OPHTHALMIC CODING SPECIALIST PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR THE FULL VERSION STUDY GUIDE

https://opthalmiccodingspecialist.examzify.com

Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.

ALL RIGHTS RESERVED.

No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.

Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.

SAMPLE

Table of Contents

Copyright 1

Table of Contents 2

Introduction 3

How to Use This Guide 4

Questions 5

Answers 8

Explanations 10

Next Steps 16

SAMPLE

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.

SAMPLE

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!

SAMPLE

Questions

SAMPLE

1. What does the modifier -57 indicate?

A. Unplanned return to OR

B. Decision for surgery

C. Unrelated service during postoperative period

D. Bilateral procedure

2. What is the primary diagnosis for an established patient with a red irritated eyelid?

A. Blepharitis only

B. Cataract surgery

C. Diabetes complication

D. Eye infection

3. What is the correct CPT code for a pupilloplasty?

A. CPT code 66986

B. CPT code 66680

C. CPT code 67028

D. CPT code 65855

4. Which specific coding rule applies to removals of foreign bodies?

A. Coding is per session

B. Coding is per eye

C. Coding can be combined

D. Coding depends on the location

5. What type of procedure is indicated by CPT code 67555?

A. Repair of the cornea

B. Repair of eyelid margin involving a flap or graft

C. Removal of a cataract

D. Correction of strabismus

6. For which situation might the code 66987 be applied?

A. Removal of a complicated cataract

B. Insertion of an accommodating IOL

C. Removal of a cataract with a secondary procedure

D. Closed-angle glaucoma treatment

SAMPLE

7. If YAG capsulotomies are performed on both eyes the same day, what percentage of payment is provided?

A. 200%

B. 150%

C. 100%

D. 75%

8. How is diabetic retinopathy classified in ICD-10-CM?

A. With generic codes for diabetes

B. With specific codes under E08.359, E09.359, or E10.359

C. As a developmental disorder

D. As an acute condition only

9. What CPT code should be used for removal of lens material via the pars plana approach?

A. 66840

B. 66852

C. 66830

D. 66930

10. What does the term "bundling" refer to in ophthalmic coding?

A. The practice of grouping related procedures together for billing purposes

B. Creating separate codes for distinct procedures performed

C. Tracking multiple diagnoses for a single visit

D. Providing additional information for billing coding

SAMPLE

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. What does the modifier -57 indicate?

A. Unplanned return to OR

B. Decision for surgery

C. Unrelated service during postoperative period

D. Bilateral procedure

The modifier -57 is used in the context of surgical coding to indicate that a decision for surgery was made during a visit or examination that led to a surgical procedure being performed. This modifier is crucial because it helps differentiate between an evaluation and management service that is part of the surgical decision and one that is unrelated. By appending modifier -57 to the relevant code, it signifies that the visit conducted on the same day as or the day prior to the surgery included the critical decision that the patient should undergo surgery. This distinction is important for correct billing and ensures that the healthcare provider is reimbursed appropriately for the services rendered during that encounter. Understanding the other choices helps clarify why they do not apply in this situation. An unplanned return to the operating room reflects a different scenario where additional surgery or procedures are required due to unforeseen complications. An unrelated service during the postoperative period refers to services provided that do not relate to the surgical procedure performed, which again does not pertain to the decision made prior to surgery. Lastly, a bilateral procedure modifier specifically indicates that a procedure was performed on both sides of the body, which is unrelated to the surgical decision-making aspect captured by modifier -57. Thus, the correct choice highlights the function of the modifier in relation to

2. What is the primary diagnosis for an established patient with a red irritated eyelid?

A. Blepharitis only

B. Cataract surgery

C. Diabetes complication

D. Eye infection

The primary diagnosis for an established patient with a red irritated eyelid is blepharitis. Blepharitis is an inflammation of the eyelid margins characterized by redness, irritation, and often crusting of the eyelashes. It is a common condition that can result from a variety of factors, including bacteria, seborrheic dermatitis, or other skin conditions affecting the eyelids. When seeking a primary diagnosis, it is essential to select the most specific and relevant condition that would account for the observed symptoms—in this case, the redness and irritation of the eyelid. While the other choices could present with symptoms related to the eyes, they do not specifically correspond to the features presented in this scenario. For instance, cataract surgery does not typically cause red and irritated eyelids, nor would diabetes complications typically present this way without other systemic signs. An eye infection could be a possible consideration, but symptoms of infection would likely be more pronounced and include additional signs such as discharge or systemic signs of infection, making blepharitis the best fit here.

SAMPLE

3. What is the correct CPT code for a pupilloplasty?

A. CPT code 66986

B. CPT code 66680

C. CPT code 67028

D. CPT code 65855

Pupilloplasty is a surgical procedure aimed at reconstructing or modifying the pupil, typically due to traumatic or congenital abnormalities. The correct CPT code for pupilloplasty is 66680, which specifically pertains to procedures involving the modification of the pupil. This code is designated for the surgical creation of an artificial pupil, or adjusting the size or shape of the natural pupil. The other codes listed pertain to different procedures; for example, CPT code 66986 is related to cataract surgery with intraocular lens insertion, indicating a different type of ocular intervention. CPT code 67028 pertains to drainage procedures for retinal conditions, which again does not align with pupilloplasty. Finally, CPT code 65855 refers to procedures involving the treatment of glaucoma by laser, which is unrelated to pupil modification. Therefore, 66680 is the appropriate choice for coding a pupilloplasty as it accurately reflects the nature of the procedure performed.

4. Which specific coding rule applies to removals of foreign bodies?

A. Coding is per session

B. Coding is per eye

C. Coding can be combined

D. Coding depends on the location

The coding rule that applies to removals of foreign bodies is that coding is per eye. This means that when a foreign body is removed from one eye, it is coded separately from any procedures done on the other eye, even if they are performed during the same session. This approach recognizes that each eye is treated as an independent unit in terms of coding, allowing for accurate documentation of the procedures and appropriate reimbursement. In certain circumstances where foreign bodies involve both eyes, documentation would clearly reflect which specific eye was affected. This ensures that the coding reflects the actual medical service provided, aligning with the principle that each eye's treatment is distinct and should be reported accurately. While coding can indeed be per session, per eye typically provides the clearest accounting for services rendered. The potential for combining codes generally applies to different procedures that can be performed on an eye, not specifically for the removal of foreign bodies. Finally, while location might influence the specific codes used (e.g., superficial vs. retinal foreign bodies), it does not override the primary coding rule that differentiates removals by eye.

SAMPLE

5. What type of procedure is indicated by CPT code 67555?

A. Repair of the cornea

B. Repair of eyelid margin involving a flap or graft

C. Removal of a cataract

D. Correction of strabismus

The procedure indicated by CPT code 67555 refers specifically to the repair of the eyelid margin involving a flap or graft. This type of surgery is performed to reconstruct the eyelid, often in cases where there has been trauma, tumor excision, or congenital deformities affecting the eyelid. The use of a flap or graft allows for a more extensive and effective repair, ensuring both functional and cosmetic outcomes for the patient. This code includes complex surgical techniques that require specialized training and skill, as they involve moving tissue from one part of the body to cover or repair another area of the eyelid. The precision needed for successful outcomes in these cases highlights the importance of correct coding to ensure appropriate reimbursement and care management for procedures involving eyelid reconstruction. In contrast, the other procedures referenced in the choices are distinct and coded differently. Repair of the cornea, removal of a cataract, and correction of strabismus involve separate techniques, anatomical areas, and patient considerations, each requiring its own specific coding to accurately reflect the services performed.

6. For which situation might the code 66987 be applied?

A. Removal of a complicated cataract

B. Insertion of an accommodating IOL

C. Removal of a cataract with a secondary procedure

D. Closed-angle glaucoma treatment

The code 66987 is specifically utilized for the removal of a cataract when accompanied by a secondary procedure. This scenario often involves complex cases where additional surgical interventions are necessary following the cataract extraction. The need for a secondary procedure could arise due to the presence of complications or an additional surgical technique required to enhance the patient's outcome. In the context of cataract surgery, a secondary procedure might include steps such as lens placement adjustments or treatments addressing complications associated with cataracts. Utilizing the 66987 code accurately reflects the complexity of the surgery and the necessity for this additional intervention, differentiating it from a standard cataract removal procedure, which would be coded differently. In contrast, other choices do not apply because they involve different procedural contexts. The removal of a complicated cataract alone would typically use a different code, while the insertion of an accommodating intraocular lens (IOL) is associated with a separate coding scenario. The treatment for closed-angle glaucoma does not relate to cataract removal and thus would be documented using entirely different coding conventions. Using 66987 correctly identifies the situation where a cataract removal is not a straightforward procedure but rather part of a more complex surgical plan.

SAMPLE

7. If YAG capsulotomies are performed on both eyes the same day, what percentage of payment is provided?

A. 200%

B. 150%

C. 100%

D. 75%

When YAG capsulotomies are performed on both eyes on the same day, the payment is typically set at 150% of the standard procedure fee for the first eye and 50% for the second eye. This payment structure reflects the understanding that while performing surgery on the second eye is less complex, it still requires resources and time. Therefore, when considering both eyes together, the total reimbursement amounts to 150% of the initial payment for a single YAG capsulotomy. This makes sense clinically and financially, as it compensates the provider adequately for performing two procedures while reflecting the reduced resource intensity for the second procedure.

8. How is diabetic retinopathy classified in ICD-10-CM?

A. With generic codes for diabetes

B. With specific codes under E08.359, E09.359, or E10.359

C. As a developmental disorder

D. As an acute condition only

Diabetic retinopathy is classified in ICD-10-CM using specific codes such as E08.359, E09.359, or E10.359. These codes are part of a structured coding system that delineates complications related to diabetes, specifically those affecting the eyes. In ICD-10-CM, diabetes is categorized into several types, including Type 1, Type 2, and secondary diabetes due to another condition. The specific codes listed not only indicate the presence of diabetes but also specify the nature of the complications, including diabetic retinopathy — a common and serious complication that can lead to vision loss if not managed properly. This level of specificity is crucial for accurate documentation, effective treatment planning, and reimbursement purposes. Using generic codes for diabetes does not provide the level of detail necessary to describe the ocular complications and could lead to insufficient information for diagnosis and treatment. Additionally, classifying diabetic retinopathy as a developmental disorder or only as an acute condition does not accurately reflect its chronic and progressive nature, as diabetic retinopathy can develop over time and often requires ongoing management rather than being solely classified as acute.

SAMPLE

9. What CPT code should be used for removal of lens material via the pars plana approach?

A. 66840

B. 66852

C. 66830

D. 66930

The procedure of removing lens material via the pars plana approach is specifically addressed by the CPT code 66852. This code is designated for the aspiration of lens material using the pars plana route, which is typically associated with conditions like dislocated lenses. The reason this code is appropriate is that it directly reflects the surgical technique utilized, distinguishing it from other types of lens surgeries. For example, code 66840 refers to an entirely different procedure involving the removal of a dislocated lens. Code 66830 involves the removal of a cataract using different methods. Similarly, code 66930 relates to cataract surgery with the insertion of an intraocular lens but does not pertain to the aspiration of lens material through the pars plana approach. Understanding the specific nuances and indications of each code is essential for accurate coding and billing in ophthalmology, ensuring proper documentation of the clinical procedures performed.

10. What does the term "bundling" refer to in ophthalmic coding?

A. The practice of grouping related procedures together for billing purposes

B. Creating separate codes for distinct procedures performed

C. Tracking multiple diagnoses for a single visit

D. Providing additional information for billing coding

Bundling refers to the practice of grouping related procedures together for billing purposes in ophthalmic coding. This approach is often used because certain services or procedures are typically performed together during a patient visit, and it streamlines the billing process. By bundling these services, it enhances administrative efficiency and can sometimes reduce the overall cost of care for the patient. When procedures are bundled, the healthcare provider can submit one comprehensive code that represents the entire set of tasks performed, rather than billing for each individual procedure separately. This not only simplifies the billing process but also helps in reducing administrative work and potential errors that might arise from submitting multiple claims. The other options reflect different concepts in medical coding. Creating separate codes for distinct procedures would indicate a different scenario where multiple, unrelated procedures need individual representation in billing, while tracking multiple diagnoses pertains to the management of patient conditions rather than the coding of procedures. Providing additional information for billing coding, while relevant, does not capture the essence of bundling as it pertains to grouping procedures.

SAMPLE

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://opthalmiccodingspecialist.examzify.com

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

SAMPLE