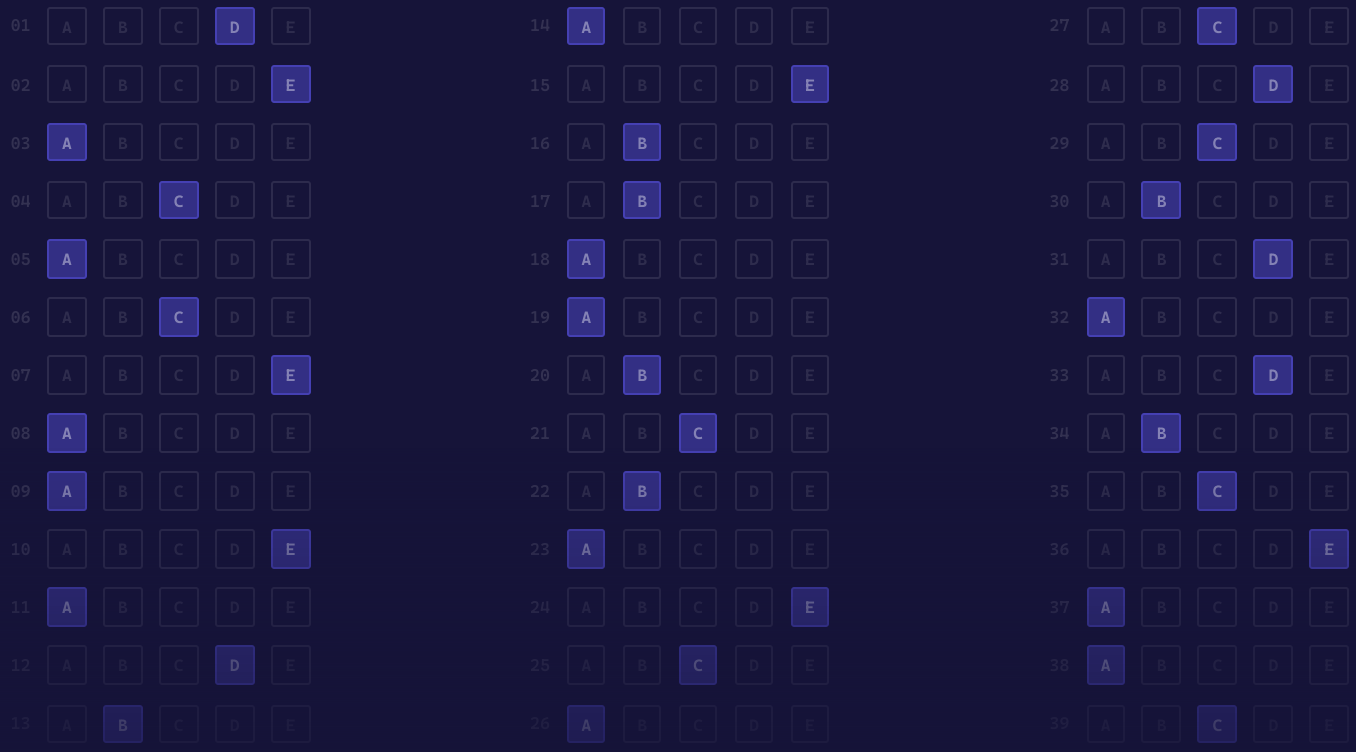
MOMETRIX
SMARTER PREP. BETTER RESULTS.



PRACTICE QUESTIONS

AIS Certification Board (AISCB)

CAISS

Certification Examination for AIS Coding Specialists

EDITION	QUESTIONS	ISSUED
Demo	9	September 4, 2026

WEB www.mometrix.net

SUPPORT support@mometrix.net

Before you begin

What this is

9 practice questions for AIS Certification Board (AISCB) `CAISS`, each with its answer key and an explanation. Answer a question before you read its key — the explanation is worth more once you have committed.

If something looks wrong

Send us three things and we will check it:

- the exam code, `CAISS`
- the question number
- the email address on your order

Write to **support@mometrix.net**. We reply within one business day.

Licence

This file is licensed to one person. Sharing or republishing it, in whole or in part, ends that licence.

Mometrix

QUESTION 1 SINGLE CHOICE

A surgeon performs a percutaneous coronary angioplasty of the left anterior descending artery with placement of a drug-eluting stent. Which ICD-10-PCS root operation is assigned for the stent placement portion of the procedure?

A Dilation

B Insertion

C Supplement

D Replacement

ANSWER B

WHY In ICD-10-PCS, the placement of a biological or synthetic material that physically reinforces or augments the function of a body part is coded to the root operation 'Supplement.' A drug-eluting stent reinforces the native coronary artery lumen and elutes a drug, fitting the PCS definition of Supplement (the device provides both physical support and a therapeutic function). 'Insertion' is used only when a device is put in but does not replace or supplement a body part's function (e.g., a temporary infusion catheter). 'Dilation' would be the root operation for the angioplasty itself. 'Replacement' is reserved for putting in a biological or synthetic material that takes the place of some/all of a body part.

Mometrix

QUESTION 2 SINGLE CHOICE

An established patient is seen in the office for a problem-focused history, a problem-focused examination, and straightforward medical decision making. Which CPT E/M code from the 99211-99215 range is most appropriate?

A 99211

B 99212

C 99213

D 99214

ANSWER B

WHY CPT code 99212 describes an established patient office visit that requires a problem-focused history, a problem-focused examination, and straightforward medical decision making. 99211 is typically used for nurse visits that do not require the presence of a physician or other qualified health care professional. 99213 requires a low level of medical decision making (expanded problem-focused history/exam with low MDM). 99214 requires a moderate level of medical decision making.

QUESTION 3 SINGLE CHOICE

A patient is admitted for the primary purpose of receiving chemotherapy for metastatic breast cancer of the left female breast. The primary diagnosis code assignment is:

A C50.912, Z51.11

B C50.912, Z85.3

C C79.81, Z51.11

D Z51.11, C50.912

ANSWER A

WHY When the reason for admission is solely for chemotherapy, ICD-10-CM Official Guidelines state that Z51.11 (Encounter for antineoplastic chemotherapy) is sequenced first, followed by the diagnosis of the neoplasm being treated. C50.912 is the correct code for malignant neoplasm of the unspecified site of the left female breast. Sequencing Z51.11 first follows the guideline for encounters solely for chemotherapy.

QUESTION 4 SINGLE CHOICE

A surgeon performs a laparoscopic appendectomy (44970) and, during the same operative session, also performs an open lysis of adhesions (44005). Which modifier should be appended to 44005?

A Modifier -22 (Increased procedural services)

B Modifier -51 (Multiple procedures)

C Modifier -59 (Distinct procedural service)

D Modifier -62 (Two surgeons)

ANSWER C

WHY Modifier -59 (Distinct procedural service) is used to indicate that a procedure or service was distinct or independent from other services performed on the same day. The lysis of adhesions is performed via an open approach while the appendectomy is laparoscopic, and the work is separately identifiable. Modifier -51 is typically used for multiple procedures performed by the same surgeon, but -59 is more specific for procedures that are distinct from each other. Modifier -22 is used for significantly greater work than usual, and -62 is for co-surgery.

QUESTION 5 SINGLE CHOICE

A patient is treated in the emergency department for injuries sustained when she fell from a ladder at her home. In addition to codes for the injuries, which external cause codes are reported for this encounter?

A W11.XXXA, Y92.009, Y93.9

B Y92.009, W11.XXXA, Y93.9

C W11.XXXA, Y93.9, Y92.009

D Y92.009, Y93.9, W11.XXXA

ANSWER A

WHY ICD-10-CM Official Guidelines for Coding and Reporting state that external cause codes should be sequenced in this order: (1) the cause (how the injury occurred) — W11.XXXA (Fall on and from ladder, initial encounter); (2) the place of occurrence — Y92.009 (Unspecified place in the home); and (3) the activity — Y93.9 (Unspecified activity). This order is followed unless another specific sequencing instruction applies.

QUESTION 6 SINGLE CHOICE

A patient undergoes a total abdominal hysterectomy with bilateral salpingo-oophorectomy via an open approach. Which ICD-10-PCS body part value is assigned for the uterus in this procedure?

A **Uterus**

B Uterus and Bilateral Fallopian Tubes

C Female Reproductive System

D Uterus and Bilateral Ovaries

ANSWER A

WHY In ICD-10-PCS, when a total hysterectomy is performed with bilateral salpingo-oophorectomy as part of a single procedure, the body part value 'Uterus' is assigned, and the ovaries and fallopian tubes are coded separately under their own body part values if individually addressed. There is no combined 'Uterus and Bilateral Ovaries' or 'Uterus and Bilateral Fallopian Tubes' body part value for this combination. The body part is identified based on the specific site of the procedure, not the entire system.

QUESTION 7 SINGLE CHOICE

An orthopedic surgeon performs an open treatment of a distal radius fracture (25607) and applies a short arm cast (29075) in the same session. Which statement best describes correct CPT coding for the cast application?

A Cast application is separately reportable with modifier -59.

B **Cast application is included in the fracture care and not separately reportable.**

C Cast application is separately reportable without a modifier.

D Cast application is separately reportable with modifier -51.

ANSWER B

WHY Per CPT guidelines, the application of a cast, splint, or strapping is considered a global component of fracture care and is not separately reportable when performed by the same physician during the same encounter. Casting/splinting/strapping supplies (Q-codes) may be reported separately, but the cast application code itself is bundled into the fracture care code.

QUESTION 8 MULTIPLE CHOICE

Which of the following HCPCS Level II code ranges and code categories are correct for durable medical equipment (DME) and prosthetics/orthotics? (Choose two.)

A **A-codes describe DME, prosthetics, orthotics, supplies, and related items.**

B E-codes describe durable medical equipment.

C **L-codes describe prosthetics and orthotics.**

D K-codes describe enteral and parenteral nutrition supplies.

ANSWER **A** · **C**

WHY In the HCPCS Level II code set, A-codes (A0000-A9999) describe DME, prosthetics, orthotics, supplies, and related items. L-codes (L0000-L9999) describe prosthetics and orthotics. E-codes describe DME rental/purchase, not prosthetics/orthotics. K-codes describe temporary DME codes assigned by CMS regional carriers, not enteral and parenteral nutrition (which are B-codes).

QUESTION 9 MULTIPLE CHOICE

Which of the following ICD-10-CM code pairs correctly demonstrate the convention of 'code also' or combination coding for a single clinical concept? (Choose two.)

A **I25.10 for atherosclerotic heart disease with angina pectoris (a single combination code).**

B E11.21 for type 1 diabetes mellitus with diabetic nephropathy (a single combination code).

C C34.90 and Z85.3 for personal history of malignant neoplasm and current lung cancer.

D **I10 and I12.9 for hypertension with hypertensive chronic kidney disease (a single combination code).**

ANSWER **A** · **D**

WHY ICD-10-CM includes single combination codes that classify two diagnoses (or a diagnosis with a manifestation) when one code fully describes both. I25.10 (Atherosclerotic heart disease of native coronary artery with unstable angina pectoris) is a combination code. I12.9 (Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified CKD) is also a combination code that captures both hypertension and CKD. E11.21 is incorrect because 'E11' codes describe type 2 diabetes mellitus, not type 1. A current lung cancer (C34.90) is not coded as personal history (Z85.3) — personal history codes are only used after the cancer has been excised/eradicated and is no longer being treated.