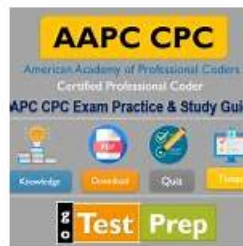


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## Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q65-Q70):

### NEW QUESTION # 65

A patient presents to physical therapy status post repair of a complete rotator cuff tear in the right shoulder due to a fall. After

applying ice to the shoulder for 8 minutes, the physical therapist performs a soft-tissue massage to the infraspinatus muscle that lasts 23 minutes. Just prior to discharge, the therapist spends 20 minutes instructing the patient on isokinetic exercises to help improve range of motion. Which CPT and ICD-IO-CM code(s) should be used to accurately describe encounter?

- A. 97010, 97140x2, 97530, M75.121
- B. 97010, 97140, 97530, S46.011A, W19XXXXA
- **C. 97110, 97010, S46.011D, W19,XXXX**
- D. 97110, 97140, 97010, Z48.89, S46.091A, W19XXXXA

**Answer: C**

Explanation:

Although CPT code 97530 does describe therapeutic activities, the focus is directed at improving functional performance, whereas the correct CPT code 97110 works to develop range of motion. The CPT code for a soft tissue massage (or manual therapy 97140) is based on 15-minute increments, however, anything over 8 minutes prior to or after can be counted as a unit. Based on this, the 23 minutes spent can be counted as two units. Sequencing is based on highest RVU.

Coding crosswalk for a rotator cuff tear is classified as a muscle strain, so answer B, which specifies

"other injury," can be eliminated. Because the patient is in the recovery period of the injury, the seventh character would not be considered active but subsequent.

#### NEW QUESTION # 66

A patient is in labor with plans to deliver vaginally. An epidural is administered at 17:30. After several hours of pushing, the obstetrician determines that the cervix is swollen, and the baby must be delivered via a c-section. The patient consents, the baby is delivered, and both are discharged to the recovery room at 22:15. What CPT code(s) should the anesthesiologist report?

- A. 01967-23, 01968, 99140
- B. 01967, 01968
- **C. 01967-23, 01968**
- D. 01967, 01968, 99140

**Answer: C**

Explanation:

For a planned vaginal delivery with the use of an epidural, followed by a Cesarean delivery, the correct CPT codes are 10967 followed by add-on code 01968. CPT code 99140 is an add-on code portraying that the procedure was an emergency and that the patient and/or baby has a significant increase in the threat to life. The documentation gives no indication that these services were emergent Modifier 23 is reported for unusual anesthesia services. This would include-but is not limited to-the use of general anesthesia for a procedure that usually requires only a local anesthetic or none and/or a procedure extending more than 4 hours. In this case, the total procedure time was 4.75 hours, and modifier 23 is appended on the primary procedure code only.

#### NEW QUESTION # 67

Code the following procedure note:

A selective catheter is placed into the thoracic aorta, where it is then manipulated into the left coronary artery and followed through into the right common carotid artery. Contrast injections are made, and digital imaging is performed. Upon completion, the catheter is removed, pressure is applied at the puncture site, and the patient is discharged.

- A. 0
- B. 1
- C. 36200, 36215, 36216-59
- **D. 36215, 36216-59**

**Answer: D**

Explanation:

The left coronary artery and the right common carotid artery would each be considered their own vascular family. Therefore, when the starting point of selective catheterization is the aorta, the left coronary artery would be considered first order (36215) in the vascular family and the right common carotid artery would be considered the second order (36216). Modifier 59 is appended to indicate that a different vascular family was examined in one session. Contrast materials and catheterization into the aorta are inclusive to the two procedures and are not to be separately coded.

### NEW QUESTION # 68

A surgeon performs a posterior fusion on the L2-L5 of the spine due to degenerative disc disease. CPT and ICD-IOOI code(s) should be reported?

- A. 22533, M51.37
- B. 22800, M51.37
- C. 22612, 22614x 3, M51.36
- **D. 22612, 22614x2, MSI.36**

**Answer: D**

Explanation:

The code for a joint fusion using a posterior approach is 22612. In this scenario, there are three fusion levels: L2-L3, L3-L4, and L4-L5. Following the primary code, 22614 would be billed twice and with no modifier because it is an add-on code. ICD-IO-CM code M51.37 is for degenerative discs in the lumbosacral region; however, L2-L5 is considered the lumbar region.

### NEW QUESTION # 69

Which healthcare professional may NOT report medical nutrition therapy?

- A. Nutritionist
- B. Dietician
- **C. Endocrinologist**
- D. Registered nurse

**Answer: C**

Explanation:

Medical nutrition therapy describes nutritional assessments and interventions in a face-to-face or group patient setting and is reported with CPT codes 97802-97804. These codes are used by nonphysician healthcare professionals only. When a physician provides nutritional advice, a preventative service or evaluation and management code should be reported.

### NEW QUESTION # 70

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