

# Ophthalmic Coding Specialist Practice Test (Sample)

## Study Guide



**Everything you need from our exam experts!**

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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

- 1. When a patient undergoes cataract extraction and corneal transplantation, which CPT code should be listed first for optimal reimbursement?**
  - A. CPT code 66984 (Cataract extraction)**
  - B. CPT code 65730 (Keratoplasty)**
  - C. CPT code 66821 (Intravitreal injection)**
  - D. CPT code 66982 (Complex cataract surgery)**
- 2. In ophthalmic coding, what is a global period?**
  - A. The time frame during which all follow-up services are included**
  - B. The period during which a patient must return for further testing**
  - C. The time taken to complete all surgical procedures**
  - D. The duration of the patient's insurance coverage**
- 3. What diagnosis code should be used for the removal of silicone oil?**
  - A. 996.70**
  - B. 998.82**
  - C. 999.99**
  - D. 996.59**
- 4. What is the primary purpose of coding guidelines in ophthalmology?**
  - A. To reduce costs for patients**
  - B. To ensure compliance and proper billing**
  - C. To promote unnecessary procedures**
  - D. To eliminate competition among practices**
- 5. What does the modifier -59 indicate in ophthalmic coding?**
  - A. A modification of a surgical procedure**
  - B. A distinct procedural service**
  - C. A minor surgical procedure**
  - D. A service covered under Medicare**

- 6. Which modifier is used for an unrelated procedure by the same physician during the postoperative period?**
- A. -50**
  - B. -57**
  - C. -78**
  - D. -79**
- 7. What type of procedure is represented by CPT code 66825?**
- A. Yag capsulotomy**
  - B. Repositioning of intraocular lens prosthesis**
  - C. Laser surgery for cataracts**
  - D. Initial cataract extraction**
- 8. How are diagnostic imaging techniques documented in ophthalmic coding?**
- A. Through standardized CPT codes applicable to imaging services**
  - B. Only using ICD codes specific to imaging**
  - C. With unique identifiers not listed in any coding system**
  - D. By using only local coding systems for billing**
- 9. What does the abbreviation BI imply regarding payment for service?**
- A. Payment is always made at a higher rate if both eyes are tested**
  - B. Service is inherently bilateral with consistent payment**
  - C. Payment will vary based on the number of eyes treated**
  - D. Restrictions apply if only one eye is involved**
- 10. What should be the color of ink used for documenting medical records to ensure easier reading during duplication?**
- A. Red or green ink**
  - B. Pencil**
  - C. Black or blue ink**
  - D. Any color ink**



## **Answers**

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

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## **Explanations**

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**1. When a patient undergoes cataract extraction and corneal transplantation, which CPT code should be listed first for optimal reimbursement?**

- A. CPT code 66984 (Cataract extraction)**
- B. CPT code 65730 (Keratoplasty)**
- C. CPT code 66821 (Intravitreal injection)**
- D. CPT code 66982 (Complex cataract surgery)**

For cataract extraction combined with corneal transplantation, the correct choice is to prioritize the CPT code for keratoplasty (corneal transplant) first. This is due to several factors related to the complexity and resource utilization of the procedures involved. When reporting surgical procedures for reimbursement, payers often emphasize the primary procedure that carries the highest risk and requires the most extensive resources. In this case, keratoplasty (CPT code 65730) is classified as a more complex visual restoration procedure when compared to cataract extraction. Typically, corneal transplantation involves additional surgical time, care, and a greater amount of post-operative management than a straightforward cataract surgery. Therefore, it is considered the primary procedure for coding purposes. Following this guideline, the correct coding practice is to list the keratoplasty first, as this aligns with both procedural hierarchy and payer expectations, ultimately promoting optimal reimbursement for the complex nature of the services rendered. In contrast, cataract extraction codes, such as 66984 or 66982, are usually secondary in this context since they do not involve the same level of complexity and resource need associated with the keratoplasty. Additionally, the option involving an intravitreal injection would not be relevant to this specific surgical combination scenario.

**2. In ophthalmic coding, what is a global period?**

- A. The time frame during which all follow-up services are included**
- B. The period during which a patient must return for further testing**
- C. The time taken to complete all surgical procedures**
- D. The duration of the patient's insurance coverage**

A global period is defined as the specific timeframe following a surgical procedure during which all necessary follow-up care related to that procedure is included without additional charges. This means that any revisits for complications, follow-up checks, or additional medical concerns directly related to the procedure performed are typically covered under the initial surgical fee. This concept is crucial in ophthalmic coding because it helps coders ensure they bill accurately for the services rendered and complies with coding guidelines concerning what is covered within that global period. Knowing the global period helps in deciding which services should be billed separately, if applicable, and which are bundled into the original surgical fee. The other choices describe aspects that are not aligned with the established definition of a global period. While follow-up testing and insurance coverage can be important in patient care, they do not specifically pertain to the bundled services included within the global period of a surgical procedure.

**3. What diagnosis code should be used for the removal of silicone oil?**

- A. 996.70**
- B. 998.82**
- C. 999.99**
- D. 996.59**

The appropriate diagnosis code for the removal of silicone oil is 996.59. This code specifically pertains to complications due to implanted prosthetic devices or foreign objects, which includes silicone oil used in ocular surgeries. The removal process of silicone oil is generally associated with its purpose as a temporary measure to manage certain retinal conditions, making the need for this code crucial when documenting the reasons behind the procedure. Other codes mentioned are not suitable for this specific scenario. For instance, code 996.70 typically refers to unspecified complications from implanted materials, which does not provide the necessary specificity related to silicone oil. Code 998.82 is used for post-operative complications, while 999.99 is a placeholder code that does not convey any meaningful diagnosis. Each of these alternatives lacks the precise correlation with the complications or procedures related to silicone oil removal, highlighting why 996.59 is the most accurate choice.

**4. What is the primary purpose of coding guidelines in ophthalmology?**

- A. To reduce costs for patients**
- B. To ensure compliance and proper billing**
- C. To promote unnecessary procedures**
- D. To eliminate competition among practices**

The primary purpose of coding guidelines in ophthalmology is to ensure compliance and proper billing. These guidelines are established to help healthcare providers accurately report the services and procedures they perform. By adhering to coding guidelines, ophthalmologists can ensure that their billing practices are in line with current regulations and standards, which helps to minimize the risk of claims denials and audits. Coding guidelines also aim to provide clarity and uniformity in how services are documented and reported. This consistency helps facilitate communication between healthcare providers, payers, and regulatory bodies, ultimately leading to appropriate reimbursement for the services rendered. Effective use of coding can also assist in the tracking of patient care outcomes and research initiatives, contributing to the improvement of ophthalmic practices. Options that suggest reducing costs for patients, promoting unnecessary procedures, or eliminating competition among practices do not align with the fundamental goals of coding guidelines in the healthcare system. These principles are not centered around patient costs directly or influencing market competition but focus on accurate and compliant documentation and billing practices.

**5. What does the modifier -59 indicate in ophthalmic coding?**

- A. A modification of a surgical procedure**
- B. A distinct procedural service**
- C. A minor surgical procedure**
- D. A service covered under Medicare**

The modifier -59 is used in ophthalmic coding to indicate a distinct procedural service. This means that the procedure being billed is separate and independent from other procedures performed on the same day, allowing for the appropriate reimbursement when multiple services are provided. Using this modifier is crucial in situations where procedures might otherwise be bundled together under a single payment. For example, if a patient undergoes two different surgical procedures on the same day that are not typically reported together, appending the -59 modifier to the secondary procedure clearly communicates to the payer that this service is distinct in nature and warrants separate payment. In contrast, the other options do not accurately describe the purpose of modifier -59. While a modification of a surgical procedure and minor surgical procedures may involve additional considerations in coding, they do not encompass the distinct service aspect that the -59 modifier signifies. Similarly, while some services may be covered under Medicare, this modifier specifically addresses the coding of distinct procedural services rather than reimbursement policies.

**6. Which modifier is used for an unrelated procedure by the same physician during the postoperative period?**

- A. -50**
- B. -57**
- C. -78**
- D. -79**

The modifier that indicates an unrelated procedure performed by the same physician during the postoperative period is the -79 modifier. This modifier specifically designates that the procedure in question is not associated with the previous surgery and, therefore, requires separate consideration for billing purposes. When a physician performs a procedure that is unrelated to the surgery already conducted, using the -79 modifier helps to clarify that the new procedure is distinct from the surgical service that preceded it. This distinction is important to ensure that the services are appropriately coded and billed, allowing the payer to understand that the two services should not be bundled or considered part of the original postoperative care. Understanding the context of this modifier is essential. Options that refer to other modifiers like -50, -57, or -78 pertain to different situations—such as bilateral procedures, surgical decision-making preceding a major surgery, or unplanned return to the operating room due to complications. Therefore, while they are important in their own right, they do not apply to the scenario of an unrelated procedure during the postoperative period.

**7. What type of procedure is represented by CPT code 66825?**

- A. Yag capsulotomy**
- B. Repositioning of intraocular lens prosthesis**
- C. Laser surgery for cataracts**
- D. Initial cataract extraction**

CPT code 66825 specifically pertains to the procedure known as "YAG capsulotomy." This procedure involves the use of a YAG (yttrium aluminum garnet) laser to create an opening in the capsule that holds the lens implant after cataract surgery. Over time, some patients may develop a condition called posterior capsule opacification (PCO), where the capsule becomes cloudy and affects vision. The YAG capsulotomy is performed to clear this obstruction, restoring clear vision for the patient. In this context, the other options do not describe the correct procedure associated with CPT code 66825. For example, repositioning an intraocular lens prosthesis would fall under a different code, as it involves adjusting the position of an implanted lens rather than addressing the capsule itself. Similarly, laser surgery for cataracts generally refers to cataract extraction procedures rather than the capsulotomy that specifically targets the capsule. Initial cataract extraction also involves the removal of the lens but does not concern the postoperative complications of capsule opacity that necessitate the YAG capsulotomy. Thus, the accurate representation of CPT code 66825 is indeed YAG capsulotomy.

**8. How are diagnostic imaging techniques documented in ophthalmic coding?**

- A. Through standardized CPT codes applicable to imaging services**
- B. Only using ICD codes specific to imaging**
- C. With unique identifiers not listed in any coding system**
- D. By using only local coding systems for billing**

Diagnostic imaging techniques in ophthalmic coding are documented through standardized CPT (Current Procedural Terminology) codes that are specifically applicable to imaging services. CPT codes are a comprehensive coding system developed and maintained by the American Medical Association (AMA) and are used to report medical, surgical, and diagnostic procedures and services. These codes allow for consistent communication and billing across providers and insurance companies, ensuring that the services rendered are accurately represented and reimbursed. Using ICD codes solely, as suggested in some options, would not be sufficient as ICD codes are primarily used for diagnostic purposes, categorizing the conditions or diseases treated rather than detailing the procedures performed. Unique identifiers not found in any coding system would lack the necessary standardization needed for billing and communication in healthcare. Additionally, relying solely on local coding systems could lead to inconsistencies and misunderstandings in billing across different regions and practices, as local codes may not be recognized universally. Hence, the use of standardized CPT codes for imaging services is the most appropriate and accurate method for documentation in ophthalmic coding.

**9. What does the abbreviation BI imply regarding payment for service?**

- A. Payment is always made at a higher rate if both eyes are tested**
- B. Service is inherently bilateral with consistent payment**
- C. Payment will vary based on the number of eyes treated**
- D. Restrictions apply if only one eye is involved**

The abbreviation BI in this context indicates that the service being provided is inherently bilateral. This means that when a procedure is performed on both eyes, it is recognized as a standard practice, and payment typically reflects that bilateral nature. Services categorized as BI often have a consistent payment structure that accounts for the evaluation or treatment of both eyes simultaneously, rather than individually assessing the conditions of each eye. In the context of reimbursement and coding, the recognition of bilateral services at a consistent rate supports streamlined billing practices and ensures that patients receiving care for both eyes are adequately compensated for the comprehensive nature of the service provided. This approach simplifies the billing process and reflects the medical understanding that many ocular conditions affect both eyes. Regarding the other options, those that suggest variable payment rates based on factors such as the number of eyes treated or restrictions on payment if only one eye is involved do not align with the standard associated with the BI designation, which emphasizes the bilateral nature and uniform payment for such services.

**10. What should be the color of ink used for documenting medical records to ensure easier reading during duplication?**

- A. Red or green ink**
- B. Pencil**
- C. Black or blue ink**
- D. Any color ink**

Using black or blue ink for documenting medical records is essential for ensuring that the records are easily readable during duplication. This is because both black and blue inks produce high contrast against white paper, which is the standard for most medical documents. High contrast aids in maintaining legibility when the records are copied, faxed, or scanned, as these processes can sometimes alter or degrade the quality of the text. In contrast, using colors such as red or green may not provide the same clarity during duplication and could be difficult to read, especially if copies are made. Pencil is not an acceptable option for official medical records because it can smudge and fade over time, leading to potential loss of important information. Allowing any color ink could result in a lack of consistency and readability issues across medical records, which could impact patient care and documentation practices. Thus, the standardized use of black or blue ink helps in maintaining legal and accurate documentation, making it easier for all healthcare professionals to access clear and legible records.



## 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](mailto:hello@examzify.com).**

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

**<https://ophthalmiccodingspecialist.examzify.com>**

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