AAPC

CASCC™

Certified Ambulatory Surgery Center Coder

STUDY GUIDE

2026

2026

Specialty Study Guide: CASCC™

AMBULATORY SURGICAL CENTER

AAPC

Contents

2026 Specialty Study Guide: CASCC™ Introduction

The *Specialty Study Guide: CASCC™* is designed to help ambulatory surgery coders, billers, and other medical office professionals prepare for the Certified Ambulatory Surgery Center Coder (CASCC™) examination. This guide is not comprehensive. Your primary resource for the exam will be your years of hands-on experience in coding for ambulatory surgery.

Healthcare in the 21st century is complex and requires expertise in proper coding to obtain payment for procedures, services, equipment, and supplies. Becoming a CASCC™ is the best defense against improper ambulatory surgical center (ASC) coding. Membership in AAPC lends integrity to your credentials, provides a large network of coders for support, and allows you access to continuing education opportunities. The *Specialty Study Guide: CASCC™* provides an overall review of coding and compliance information for the more experienced coder, as well as for someone preparing for the CASCC™ examination.

We will review the importance of using the coding guidelines in ICD-10-CM and CPT®. You will need 2026 versions of ICD-10-CM, CPT®, and HCPCS Level II code books for the study guide and the CASCC™ exam.

ASC General Coding Concepts

It is important for ASC coders to understand general coding and reimbursement concepts. In this chapter, we will discuss National Correct Coding Initiative (NCCI) edits, common modifiers, the Centers for Medicare & Medicaid Services (CMS) and private payer policies, and the importance of working with providers for proper documentation.

CPT® Coding

Surgical procedures specific to ambulatory surgery will be discussed in this section. Special attention will be given to the guidelines and parenthetical phrases associated with procedures. Understanding CPT® coding conventions will be helpful, as well. For the exam, you must be able to select the appropriate CPT® codes and sequence the codes correctly when multiple procedures are performed. CPT® codes are sequenced based on the most complex or labor-intensive procedures. The codes with the highest relative value units (RVUs) are sequenced first.

ICD-10-CM Coding

Proper diagnostic coding reports the medical necessity of procedures performed and contributes to data that determines health policies for tomorrow. Because outpatient facilities have traditionally been paid by CPT® code values, coders have sometimes given little importance to correct ICD-10-CM coding. Regulatory trends show that diagnoses will play a larger role in future reimbursement. It is important to code correctly now, so that you can be prepared for that day.

We will discuss the major topics of diagnosis coding for ambulatory surgery. You must become familiar with the ICD-10-CM Official Coding Guidelines for Coding and Reporting and know how to select the appropriate ICD-10-CM codes, as well as the proper sequencing of diagnosis codes when more than one diagnosis code is required to report a patient's condition(s). This year's guidelines can be found at https://www.cms.gov/files/document/fy-2026-icd-10-cm-coding-guidelines.pdf. You also must understand the conventions, general coding guidelines, and chapter-specific guidelines in the ICD-10-CM code book.

Top 10 Missed Coding Concepts

In this chapter, we will review the Top 10 Missed Coding Concepts for the CASCC™ certification exam. The list is not presented in any specific order. The information is determined after an evaluation by the AAPC Exam Department of the commonly missed questions on the exam.

Practice Exam

The practice exam and the exam itself were written by coders with extensive experience in coding for ambulatory surgery. The practice exam mimics the format and structure of the CASCC™ certification exam.

AAPC has developed specialty credentials enabling coders to demonstrate superior levels of expertise in their respective specialty disciplines. Here is information on the CASCC™ credential:

- CASCC™ stands alone as a certification with no prerequisite that the examinee holds a CPC®, COC®, or CIC® credential.
- Exams aptly measure preparedness for real world coding by being entirely operative/patient-note based. These operative (op) notes are redacted op notes from real surgical centers.

The CASCC™ examination tests your knowledge of coding concepts, anatomic principles, and coding guidelines only. When you take the exam, remember that individual payer rules are not a consideration when choosing the right answer. Unless it is specifically stated in the case note or exam question that Medicare covers the patient, follow the CPT® coding guidelines.

The exam tests competency. The candidate most qualified to pass the exam will be proficient in understanding:

- Medical terminology and anatomy
- Medical physiology
- HIPAA regulations
- Reimbursement methodology for procedures performed in an ASC
- Proper use of the Advanced Beneficiary Notice (ABN)
- ICD-10-CM coding

CPT® coding for common procedures:

- 10000 Series
- 20000 Series
- 30000 Series
- 40000 Series
- 50000 Series
- 60000 Series
- Laboratory and pathology
- Radiology
- Medicine

CPT® and HCPCS Level II modifier usage

- HCPCS Level II coding

Familiarity with practical coding and the code books is essential, as time is an important element in successfully completing the exam. Approach the exam as you would approach your work—by demonstrating coding abilities essential to success. This is not a general aptitude test, and each question has a specific goal for measuring your competency. The practice exam in the *Specialty Study Guide: CASCC™* course is highly representative of the subject matter and level of difficulty you will encounter in the full-length exam.

Test Answers and Rationales

The final chapter in the book contains the answers to the practice exam. Accompanying each answer is a rationale that explains the coding guidelines contributing to selecting the right answer. These rationales should help you understand what is needed to successfully approach and answer questions on the real exam because they allow you a glimpse into the minds of the test's creators.

If you pass the CASCC™ certification examinations, you will receive recognition in AAPC's monthly magazine, *Healthcare Business Monthly,* and receive a diploma suitable for framing.

About AAPC

AAPC was founded in 1988 in an effort to elevate the standards of medical coding by providing training, certification, ongoing education, networking, and recognition.

AAPC provides medical coding certification exams for coders in physician practices and the outpatient/facility environment. AAPC has expanded beyond outpatient coding to include training and credentials in documentation and coding audits, inpatient hospital/facility coding, regulatory compliance, and physician practice management. The purpose of AAPC coding certifications is to test an examinee's knowledge of coding principles and proficiency in coding accurately and efficiently. AAPC examinations measure a coder's skill of both coding accuracy and efficiency.

AAPC Member Code of Ethics

Members of AAPC shall be dedicated to providing the highest standard of professional service for the betterment of healthcare to employers, clients, vendors, and patients. Professional and personal behavior of AAPC members must be exemplary.

It shall be the responsibility of every AAPC member, as a condition of continued membership, to conduct themselves in all professional activities in a manner consistent with ALL of the following ethical principles of professional conduct:

- Integrity
- Respect
- Commitment
- Competence
- Fairness
- Responsibility

Adherence to these ethical standards assists in assuring public confidence in the integrity and professionalism of AAPC members. Failure to conform professional conduct to these ethical standards, as determined by AAPC's Ethics Committee, may result in the loss of membership with AAPC.

In this portion of the text, we will review the following areas:

- CPT® and its use in the ambulatory surgical center (ASC)
- How to use the available physician documentation
- Anatomy and medical terminology
- When to query physicians for additional procedure details
- Add-on codes
- American Medical Association (AMA) incidental and separate procedure rules
- Medicare and commercial payer guidelines
- Category III codes, S codes, and G codes
- HCPCS Level II codes for devices and implanted durable medical equipment (DME)

CPT® and Its Use in the ASC

CPT® codes are HCPCS Level I codes. CPT® is a uniform coding system consisting of descriptive terms and codes used to identify medical services and procedures furnished by physicians and other healthcare providers. These codes are the industry standard for reporting outpatient services to private health insurance companies, Medicare, Medicaid, and TRICARE.

The CPT® code book is organized by body system (integumentary, musculoskeletal, digestive, etc.). Within each section, codes are grouped by procedure type (incision, excisions, repairs, etc.).

Procedures performed via scope have their own family of codes and they are grouped together in each body section. Interpret the operative report to determine the method used to perform the procedure. Open procedures cannot be coded using a code from the scope section, or vice versa. Procedures that state any method but reside in the open section are considered open procedures.

CPT® also provides modifiers that may be appended to a coded procedure. Modifiers indicate a service or procedure has been altered by a specific circumstance but has not changed in its definition or code. Not all payers follow uniform rules for modifier application. Be sure to consult your individual payer rules when appending modifiers.

Never select a CPT® code that merely "approximates" the documented procedure(s). Select an unlisted procedure code, by body area, if a specific CPT® or HCPCS Level II code is not available.

Common Modifiers

Modifiers LT and RT

Modifiers LT *Left side* and RT *Right side* are not used to report a bilateral service, per the Centers for Medicare & Medicaid Services (CMS) guidelines. Rather, these modifiers are used to denote a different procedure performed on the contralateral body part.

Modifier TC

Modifier TC *Technical Component*. Under certain circumstances, a charge may be made for the technical component, only. Under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure code. Technical component charges are institutional charges. An example is the use of fluoroscopy performed during a surgical procedure. The ASC submits the CPT® code with modifier TC. Modifier TC is not required by all payers. Check your payer policy to determine if the modifier is appropriate to use.

Modifier 58

Modifier 58 *Staged or Related Procedure or Service by the Same Physician or Other Qualified Healthcare Professional During the Postoperative Period* applies when a planned supplementary service or required supplementary service is necessary to complete treatment begun earlier in the day. In the ASC setting, the global period for services is one day. You would report modifier 58 only if both services were performed at different surgical session on the same date.

CPT® instructs you to consider modifier 58 for a procedure or service if the procedure or service is:

- Planned prospectively at the time of the original procedure (staged)
- More extensive than the original procedure
- For therapy following a diagnostic surgical procedure

Modifier 59

Use modifier 59 *Distinct Procedural Service* to identify procedures distinctly separate from any other procedure the physician provides on the same date. According to CPT® instructions and chapter 1 of the National Correct Coding Initiative (NCCI), append modifier 59 when the provider:

- Sees a patient during a different session
- Treats a different site or organ system
- Makes a separate incision/excision
- Tends to a different lesion
- Treats a separate injury

Medicare allows placement of modifier 59 on either the column 1 or column 2 code of the edit pair. For consistency in the study guide and exam, place the modifier on the column 2 code.

Modifier 73

Modifier 73 *Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia* is used by the facility to indicate that a surgical or diagnostic procedure requiring anesthesia was terminated due to extenuating circumstances or to circumstances that threatened the well being of the patient after the patient had been prepared for the procedure (including procedural pre-medication when provided) and taken to the room where the procedure was to be performed, but prior to administration of anesthesia. For billing services furnished in the ASC, anesthesia is defined to include local, regional block(s), monitored anesthesia care (MAC) deep sedation/analgesia, or general anesthesia.

Modifier 74

Modifier 74 *Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia* is used by the facility to indicate that a surgical or diagnostic procedure requiring anesthesia was terminated after the induction of anesthesia or after the procedure was started (for example, incision made, intubation started, scope inserted) due to extenuating circumstances or circumstances that threatened the well-being of the patient. For billing services furnished in the ASC, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia ("conscious sedation"), deep sedation/analgesia, and general anesthesia.

The most common service performed by an ASC is surgery. Some of the ASCs do limit their scope of services to noninvasive procedures like endoscopy, but most of facilities offer more complex procedures that can be performed safely in an outpatient setting.

How to Use the Available Physician Documentation

Although you may think the operative report is all you need to code the case, you should review other documents in the medical record. The entire medical record can help you determine why a patient was seen, and to code correctly the condition or diagnosis and procedures or services performed.

Be wary of coding from superbills. Although they may provide codes, they do not include a detailed description of how the procedure was performed. Similarly, treat standardized documentation templates with caution. Not all patients have the same anatomy, the same conditions, or the same treatment.

Any document you use for a final code selection must be provider confirmed. Nursing documentation alone, although vital to a medical record, cannot be used for code selection. The portions of the documentation most valuable for guiding code selection include the operative report, the patient history and physical (H&P), and the pathology report.

The operative report can be transcribed or written by the provider. It provides a detailed account of the procedures and services performed. To select CPT® codes accurately, you must read the entire operative report. That is, read the body of the operative report in addition to the header or summary identifying the performed procedures. You may find that the body of the operative report describes additional and different procedures than what are indicated in the summary. Coding only from the summary can lead to mistakes and can possibly be misconstrued as a fraudulent selection in CPT® coding.

The H&P can be useful, not because you will obtain any procedures from this report, but because you can gain knowledge of previous services. For example, a patient presents for an excision of a ganglion in her wrist. In reviewing the H&P, you may find documentation of a recurrent ganglion cyst in the same area. This information will help to determine the correct diagnosis and CPT® codes.

A pathology report, although generally not available until a few days following surgery, is important to use for the outcome of the morphology of the specimen (for example, benign vs. malignant neoplasm). Pathology results may affect both ICD-10-CM and CPT® code selection. Without the pathology report, you are unable to choose the proper family of codes. Keep in mind if the surgeon dictates morphology within the operative report, it is appropriate to select a code based on documentation.

Along with morphology, the pathology report documents the size or weight of the specimen sent for analysis. In relation to code assignment, size is needed to determine the proper code. We recommend using the size reported by the surgeon for coding; once the specimen is removed, it can decrease in size. If

This chapter reviews CPT® coding for common procedures performed in an Ambulatory Surgical Center (ASC).

Integumentary

Skin Lesions (Benign or Malignant)

Determine the size, pathology, and closure when assigning CPT® codes 11400–11646. When calculating size, add the largest dimension of the lesion, plus twice the smallest margin. For instance, to report a 4 cm x 3 cm area lesion with a 0.5 cm margin on all sides, the size for coding is 5 cm (largest dimension 4 cm, plus twice the smallest margin (0.5 x 2). Assign one CPT® code per lesion excised.

Closures

To select the appropriate code(s) when reporting closures 12001-13160, add together the lengths of all closures of the same type in the same anatomic location. There are three categories of repairs:

- Simple repairs (12001–12021) include local anesthesia and chemical or electrocauterization. Chemical cauterization, electrocauterization, or wound closure with adhesive strips only are not counted as a simple repair but are instead included in the evaluation and management (E/M) service reported for the day of service. Simple wound repair is not included in lesion removal procedures but documented intermediate or complex repairs may be reported separately with lesion removal. Medicare generally specifies a 10-day global period for simple repairs.
- Intermediate repairs (12031–12057) are more substantial and may include layered closure. These repairs reach into the subcutaneous and non-muscle fascia and closing the wound in layers requires more extensive work. This type of repair may involve removal of particulate matter or single closure wounds that are heavily contaminated and require extensive cleaning. Intermediate repairs may include limited undermining (defined as a distance less than the maximum width of the defect, measured perpendicular to the closure line, along at least one entire edge of the defect). Medicare generally specifies a 10-day global period for intermediate repairs.
- Complex repairs (13100–13160) require more than just a layered closure for deep wounds. Necessary preparation includes creation of a limited defect for repairs or debridement of a complicated laceration or avulsion wound. In addition to the requirements of intermediate repair, complex repairs require at least one of the following: exposure to bone, cartilage, tendon, or named neurovascular structure; debridement of wound edges, such as traumatic lacerations or avulsions; extensive undermining (defined as a distance greater than or equal to the maximum width of the defect, measured perpendicular to the closure line along at least one entire edge of the defect); involvement of free margins of helical rim, vermilion border or nostril rim; placement of retention sutures. As well, cosmetic closures are usually complex repairs. These repairs might involve some mattress stitching or undermining stitching, and usually involve longer (90-day) global periods.

Wound repair codes are selected based on the complexity of repair, as well as the site of laceration or wound, and the length of the wound repair. Wound measurements should be made prior to administration of topical or injectable anesthetic.

Adjacent Tissue Transfer or Rearrangement

Tissue transfer procedures (14000–14302) include advancement flaps and V-Y rearrangements, among others. These are coded by size/area. For example, a 6 cm x 6 cm area equals a 36 cm^2 closure. Do not code for the excision of the lesion when a flap is used for closure.

Skin Grafts

Procedures for harvesting of skin graft, carrying to the donor site, applying the graft or substitute by location and incremental units are reported using 15040–15278. Autografts are grafts taken from one part of the patient's body and transplanted to another part of the patient's body. Autografts are reported with 15040–15261. Skin grafts performed using a skin substitute are reported with 15271–15278.

Skin graft codes are selected based on the type of graft used and the location and size of the defect.

Both split thickness skin graft (STSG) and full thickness skin graft (FTSG) are types of autograft. Healthy tissue is harvested from one area, using a device called a dermatome, and transplanted to a different area of the body. The dermatome removes skin like a cheese slicer: STSG takes the epidermis and a small portion of dermis, while FTSG takes the epidermis and the dermis to a complete depth.

Code range for STSG:

- 15100-15101 (Trunk, arms, and legs)
- 15120-15121 (Face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits)

Code range for FTSG:

- 15200-15201 (Trunk)
- 15220-15221 (Scalp, arms, and/or legs)
- 15240-15241 (Forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet)
- 15260-15261 (Nose, ears, eyelids, and/or lips)

Blepharoplasty

A blepharoplasty is performed to remove excess eyelid skin and, in many cases, extensive herniated fat pad from both the upper and the lower eyelids. Often the excessive skin blocks the patient's visual field. Once this skin is removed, the patient will notice improvement in ability to see. The codes are selected based on the location (upper or lower lid) and whether the fat pad is herniated. The code range for blepharoplasty is 15820–15823.

The proper HCPCS modifiers are appended to report the eyelid the surgery is performed on:

- E1 Upper left, eyelid
- E2 Lower left, eyelid
- E3 Upper right, eyelid
- E4 Lower right eyelid

If the procedure is performed bilaterally, modifier 50 can be appended in lieu of the HCPCS anatomical modifiers.

Excessive Skin and Subcutaneous Tissue Excision

With the increase of gastric bypass surgery, there has been an increase of men and women requesting large amounts of excess skin be removed due to the large amount of weight loss. The codes are selected based on anatomical site. The procedures are reported with code range 15830–15839.

Destruction

Use of destruction codes 17000–17004 describes destruction of premalignant lesions, such as actinic keratosis. Apply 17000 for the first lesion. Report a separate unit for each lesion when performed on lesions 2-14 with add-on code 17003. For 15 or more lesions, code neither 17000 nor 17003, instead report 17004.

Codes 17110-17111 describe destruction of benign lesions (example, plantar warts) other than skin tags or cutaneous vascular lesions. Report 17110 for destruction of any number of lesions, up to 14. For 15 or more lesions, code 17111.

If the provider's documentation specifies "destruction," but tissue was sent to pathology, ask for procedure clarification (there would be no tissue to send to pathology, if the lesion was destroyed). The provider may have taken a biopsy prior to destroying the remainder of the lesion.

Breast Surgery

Breast biopsies are common procedures. The code is selected based on the technique used to remove the tissue. Percutaneous needle core biopsy without imaging is reported with 19100. If imaging is performed for a percutaneous needle core biopsy, codes are selected based on the type of imaging used: 19081 (stereotactic), 19083 (ultrasound), and 19085 (magnetic resonance). Add-on codes (+19082, +19084, +19086) are assigned for each additional lesion. An incisional biopsy is reported with 19101. A biopsy is reported when a piece of tissue is obtained for pathology testing. If the entire lesion, cyst, tumor, or fibroadenoma is excised, report 19120.

Breast Repair

The most common reason for breast reconstruction is breast cancer. Breast reconstruction can be performed in several different ways. Let us review mastopexy, reduction mammoplasty, the immediate insertion of a breast prosthesis following mastopexy, mastectomy, and reconstruction.

Mastopexy

Mastopexy is the removal of the excessive tissue that begins to sag because of age or as a result of having nursing children. The excessive tissue is removed and the breast is lifted up above the inframammary line. This procedure is reported 19316.

Reduction Mammaplasty

Reduction mammaplasty is performed to correct hypertrophic breasts. One breast is not necessarily of the same size as the other breast. In reduction mammaplasty, the goal of the surgeon is to get the breasts to be equal in size. Reduction mammaplasty is often done to relieve neck pain, shoulder pain, skin rashes that appear underneath the breasts, shoulder grooving, and numbness that goes down the fingers. This type of procedure is often covered when the patient presents with these symptoms. Check with your payer to see if the procedure meets medical necessity for those symptoms.

Insertion of Breast Prosthesis

Report 19340 when the surgeon performs an immediate insertion of a breast prosthesis following a mastectomy. In the case of 19342, there is a delayed insertion of the breast prosthesis.

AAPC continuously evaluates and enhances our certification exams throughout the year. As AAPC continues to enhance the certification exams, we are beta testing the inclusion of a fill-in-the-blank item type on our certification exams. To prepare you for both item types (multiple choice and fill-in-the-blank), we have provided two versions of this practice exam. The same questions are on both versions of the Test Your Knowledge practice exam; however, the last three cases on this version of the practice exam are fill-in-the-blank. If you prefer to test using the multiple-choice item type for all the cases, use practice exam B.

The following questions will test your comprehension of the information covered in this study guide. The answer key is used for both versions of the Test Your Knowledge practice exams.

Version A

CASE 1

Introduction: A 46-year-old male patient presents for an elective outpatient colonoscopy.

Indications: Screening.

Consent: The benefits, risks, and alternatives to the procedure were discussed, and informed consent was obtained from the patient.

Preparation: Pulse, pulse oximetry, and blood pressure were monitored throughout the procedure.

Medications:

- Versed 5 mg IV throughout the procedure.
- Fentanyl 100 mg IV throughout the procedure.

Rectal Exam: Normal rectal exam.

Procedure: The colonoscope was passed with ease through the anus under direct visualization; it was extended to the cecum, confirmed by appendiceal orifice and ileocecal valve. The scope was withdrawn, and the mucosa was carefully examined. The quality of the preparation was good. The views were good. The patient's toleration of the procedure was good. Retroflexion was performed in the rectum.

Findings: Cecum, ascending, descending, and transverse colon - unremarkable. At 50 cm - diminutive polyp was removed by cold forceps in the sigmoid - diverticula. At 20 cm, diminutive another polyp was removed by cold forceps. Rectum - internal hemorrhoids.

Complications: There were no complications associated with the procedure.

Impressions:

- Cecum, ascending, descending, and transverse colon - unremarkable.
- At 50 cm - diminutive polyp was removed by cold forceps.
- Sigmoid - diverticula.
- At 20 cm, diminutive polyp was removed by cold forceps.
- Rectum - internal hemorrhoids.

Recommendations:

- Follow-up on the results of the biopsy specimens.
- Repeat colonoscopy in 5 years depending upon results of pathology.

Biopsy results: Benign polyp

Non-Medicare patient

1. What is the first listed CPT® code for this patient encounter?

   A. 45378
   B. 45380
   C. 45385
   D. 45384

2. What is the ICD-10-CM coding for this encounter?

   A. Z12.11, D12.6, K57.30, K64.8
   B. D12.6, K57.30, K64.4, Z12.11
   C. K64.8, K57.30, D37.4
   D. K64.8, K57.30, Z86.0100

CASE 2

Preoperative Diagnosis: Left chronic serous otitis media.

Postoperative Diagnosis: Left chronic serous otitis media.

Procedures Performed:

1. Left transcanal tympanoplasty.
2. Operative micorsocpe.

Anesthesia: General.

Indications: This is a 5-year-old male who has had about a year of intermittent infection and drainage from his left ear. He previously had a tube, which was removed, but he continued to have drainage perforation. He returns to the OR for definitive tympanoplasty. The risks, benefits, and alternatives of the procedure were described to the patient's mother who voiced understanding and wishes to proceed.

Findings:

1. A small inferior perforation.
2. Thickened granular mucosa throughout the middle ear with thick mucoid effusion. Cultures were taken.

Operative Procedure: After properly identifying the patient, he was taken to main operating room where general anesthetic was induced. The table was turned to 180 degrees, and a left-sided postauricular injection of 1% lidocaine plus 1:100,000 epinephrine was performed. The patient was then prepped and draped in usual sterile fashion using the operating microscope. Canal injections were made and the tympanomeatal flap was elevated after rimming the perforation. The middle ear was entered, and large pieces of thickened pale mucosa were noted. The incus was mobile and covered in thickened mucosa but appeared to be intact. The middle ear was also full of thick mucoid effusions. Cultures were taken of this and a small piece of

After reviewing the answers and rationales, if you have further questions, please send them to: mct@aapc.com

CASE 1

Introduction: A 46-year-old male patient presents for an elective outpatient colonoscopy. [1]

Indications: Screening. [2]

Consent: The benefits, risks, and alternatives to the procedure were discussed, and informed consent was obtained from the patient.

Preparation: Pulse, pulse oximetry, and blood pressure were monitored throughout the procedure.

Medications:

- Versed 5 mg IV throughout the procedure.
- Fentanyl 100 mg IV throughout the procedure.

Rectal Exam: Normal rectal exam.

Procedure: The colonoscope was passed with ease through the anus under direct visualization; it was extended to the cecum, confirmed by appendiceal orifice and ileocecal valve. The scope was withdrawn, and the mucosa was carefully examined. The quality of the preparation was good. The views were good. The patient's toleration of the procedure was good. Retroflexion was performed in the rectum.

Findings: Cecum, ascending, descending and transverse colon - unremarkable. At 50 cm - diminutive polyp was removed by cold forceps in the sigmoid - diverticula. At 20 cm, diminutive polyp was removed by cold forceps. [3] Rectum - internal hemorrhoids.

Complications: There were no complications associated with the procedure.

Impressions:

- Cecum, ascending, descending, and transverse colon - unremarkable.
- At 50 cm - diminutive polyp was removed by cold forceps.
- Sigmoid - diverticula. [4]
- At 20 cm, diminutive polyp was removed by cold forceps.
- Rectum - internal hemorrhoids. [5]

Recommendations:

- Follow up on the results of the biopsy specimens.
- Repeat colonoscopy in 5 years depending upon results of pathology.

Biopsy results: Benign polyp. [6]

Non-Medicare patient.

[1] Indication of the procedure being performed and the place of service.

[2] Primary diagnosis.

[3] Indication of a diagnostic colonoscopy becoming a therapeutic colonoscopy for the removal of the polyps via cold forceps.

[4] Additional diagnosis reported.

[5] Additional diagnosis reported.

[6] Pathology report indicating type of polyp.

1. **Answer:** B. 45380

   Rationale: The patient is admitted for a screening colonoscopy, but the procedure is converted to a therapeutic procedure and polyps are removed at 50 cm and 20 cm by cold forceps. Look in the CPT® Index for Colonoscopy/Flexible/Biopsy. The description further confirms this is correct.

2. **Answer:** A. Z12.11, D12.6, K57.30, K64.8

   Rationale: In the ICD-10-CM Alphabetic Index look for Screening/neoplasm (malignant) (of)/colon referring you to Z12.11 or Screening (for)/colonoscopy Z12.11. The pathology report indicates benign polyp. Next look in the ICD-10-CM Table of Neoplasms for Neoplasm, neoplastic/intestine/large/colon/Benign column referring you to D12.6. Look for Diverticulosis/large intestine referring you to K57.30. For the final diagnosis, look for Hemorrhoids/internal (without mention of degree referring you to K64.8, and there is no indication of a complication. Verify your code selection in the Tabular List. A screening colonoscopy Is always listed first, followed by the findings (see ICD-10-CM Coding Guideline I.C.21.c.5).

CASE 2

Preoperative Diagnosis: Left chronic serous otitis media.

Postoperative Diagnosis: Left chronic serous otitis media. [1]

Procedures Performed:

1. Left transcanal tympanoplasty. [2]
2. Operative microscope.

Anesthesia: General.

Indications: This is a 5-year-old male who has had about a year of intermittent infection and drainage from his left ear. [3] He previously had a tube, which was removed, but he continued to have drainage perforation. He returns to the OR for definitive tympanoplasty. The risks, benefits, and alternatives of the procedure were described to the patient's mother who voiced understanding and wishes to proceed.

Findings:

1. A small inferior perforation.
2. Thickened granular mucosa throughout the middle ear with thick mucoid effusion. Cultures were taken.

Operative Procedure: After properly identifying the patient, he was taken to main operating room where general anesthetic was induced. The table was turned to 180 degrees, and a left-sided postauricular injection of 1% lidocaine plus 1:100,000 epinephrine was performed. The patient was then prepped and draped in usual sterile fashion using the operating microscope.

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"If you want to rise in the ranks of the Healthcare business portion of the medical field, I highly suggest that you become a member of AAPC and obtain your certifications through them. They will help you to advance and open the door of opportunity for you."

- Latisha Booker, CPC

"APPC has not only provided me with the opportunity to earn multiple credentials but has also opened important doors for me in my career."

- Mary Arnold, CPC, CPMA, CRC, RMA, HR-C

"While taking classes, I was introduced to AAPC. I became a member to help boost my career, and more than 20 years later, I'm still an AAPC member."

– Bradley Miller, CPC, CRC, CDEO

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