2

Explanation:

A. Incorrect. 99203 represents a low level of MDM. This case meets moderate complexity (multiple chronic conditions, extensive data review, new drug management). Also, 93005 is the technical component only, but the scenario states the cardiologist both performs and interprets the ECG.
B. Correct. 99204 is appropriate for a new patient visit with moderate MDM. 93000 correctly describes a 12-lead ECG with both tracing and interpretation. 93306 is the complete transthoracic echo with spectral and color Doppler. R07.9 is unspecified chest pain, I10 is essential hypertension, and E78.2 is mixed hyperlipidemia, matching the documented diagnoses.
C. Incorrect. 99214 is for an established patient, but this is clearly documented as a new patient consultation. I20.9 (unspecified angina pectoris) is not supported as a definitive diagnosis; the scenario describes suspected angina/chest pain, not confirmed ischemic heart disease. E78.5 is

hyperlipidemia, unspecified, but the chart documents mixed hyperlipidemia, better captured by E78.2.
D. Incorrect. 99205 is high-complexity MDM, which is not supported here (moderate-level data and risk). 93010 is the professional component only; there is no indication the technical component is billed separately. 93307 is an older code for complete echo without Doppler; the case explicitly includes spectral and color Doppler, so 93306 is more accurate.

93. A 44-year-old patient presents to the Emergency Department with sudden onset right lower quadrant abdominal pain, nausea, and fever. The ED physician performs:
- History: Comprehensive symptom history including onset, progression, aggravators, and full ROS.
- Exam: Comprehensive abdominal, GU, and systemic exam.
- MDM:
  - Problems: Acute abdominal pain with suspected appendicitis; dehydration; tachycardia.
  - Data: Ordered and independently interpreted a CT abdomen/pelvis with contrast; reviewed and interpreted CBC and CMP; reviewed prior ED visit from 2 months ago for unrelated gastroenteritis.
  - Risk: High — due to decision for urgent surgery if appendicitis confirmed, prescription antiemetics and IV fluids administered, parenteral analgesia.
Diagnostics:

Medical Coding Ace

- CT abdomen/pelvis w/ contrast → findings: Enlarged, inflamed appendix with periappendiceal fat stranding.
- CBC: Leukocytosis.

Final ED diagnoses: Acute appendicitis; dehydration; abdominal pain.

The ED physician provides a high-complexity ED evaluation, initiates IV fluids, antiemetics, and analgesia, and arranges immediate consult with general surgery. No procedures were performed by the ED physician.

What is the correct coding for this encounter?

Answer: B. 99285, 74177-26, K35.80, E86.0

Explanation:

A. Incorrect. 99284 reflects moderate MDM; this encounter meets high-complexity due to urgent surgical decision-making, extensive data, and high risk. Also, the ED physician only interpreted the CT; the technical component should not be billed.

B. Correct. 99285 is supported by high-complexity MDM. 74177-26 correctly captures the professional component only (physician interpretation). K35.80 is the correct 2026 code for acute appendicitis without generalized peritonitis, without perforation, without abscess, matching the scenario. Dehydration (E86.0) is a secondary diagnosis supported by documentation.

C. Incorrect. 74177 should be appended with -26 for professional component; otherwise, it would incorrectly

represent a global service. K35.2 describes appendicitis with perforation, which is not supported.
D. Incorrect. 99284 is not supported. 74177-TC is incorrect because the ED physician did not provide the technical component. K35.2 is not supported by the findings.

94. A 62-year-old diabetic patient presents to outpatient dermatology with a rapidly enlarging, painful lesion on the left upper back. The dermatologist performs the following:

History & Exam: Comprehensive review of expanding skin lesion, fever, pain, and risk factors (diabetes, prior MRSA infection). Exam of skin, lymphatic system, and constitutional symptoms.

Medical Decision Making:
• Problems: Rapidly progressing abscess with surrounding cellulitis; concern for early MRSA infection; uncontrolled type 2 diabetes.
• Data: Ordered and interpreted wound culture; independently reviewed recent A1c from PCP; reviewed previous dermatology note from 6 months prior regarding recurrent MRSA.
• Risk: High — decision to initiate systemic antibiotics (parenteral), perform I&D, and begin close follow-up due to risk of systemic infection.

Medical Coding Ace

Procedure: Incision and drainage of a complex abscess of the left upper back, requiring blunt dissection to break up loculations and iodoform packing.

Treatment: Parenteral antibiotic administered in-office; oral doxycycline prescribed.

Diagnoses documented: Complex cutaneous abscess of back; cellulitis of back; type 2 diabetes mellitus; fever.

What are the correct codes for this encounter?

Answer: B. 10061, 99215-25, L03.312, L02.212, R50.9, E11.65

Explanation:

A. Incorrect. 10060 is for simple I&D. The documentation clearly describes complex drainage with breaking up loculations and packing, which supports 10061. The E/M also meets high MDM, supporting 99215 rather than 99214. Diabetes with hyperglycemia (E11.65) is more appropriate than E11.9 because the case explicitly notes uncontrolled diabetes.
B. Correct. 10061 is appropriate for complex I&D of an abscess. The visit meets high-complexity MDM (high-risk infection, parenteral antibiotics, multiple comorbidities), supporting 99215 with modifier -25. ICD-10-CM codes: L03.312 (cellulitis of back), L02.212 (cutaneous abscess of back), R50.9 (fever), and E11.65 (type 2 diabetes with

hyperglycemia — appropriate since the scenario specifies uncontrolled diabetes).
C. Incorrect. 99215 is appropriate, but 10060 is incorrect because the abscess drainage was complex. Missing key diagnoses (cellulitis and diabetes).
D. Incorrect. 99214 is insufficient given high MDM. E11.9 does not reflect the stated uncontrolled diabetes. Cellulitis is also missing.

95. A 28-year-old G2P1 at 30 weeks' gestation is referred to a maternal-fetal medicine specialist for evaluation of decreased fetal movement and newly diagnosed gestational diabetes controlled by diet.

The MFM physician performs:
- History: Detailed pregnancy history, prior cesarean delivery, course of current pregnancy, and review of decreased fetal movement.
- Exam: Detailed obstetric exam including fundal height, fetal heart tones, maternal vitals, and limited neurologic and cardiovascular assessment.
- Medical Decision Making:
  - Problems: 1 acute pregnancy-related problem (decreased fetal movement) and 1 chronic pregnancy complication (gestational diabetes, diet controlled).
  - Data: Orders and interprets a biophysical profile ultrasound; reviews prior OB records from the referring provider; reviews 2 weeks of home blood glucose logs.

- Risk: Moderate – due to pregnancy complication (gestational diabetes) and evaluation of fetal well-being.

Diagnostics performed today:
- Biophysical profile (BPP) ultrasound of single fetus including NST.

Final diagnoses:
- Maternal care for decreased fetal movements in third trimester (single fetus).
- Gestational diabetes mellitus in pregnancy, diet controlled.
- 30 weeks' gestation of pregnancy.

What is the most appropriate coding for this encounter?

Answer: B. 99204, 76818, O36.8130, O24.410, Z3A.30

Explanation:

A. Incorrect. 76805 is a standard second or third trimester OB ultrasound, not a biophysical profile. The scenario describes a BPP with NST, which is captured by 76818. 99203 reflects low MDM, but this case supports moderate complexity.
B. Correct. 99204 is appropriate for a new patient with moderate MDM (complicated pregnancy with gestational diabetes and evaluation of decreased fetal movement, multiple data elements, and risk at the moderate level). 76818 correctly describes a fetal biophysical profile with non-stress testing. O36.8130 (maternal care for decreased fetal

movements, third trimester) and O24.410 (gestational diabetes in pregnancy, diet controlled) with Z3A.30 (30 weeks' gestation) accurately capture the encounter.
C. Incorrect. 76816 is a follow-up ultrasound for fetal growth, not a BPP. O24.419 is gestational diabetes, unspecified control, but the case clearly indicates diet-controlled GDM, better captured by O24.410. Also missing the code for decreased fetal movement.
D. Incorrect. 99214 is for an established patient; this is a new patient consultation. While 76818 and the ICD-10-CM codes are correct, the E/M level and patient status do not match.

96. A 33-year-old recreational soccer player presents for outpatient surgery after MRI-confirmed complete tear of the anterior cruciate ligament (ACL) in the right knee.

Operative report summary:
- Procedure: Diagnostic arthroscopy of the right knee followed by arthroscopically aided ACL reconstruction using patellar tendon autograft. Menisci are inspected and found intact. No additional procedures (e.g., meniscectomy, chondroplasty) are performed.
- Anesthesia: General.
- Findings: Complete ACL tear, right knee; no other intra-articular injuries.

Preoperative and postoperative diagnoses: Complete tear of ACL, right knee, initial encounter.

No separate E/M service is reported on the same day.

What is the correct coding for this surgical encounter?

Answer: A. 29888-RT, S83.511A

Explanation:

A. Correct. 29888 describes arthroscopically aided ACL reconstruction. RT correctly indicates the right knee. S83.511A captures the complete ACL tear of the right knee, initial encounter for closed injury.
B. Incorrect. 29881 is a meniscectomy code and is not performed here. S83.511D is for a subsequent encounter, not appropriate for a surgical repair following an acute injury episode coded as initial.
C. Incorrect. 29870 is a diagnostic arthroscopy, which is not separately reportable when a more extensive arthroscopic procedure (29888) is performed in the same compartment and session.
D. Incorrect. Modifier 50 is for bilateral procedures; only the right knee is treated. S83.512A would describe a left ACL tear, which is not documented.

97. A 74-year-old patient is seen by a neurologist for progressive memory loss and behavioral changes. The visit is an established patient office follow-up.

Medical Coding Ace

History: Detailed history from the patient and spouse, including worsening short-term memory, disorientation, and new agitation with wandering. Social history reveals the patient recently moved into a crowded multi-family home due to financial strain and housing instability.

Exam: Detailed neurologic exam (cranial nerves, motor, sensory, gait), mental status testing, and focused cardiovascular exam.

Medical Decision Making:

- Problems: Progressive major neurocognitive disorder due to probable Alzheimer's disease with behavioral disturbance; hypertension (stable).
- Data: Review of prior neuroimaging and neuropsychological testing; review of recent PCP notes; ordering of updated labs (TSH, B12) to rule out reversible contributors.
- Risk: Moderate – initiation of cholinesterase inhibitor and adjustment of antihypertensive medication, counseling on safety and supervision.

Final diagnoses (2026 terminology):
- Major neurocognitive disorder due to Alzheimer's disease with agitation and wandering behavior.
- Essential hypertension.
- Housing instability impacting care.

What is the most appropriate coding for this encounter?

Answer: C. 99214, F03.A3, I10, Z59.19

Explanation:

A. Incorrect. 99213 typically corresponds to low MDM; this case includes multiple chronic conditions with exacerbation, extensive data review, and new prescription drug management, supporting moderate complexity (99214). F03.90 is unspecified dementia, which does not capture the specified Alzheimer's etiology or behavioral disturbance. Z59.19 correctly reflects housing instability but is missing if option A were selected.
B. Incorrect. While G30.9 and F02.81 reflect Alzheimer's disease with behavioral disturbance in older coding structures, the 2026 update provides more specific classification. This option also omits the social determinant code for housing instability.
C. Correct. 99214 is appropriate for an established patient visit with moderate MDM (progressive dementia, medication adjustments, multi-source data review). F03.A3 represents the 2026-updated code for major neurocognitive disorder due to Alzheimer's disease with agitation and wandering, providing greater specificity. I10 captures essential hypertension, and Z59.19 represents housing instability impacting care, consistent with SDOH documentation.
D. Incorrect. 99215 would require high-complexity MDM (e.g., severe risk, significant new diagnostic uncertainty, or major change in management beyond this scenario). It also omits

the SDOH diagnosis, which is clinically relevant and documented.

98. A 68-year-old established patient with chronic systolic heart failure and hypertension has a scheduled telehealth follow-up with a cardiologist using real-time audio-visual communication. The patient has been enrolled in a remote physiologic monitoring (RPM) program for weight and blood pressure tracking for the past month.

During today's 30-minute visit, the cardiologist:
- Reviews RPM data (daily weights and blood pressures) collected over the past 30 days through a connected home device.
- Adjusts the patient's diuretic dose based on rising weight trends and mild shortness of breath.
- Reviews adherence to ACE inhibitor therapy and reinforces low-sodium diet.
- Documents moderate MDM due to chronic illness with exacerbation and prescription drug management.

RPM service elements:
- Initial device setup and patient education were performed last month by the same practice.
- Ongoing monitoring and minimum 20 minutes of interactive management this month are documented by the cardiology team.

Final diagnoses:

- Chronic systolic (heart failure with reduced ejection fraction).
- Essential hypertension.

What is the most appropriate coding combination for this month's services (telehealth visit + RPM)?

Answer: A. 99214-95, 99457, I50.22, I10

Explanation:

A. Correct. 99214-95 captures an established patient telehealth E/M visit with moderate MDM and real-time audio-visual communication. 99457 is reported for 20+ minutes of RPM treatment management in a calendar month, which is documented. I50.22 represents chronic systolic heart failure and I10 covers essential hypertension.
B. Incorrect. 99213-95 underestimates the MDM (moderate complexity is supported). 99453 is for initial setup and patient education for RPM, which was already performed in a prior month and should not be reported again. I50.9 is unspecified heart failure; I50.22 is more specific and appropriate.
C. Incorrect. The -95 modifier is needed to indicate telehealth for the E/M service. 99458 is an add-on to 99457 for each additional 20 minutes of RPM management; the scenario documents 20 minutes, not more than 20, so only 99457 is reported.
D. Incorrect. 99215-95 requires high-complexity MDM, which is not supported. 99454 is the supply/device code for RPM

data transmission, but the question asks specifically for services this month including the telehealth visit and interactive management. Also, I50.9 is too nonspecific.

99. A 66-year-old long-term smoker undergoes CT-guided percutaneous needle biopsy of a suspicious right upper lobe lung nodule.

Procedures performed (same day, same facility):
- Interventional radiologist performs CT-guided percutaneous core needle biopsy of the right lung lesion.
- Pathologist performs microscopic examination of the core biopsy (surgical pathology, level IV) and orders a comprehensive next-generation sequencing (NGS) panel for lung cancer biomarkers using formalin-fixed paraffin-embedded (FFPE) tissue.

Findings:
- Pathology confirms non-small cell carcinoma of the right upper lobe.
- Molecular panel evaluates multiple genetic alterations relevant to targeted therapy; 2026 CPT updates consolidate prior lung panels into a single comprehensive code.

Final diagnoses:
- Malignant neoplasm of upper lobe, right bronchus or lung.

Medical Coding Ace

Assume the coder is reporting for the physician services (radiology and pathology components), not the facility. What is the most appropriate coding combination?

Answer: C. 32408, 77012-26, 88305-26, 81X45, C34.11

Explanation:

A. Incorrect. 32408 is correct for percutaneous core needle biopsy of the lung, and 77012-26 captures the CT guidance. However, 88305 without a -26 implies global pathology, which is not appropriate when reporting only the physician component. 81445 reflects older targeted genomic panels; the scenario specifies a comprehensive, consolidated NGS panel code updated for 2026.
B. Incorrect. 32408-26 would inappropriately apply a professional modifier to the surgical procedure itself rather than the imaging guidance. 81450 does not match the described 2026 lung-specific comprehensive panel. Also missing CT guidance.
C. Correct. 32408 accurately reports percutaneous core needle biopsy of the lung. 77012-26 describes CT guidance with professional component only for the radiologist. 88305-26 captures the surgical pathology, level IV, professional interpretation. 81X45 represents the 2026-updated comprehensive NGS panel code for lung cancer biomarkers. C34.11 is the correct ICD-10-CM code for malignant neoplasm of upper lobe, right bronchus or lung.

D. Incorrect. 88307-26 is for more complex surgical pathology than described. 81X45 is correct for the 2026 lung NGS panel, but R91.1 (solitary pulmonary nodule) is no longer appropriate once malignancy is confirmed; C34.11 should be reported.

100. A 10-year-old child with a history of asthma is brought to the Emergency Department with acute shortness of breath and wheezing after running at school.

History & Exam: Comprehensive history from parent and child. Exam shows tachypnea, diffuse expiratory wheezes, and use of accessory muscles. Oxygen saturation is 91% on room air.

Medical Decision Making:

- Problems: Moderate persistent asthma with acute exacerbation; no evidence of pneumonia.
- Data: Pulse oximetry performed and interpreted; chest X-ray ordered and interpreted as negative for infiltrate.
- Risk: Moderate – nebulized bronchodilator treatments given in ED, systemic steroids initiated, with observation for potential deterioration.

Procedures/Services performed:
- Two nebulized bronchodilator treatments.
- Chest X-ray, 2 views, interpreted by ED physician.

Medical Coding Ace

Social history notes: Family currently living in a temporary shelter due to recent eviction.

Final diagnoses:
- Moderate persistent asthma with acute exacerbation.
- Housing instability due to lack of permanent residence.

What is the correct coding for this encounter?

Answer: B. 99284, 94640, 71046-26, J45.41, Z59.01

Explanation:

A. Incorrect. 99283 is more consistent with low to moderate MDM; this encounter includes systemic steroids, multiple nebulizer treatments, and imaging, supporting 99284. 94640 is appropriate for nebulizer treatment. 71046-26 correctly indicates a two-view chest X-ray with professional component only. J45.41 (moderate persistent asthma with acute exacerbation) and Z59.01 (homelessness/housing instability) are appropriate. The E/M level is the primary issue.
B. Correct. 99284 is supported by moderate-complexity MDM (exacerbation of a chronic respiratory condition, systemic steroid therapy, multiple neb treatments, imaging). 94640 reports nebulized bronchodilator treatment. 71046-26 captures the two-view chest X-ray interpretation. J45.41 correctly describes moderate persistent asthma with acute exacerbation, and Z59.01 captures housing instability/homelessness, as documented.

C. Incorrect. 71045 is for a single-view chest X-ray; the scenario documents two views. J45.909 is unspecified asthma without complication, but the case clearly describes moderate persistent asthma with acute exacerbation, which is more accurately coded as J45.41. Z59.0 is less specific than Z59.01 when homelessness or shelter living is documented.
D. Incorrect. 99285 reflects high-complexity ED care, such as impending respiratory failure or ICU-level risk, which is not supported here. J45.21 is mild intermittent asthma with exacerbation, which does not match the documented moderate persistent asthma.

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