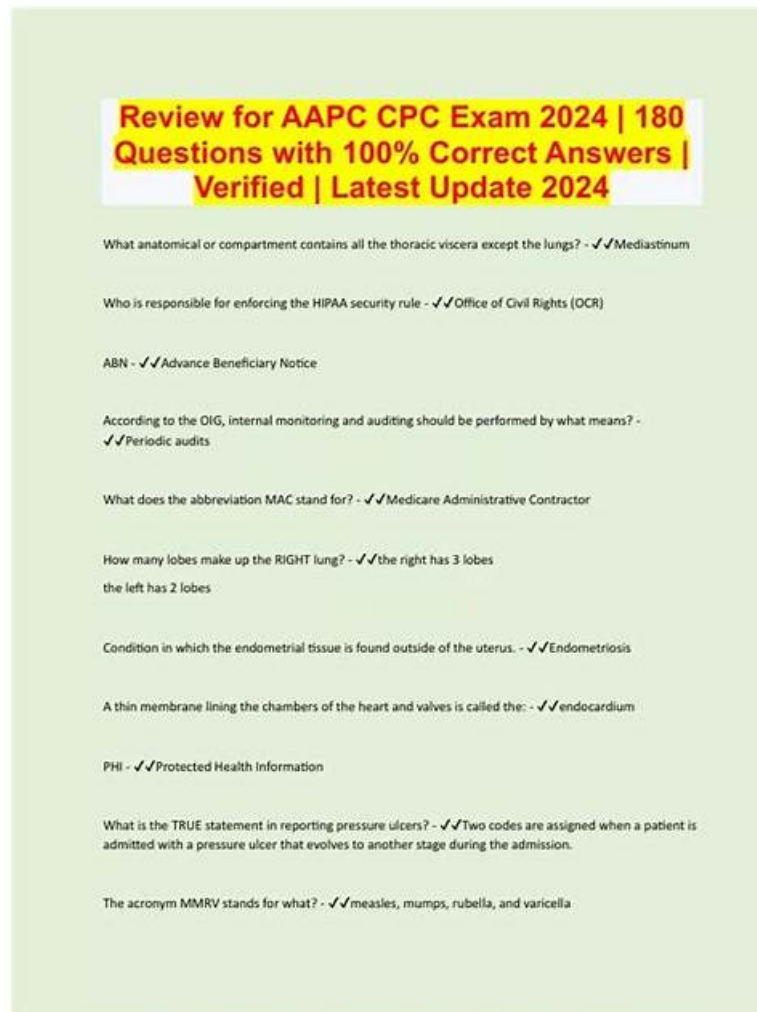


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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q32-Q37):

NEW QUESTION # 32

Which term describes a procedure in which real-time moving images of an organ are displayed on a screen so that a physician can examine its function and/or structure?

- A. Tomography
- **B. Fluoroscopy**
- C. Magnetic resonance imaging
- D. Computed tomography

Answer: B

Explanation:

Magnetic resonance imaging (MRI) uses magnets, radio waves, and a computer to display detailed pictures of the inside of the body. Tomography uses waves of energy to create three- dimensional, computer-generated images of any internal structure. Computed tomography is cross- sectional images of the body obtained by a narrow beam of x-rays that quickly rotates around the body.

NEW QUESTION # 33

Which service is NOT included in the central nervous system assessment?

- **A. Prescription for an opioid**
- B. Clinical dementia rating
- C. Discussion of suicidal intentions
- D. Review of an advance care plan

Answer: A

Explanation:

A central nervous system assessment is comprised of multiple screenings that are reported with CPT codes 96105-96146 and includes, but is not limited to, the following elements: use of standardized instruments for staging and rating clinical dementia; evaluation for behavioral symptoms using standardized screening instruments; and development, updating, revision, and/or review of an Advance Care Plan. A review of high-risk medications is also included in the central nervous system assessment; however, if in the same encounter a prescription is issued, the clinician should document and report the treatment with an appropriate E/M.

NEW QUESTION # 34

A patient has an elective bilateral vasectomy under regional anesthesia

a. The procedure is completed within 15 minutes. What CPT and ICD-IO-CM code(s) should the provider report?

- **A. 55250, Z30.2**
- B. 55250, 00921, Z30.2
- C. 55250-50, Z30.8
- D. 55250, 89321, Z30.8

Answer: A

Explanation:

A vasectomy includes a sperm analysis and regional anesthesia and should not be unbundled for higher reimbursement. A vasectomy

includes both unilateral and bilateral sides, so modifier 50 should never be appended. In this circumstance, CPT 55250 should be billed as a standalone procedure to encompass all services delivered. Additionally, although the documentation does not give a specific diagnosis, it can be inferred from "elective" that the procedure is not to treat an underlying illness or injury. Therefore, Z30.2 (encounter for sterilization) is the evident diagnosis for this type of procedure because the patient is being sterilized. Z30.8 (encounter for other contraceptive management) can be used for an encounter discussing post vasectomy sperm count.

NEW QUESTION # 35

A physician performs a thyroidectomy on a 26-year-old female patient with thyroid cancer. A radical neck dissection with a partial parathyroidectomy and autotransplantation of two parathyroid glands is also completed in the same session. What CPT code(s) should the physician report?

- A. 60254, 60500-51, 60512
- B. 60254, 60512-52
- C. 60254, 60500-51, 60512-51
- D. 0

Answer: B

Explanation:

The CPT code for a thyroidectomy with a radical neck dissection is 60254 and sequenced first because it is the primary procedure with the highest RVU. CPT 60500, which describes a parathyroidectomy, is bundled into a thyroidectomy. Therefore, the two procedures should never be reported together. Parathyroid autotransplantation (CPT 60512) involves the removal of all four parathyroid glands. If not all four glands are removed, report the code with modifier 52 to indicate reduced services. As this is an add-on code, do not append modifier 51.

NEW QUESTION # 36

A 74-year-old male patient recently had a bone marrow transplant due to aplastic anemia. At his follow-up visit with the doctor, his blood is drawn and sent to the laboratory to determine if the engraftment was successful. The laboratory evaluates the immature reticulocyte fraction (IRF) using an automated cell counter and total reticulocyte by way of a manual count. What codes should the laboratory report?

- A. 85046, 85044, D61.9, Z94.81
- B. 85046, D61.9, Z79.89
- C. 85046, D61.9
- D. 85046, 85044, D61.9

Answer: C

Explanation:

When a hematology procedure that could be billed alone is encompassed in another code, only the most complex of the two should be reported. Because CPT 85046 includes the reticulocyte count billing CPT 85044 as secondary despite using a different method would be considered an unbundling of services. Per ICD-IO-CM guidelines, an organ or tissue transplant status code is for use "only if there are no complications or malfunctions of the organ or tissue replaced." As the testing is to determine whether the engraftment was successful, a bone marrow transplant status code would not be appropriate until deemed by the provider.

NEW QUESTION # 37

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