

CPT SURGERY CODING PRACTICE TEST (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

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THE FULL VERSION STUDY GUIDE**

<https://cptsurgerycoding.examzify.com>



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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. Which section of the CPT code manual primarily contains codes for surgical procedures?**
 - A. The Surgery section
 - B. The Radiology section
 - C. The Evaluation and Management section
 - D. The Pathology and Laboratory section
- 2. What does "open" refer to in the context of surgical procedures?**
 - A. A method requiring minimal incisions
 - B. Endoscopic techniques
 - C. A method requiring large incisions for access to internal structures
 - D. Non-invasive techniques
- 3. For a vein graft repair of a blood vessel in the right arm, which code should be used?**
 - A. 35236
 - B. 35236-RT
 - C. 35237
 - D. 35235
- 4. How are unlisted procedure codes designated in the CPT coding system?**
 - A. By the use of a specific code that ends in "00"
 - B. By the use of a specific code that ends in "99"
 - C. By not assigning any number
 - D. By using a prefix code
- 5. During a direct laryngoscopy for the removal of a fish bone stuck in the throat, what code(s) should be reported?**
 - A. 31530
 - B. 31531
 - C. 31532
 - D. 31533

- 6. What was the medical specialty of Dr. White, who performed the tube removal surgery?**
- A. General Surgery
 - B. Otolaryngology
 - C. Pediatrics
 - D. Anesthesiology
- 7. Why is accurate documentation of complications crucial in coding?**
- A. It aids in the assessment of surgical skill
 - B. It influences the payment and reimbursement process
 - C. It provides historical data for future surgeries
 - D. It eliminates the need for further reviews
- 8. A 65-year-old male patient undergoes a transurethral resection of the prostate gland with vasectomy; what code should be reported?**
- A. 52600
 - B. 52601
 - C. 52602
 - D. 52603
- 9. When performing a direct laryngoscopy on a newborn, which additional procedure is commonly performed?**
- A. Tracheoscopy
 - B. Angioplasty
 - C. Bursa drainage
 - D. Voiding pressure study
- 10. Which types of surgical procedures might necessitate a lengthy global period?**
- A. Minor outpatient surgeries
 - B. Major surgical procedures requiring extensive recovery time
 - C. Same-day procedures
 - D. Routine diagnostic tests

Answers

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1. A
2. C
3. B
4. B
5. B
6. B
7. B
8. B
9. A
10. B

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Explanations

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1. Which section of the CPT code manual primarily contains codes for surgical procedures?

- A. The Surgery section**
- B. The Radiology section
- C. The Evaluation and Management section
- D. The Pathology and Laboratory section

The Surgery section of the CPT code manual is specifically designed to include codes for a wide range of surgical procedures. This section is extensive and categorizes surgical interventions based on the body system, the type of procedure, and the complexity involved. It encompasses both minor and major surgeries, and includes codes for procedures performed in different specialties such as orthopedic, cardiovascular, general surgery, and more. In contrast, other sections of the CPT code manual serve different purposes. The Radiology section focuses on imaging procedures such as X-rays, MRIs, and CT scans. The Evaluation and Management section contains codes for office visits, consultations, and other patient evaluations that do not involve surgical procedures. The Pathology and Laboratory section comprises codes related to laboratory tests and pathological examinations, which are also distinct from surgical interventions. Thus, the Surgery section is the primary and most relevant part of the CPT code manual for coding surgical procedures.

2. What does "open" refer to in the context of surgical procedures?

- A. A method requiring minimal incisions
- B. Endoscopic techniques
- C. A method requiring large incisions for access to internal structures**
- D. Non-invasive techniques

In the context of surgical procedures, the term "open" specifically refers to techniques that involve making larger incisions to access internal structures of the body. This method allows surgeons to have a direct view and access to the area being operated on, which is necessary for certain complex procedures. Open surgery contrasts with minimally invasive techniques, where smaller incisions are made, often involving cameras and specialized instruments to perform the surgery with less disruption to surrounding tissues. Understanding the specifics of open surgery is important because it typically involves considerations such as longer recovery times, increased risk of infection due to larger wounds, and greater postoperative pain. Open procedures are often warranted when the complexity of the surgery or the condition of the patient necessitates direct access rather than the limited view provided by minimally invasive techniques. Therefore, in this context, recognizing that "open" describes the need for larger incisions helps clarify the different approaches to surgical procedures and their implications for patient care.

3. For a vein graft repair of a blood vessel in the right arm, which code should be used?

- A. 35236
- B. 35236-RT**
- C. 35237
- D. 35235

The appropriate code for a vein graft repair of a blood vessel in the right arm is indeed 35236-RT. This code accurately reflects the procedure performed while also specifying the anatomical location involved in the surgery. The base code, 35236, pertains to the repair of a blood vessel using a graft but does not specify laterality. When the procedure is performed on the right arm, the additional modifier "RT" is added to indicate that the operation specifically took place on the right side of the body. This is crucial for proper identification of the procedure, ensuring accurate billing and documentation that it was not performed on a different site or limb. Using the modifier in this context is essential for coding standards and helps to convey precise information to insurers and other parties reviewing the medical records. The other codes listed do not fully capture the combination of procedure and laterality or refer to different types of procedures that are not related to this specific scenario.

4. How are unlisted procedure codes designated in the CPT coding system?

- A. By the use of a specific code that ends in "00"
- B. By the use of a specific code that ends in "99"**
- C. By not assigning any number
- D. By using a prefix code

In the CPT (Current Procedural Terminology) coding system, unlisted procedure codes are designated by the use of specific codes that end in "99." This numbering convention indicates that the code does not correspond to a specific procedure that is otherwise listed in the CPT. Unlisted codes are created to account for procedures or services that are not well-defined or recognized by a dedicated code, allowing for flexibility in coding for unique or new treatments. Utilizing a code that ends in "99" serves to signal to payers that the procedure is atypical or does not fit into the established categories within the CPT. This is significant for documentation and billing purposes, as it prompts further description and clarification of the procedure being billed. Other options do not accurately reflect how unlisted procedure codes are categorized in the CPT system, thus reinforcing the importance of recognizing "99" as the definitive ending for these unlisted codes.

5. During a direct laryngoscopy for the removal of a fish bone stuck in the throat, what code(s) should be reported?

- A. 31530
- B. 31531**
- C. 31532
- D. 31533

The appropriate code for reporting the procedure of direct laryngoscopy for the removal of a foreign body, such as a fish bone stuck in the throat, is indeed 31531. This code specifically pertains to the removal of a foreign body from the larynx and pharynx using direct laryngoscopy, making it the correct choice in this scenario. In the context of surgical coding, each code is designed to reflect not just the procedure performed but also the complexity and specifics of that procedure. In this case, 31531 indicates that direct laryngoscopy was utilized and that a foreign body removal was accomplished, which is crucial for accurate coding and billing. Other codes in the range might pertain to different types of laryngoscopy procedures or scenarios that do not specify foreign body removal, which is why they would not be appropriate for this situation. The specificity of 31531 to the removal of a foreign body during direct laryngoscopy is what distinguishes it and confirms its correctness for this specific clinical action.

6. What was the medical specialty of Dr. White, who performed the tube removal surgery?

- A. General Surgery
- B. Otolaryngology**
- C. Pediatrics
- D. Anesthesiology

Dr. White's specialty in otolaryngology, also known as ENT (ear, nose, and throat), is significant in the context of tube removal surgery, which often pertains to the management of conditions such as ear infections or fluid buildup in children. Otolaryngologists frequently perform surgical procedures to insert or remove tympanostomy tubes, which help alleviate these issues by allowing fluid to drain from the middle ear. In contrast, general surgery encompasses a broader range of surgical procedures but does not focus specifically on the head and neck region like otolaryngology does. Pediatrics deals primarily with children's health but does not define the surgical specialty itself. Anesthesiology is focused on the administration of anesthesia and perioperative care, rather than performing surgical procedures. Therefore, the specificity of Dr. White's practice in otolaryngology directly aligns with the nature of tube removal surgery, making it the correct choice.

7. Why is accurate documentation of complications crucial in coding?

- A. It aids in the assessment of surgical skill
- B. It influences the payment and reimbursement process**
- C. It provides historical data for future surgeries
- D. It eliminates the need for further reviews

Accurate documentation of complications is crucial in coding primarily because it significantly influences the payment and reimbursement process. Health insurance providers and government payers often rely on specific coding to determine the amount they will reimburse healthcare providers for services rendered. Properly documented complications can lead to appropriate coding that reflects the complexity of the patient's condition, which can directly impact the severity of the case and the reimbursement rates associated with it. Additionally, well-documented complications ensure that healthcare providers are compensated fairly for the additional resources, time, and care that may be required to address those complications. This is particularly important because reimbursement models increasingly depend on detailed coding that accounts for not only the primary procedure but also any complications or additional challenges that arise during patient care. Other aspects of accurate documentation, such as assessing surgical skill or providing future historical data, are also beneficial but do not carry the same direct financial implications as reimbursement-related accuracy. Hence, the role of accurate documentation in the payment process is paramount.

8. A 65-year-old male patient undergoes a transurethral resection of the prostate gland with vasectomy; what code should be reported?

- A. 52600
- B. 52601**
- C. 52602
- D. 52603

The procedure performed in this scenario is a transurethral resection of the prostate (TURP) accompanied by a vasectomy. In the context of CPT codes, the coding for such combined procedures is more specific. The correct CPT code for reporting a transurethral resection of the prostate with vasectomy is 52601. This code specifically denotes a transurethral resection, in which part of the prostate is removed to relieve urinary obstruction, while also indicating that it is being performed in conjunction with a vasectomy. CPT coding emphasizes specificity and accuracy in reporting procedures. When multiple procedures are performed during the same operative session, documentation is required to justify the use of codes that represent each procedure. Therefore, the selection of code 52601 reflects the combination of the TURP and vasectomy, providing an accurate representation of the surgical services rendered. The other options do not correctly encompass both components of the procedure. Each of them represents variations of procedures related to the prostate but without indicating the combination with a vasectomy or inaccurately describes the procedure, hence making them unsuitable in this context.

9. When performing a direct laryngoscopy on a newborn, which additional procedure is commonly performed?

- A. Tracheoscopy**
- B. Angioplasty
- C. Bursa drainage
- D. Voiding pressure study

In the context of performing a direct laryngoscopy on a newborn, it is common to also perform a tracheoscopy. This procedure involves visualizing the trachea, allowing the physician to assess potential issues such as airway obstructions, abnormalities, or lesions that may also impact the larynx. The close anatomical relationship between the larynx and the trachea makes it practical and relevant to examine both areas in cases where airway intervention is necessary, especially in infants who may have congenital issues or other respiratory problems. The other options—angioplasty, bursa drainage, and voiding pressure study—are not typically associated with direct laryngoscopy. Angioplasty is a vascular procedure, bursa drainage pertains to joint issues, and voiding pressure studies are related to urinary function, none of which are relevant to the upper airway examination performed during a laryngoscopy. Therefore, tracheoscopy is the logical complementary procedure that aligns with the goals of evaluating and addressing airway concerns in newborns during a direct laryngoscopy.

10. Which types of surgical procedures might necessitate a lengthy global period?

- A. Minor outpatient surgeries
- B. Major surgical procedures requiring extensive recovery time**
- C. Same-day procedures
- D. Routine diagnostic tests

A lengthy global period is typically associated with major surgical procedures that require extensive recovery time. These procedures are often more complex, involving significant surgical interventions that can lead to prolonged healing processes and comprehensive postoperative care. Such surgeries usually entail more extensive follow-up and management after the initial procedure, which is recognized by the longer global period designation. In terms of coding, the global period represents the time frame during which all necessary preoperative and postoperative care related to that surgical procedure is bundled into the surgical code. Major surgeries often entail complications and a need for frequent monitoring, which justifies the extended global period. This is different from minor outpatient surgeries or same-day procedures, which generally have shorter global periods due to their lower complexity and quicker recovery times. Routine diagnostic tests do not fall under surgical procedures at all, as they do not require surgical intervention or recovery, making them unrelated to the concept of global periods in surgery coding.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://cptsurgerycoding.examzify.com>

We wish you the very best on your exam journey. You've got this!

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