AAPC

CGIC™

Certified Gastroenterology Coder

STUDY GUIDE

2026

2026

Specialty Study Guide: CGIC™

GASTROENTEROLOGY

AAPC

Contents

2026 Specialty Study Guide: CGIC™ Introduction

The *Specialty Study Guide: CGIC™* is designed to help gastroenterology coders, billers, and other medical office professionals prepare for the CGIC™ examination. This guide is by no means comprehensive. Your primary resource for the exam will be your years of hands-on experience in coding for gastroenterology.

Healthcare in the 21st century is complex and requires expertise in proper coding to obtain payment for procedures, services, equipment, and supplies. Becoming a CGIC™ shows your expertise in gastroenterology 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: CGIC™* is designed to provide an overall review of coding and compliance information for the more experienced coder, as well as for someone preparing for the CGIC™ examination.

We will review the importance of using the coding guidelines within ICD-10-CM and CPT® as well as emphasize the importance of correct Evaluation and Management (E/M) leveling. In addition to this study guide, you will need 2026 versions of ICD-10-CM, CPT®, and HCPCS Level II code books. These are the books you will need for your CGIC™ exam, as well.

ICD-10-CM Coding

Proper diagnostic coding not only reports the medical necessity of procedures performed, but also contributes to data that determines health policies for tomorrow. Because physicians 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 gastroenterology. The examinee must be familiar with the Official Coding Guidelines for ICD-10-CM. The examinee must 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. The examinee must understand the conventions, general coding guidelines, and chapter specific guidelines in the ICD-10-CM code book.

Evaluation and Management Coding

Office visits consume a lion's share of the physician's time in most practices, and consequently represent the largest revenue source. Compliance is an increasing concern at practices, and the E/M material will focus on the E/M services for gastroenterology and underscore the importance of modifier use. An understanding of the AMA E/M guidelines and subsection notes is an important foundation for accurate code selection that is provided in your CPT® code book.

An online E/M calculator is provided for the online exam (https://www.aapc.com/codes/em-calculator) and your CPT® code book provides a Medical Decision Making (MDM) table to level an E/M service.

CPT® Coding

Surgical procedures specific to gastroenterology 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. The examinee 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 RVUs (Relative Value Units) are sequenced first.

Top 10 Missed Coding Concepts

In this chapter, we will review the Top 10 Missed Coding Concepts for CGIC™ certification exam. The list is not presented in a 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 gastroenterology. The practice exam mimics the format and structure of the CGIC™ certification exam.

AAPC has developed specialty credentials to enable coders to demonstrate superior levels of expertise in their respective

specialty disciplines. Here is information on the CGIC™ credential:

- CGIC™ 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/physician-note based. These operative (op) notes are redacted op notes from real gastroenterology practices.

The CGIC™ 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 the patient is covered by Medicare, you should 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
- Teaching physician guidelines
- Incident-to guidelines
- Split/Shared services
- HIPAA regulations
- Proper use of the Advance Beneficiary Notice (ABN)
- ICD-10-CM coding
- E/M code selection using the AMA CPT® E/M guidelines
- CPT® coding for common procedures
  - 40000 Series
  - Laboratory and Pathology
  - Radiology
  - Medicine
  - Category III codes
- 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 within the *Specialty Study Guide: CGIC™* 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.

Examinees that pass the CGIC™ certification examinations 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.

Introduction to ICD-10-CM Coding Guidelines

The National Center for Health Statistics (NCHS) developed ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) in consultation with a technical advisory panel, physician groups, and clinical coders to assure clinical accuracy and utility. ICD-10-CM coding guidelines are developed by the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics. Healthcare providers must begin using the most recent ICD-10-CM code revisions on October 1 of each year, with no "grace period" to transition to the changes.

All versions of the ICD-10-CM code book typically include the ICD-10-CM Official Guidelines for Coding and Reporting. These guidelines are an invaluable source for diagnosis coding information and provide instruction supplemental to that found in the Tabular List and the Alphabetic Index of the ICD-10-CM code book.

ICD-10-CM codes are utilized to facilitate payment of health services, to evaluate utilization patterns, and to study the appropriateness of healthcare costs. Case-by-case success in achieving these goals requires an open line of communication between the coder and the documenting physician.

The Official Guidelines note, "A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures." Each ICD-10-CM code assigned must be supported by documentation linked to that particular claim (individual dates of service must stand alone), and coders must be mindful not to assume or extrapolate information from the medical record (for instance, coding a condition as acute when it isn't documented as such).

The Official Guidelines are divided into four sections:

- Section I lists ICD-10-CM Conventions, General Coding Guidelines, and Chapter Specific Guidelines.
- Section II explains the Selection of Principal Diagnosis. The Uniform Hospital Discharge Data Set (UHDDS) defines the principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
- Section III gives rules for Reporting Additional Diagnoses (diagnoses, in addition to the principal diagnosis, that affect the patient's care).
- Section IV provides Diagnostic Coding and Reporting Guidelines for Outpatient Services. These include information about coding signs and symptoms, when to report chronic diagnoses, ambulatory surgery, routine outpatient prenatal visits, and more.

General Tips for Using ICD-10-CM

Use the Alphabetic Index and Tabular List of the ICD-10-CM code book together to determine the diagnosis code. When attempting to select an ICD-10-CM diagnosis code, begin by searching for the main term—such as "lesion," "burn," etc. —in the Alphabetic Index. Follow all cross-references and "see also" entries. When you have located the code you are seeking, turn to that code in the Tabular List. Be sure to pay close attention to disease definitions, footnotes, color-coded prompts, and other instruction. Read all supplemental information completely to be certain you are choosing the correct code. Always select a diagnosis to the highest level of specificity supported by the available documentation.

The first-listed diagnosis should describe the most significant reason for the procedure or visit. Generally speaking, the first-listed diagnosis will be reflective of the patient's chief complaint. Relevant co-existing diseases and conditions, as well as related history or family history conditions, are reported as secondary diagnoses. When coding preexisting conditions, make sure the assigned diagnosis code identifies the current reason for medical management. Do not report conditions that no longer exist, or do not pertain to the visit.

Many patients will have numerous chronic complaints. Report a chronic complaint diagnosis *only* when that chronic condition is treated or becomes an active factor in the patient's care.

Always select ICD-10-CM codes to the highest level of specificity supported by documentation. For example, diagnosis coding for fractures of the wrist and hand requires a 5th character (which specifies location), a 6th character (which specifies the laterality and whether the fracture is displaced or nondisplaced), and a 7th character (which specifies the episode of care). If this information is not documented, appropriate code selection is impossible. You should work with your provider to ensure that the information necessary for proper coding is always noted.

General ICD-10-CM Guidelines

Signs/Symptoms and Confirmed/ Unconfirmed Diagnoses

Use of codes that describe signs and symptoms are acceptable when the provider has not established a related, definitive diagnosis. Report only confirmed diagnoses. Uncertain diagnoses described as "probable," "possible," "suspected," "likely," "rule out," "compatible with," "consistent with," etc., are not coded. Code the highest level of certainty known, using codes that describe known signs, symptoms, abnormal test results, etc.

For example, if a patient has a breast mass and the provider suspects breast cancer, you should not report breast cancer as the diagnosis. Instead, report the signs and symptoms, such as breast mass, that prompted the exam. If testing later confirms cancer, only then should you report the cancer diagnosis.

For outpatient encounters that include diagnostic tests which have been previously interpreted by a physician, and the final report is available at the time of coding, report any confirmed or definitive diagnosis(es) documented in the interpretation. If a definitive diagnosis is known, do not code related signs and symptoms as additional diagnoses; that is, if the test is positive, you report the findings. For tests interpreted as "normal" code the condition, symptom, or sign that necessitated the diagnostic study.

In rare occurrences, a test is ordered without a clear indication of reason, and the ordering physician is not available to gather enough information prior to treating the patient. In such a case, you will want to confirm the order with the ordering provider to obtain the reason(s) for the tests. When you are provided with both a preoperative and postoperative diagnosis, always report the *postoperative* diagnoses if the pre- and postoperative diagnoses differ.

Signs and symptoms attributable to a definitive diagnosis should not be reported separately. Cite additional signs and symptoms beyond the primary diagnosis only when those signs and symptoms are not integral to the disease process. Report only those additional conditions that affect treatment, and that the provider documents for the current visit.

For example, a patient presents with shortness of breath. The next day, the physician determines the patient has pneumonia; but he feels that the shortness of breath may be due to a cardiac condition, not pneumonia. In such case, you may report the shortness of breath as a sign and symptom with pneumonia because the physician has a documented reason to believe that the conditions are unrelated.

Above all, do not extrapolate or assume information. Select codes only from what is apparent in the available documentation.

Acute vs. Chronic

The doctor makes the determination as to when a condition becomes chronic. Coders will select an appropriate code for acute or sub-acute (primary) versus chronic (secondary) condition based on the available documentation. For example, a torn meniscus (S83.2-) will become an internal derangement of knee (M23.-) after a defined period of time.

If a patient's condition is described as being *both* acute/ sub-acute and chronic, and a single code does not describe this combination, the ICD-10-CM code book provides instruction that you would report the acute (sub-acute) code as first-listed, with the chronic code secondary.

Sequela (Late Effects)

Sequela (late effects) codes are usually reported as secondary diagnoses, with the effect or reason for the visit as primary. There is no time limit (such as 90 days, one year, etc.) in which late effects can occur.

Sequela (late effects) of cerebrovascular disease fall specifically to category I69, which indicate conditions classifiable to I60-I67 (hemorrhage, occlusion, and stenosis, etc.) as the cause of sequela (late effects). Guidelines indicate the "late effects" include neurologic deficits caused by cerebrovascular disease and may be present from the onset or may arise at any time after the onset of the condition classifiable to categories I60-I67. A code(s) from category I69 may be assigned on a health case record with codes from I60-I67 if the patient has a current Cerebrovascular Accident (CVA) and deficits from an old CVA.

Some of the codes in category I69 that specify hemiplegia, hemiparesis and monoplegia also identify whether the dominant or nondominant side is affected. If the dominance is not stated (right-handed, left-handed, or ambidextrous), and the classification does not indicate a default, then the following applies:

- For ambidextrous patients, the default is always dominant.
- If the left side is affected, the default is nondominant.
- If the right side is affected, the default is dominant.

Evaluation and Management Coding for Gastroenterology

This chapter examines the documentation requirements for the evaluation and management (E/M) codes used by physicians and non-physician practitioners (NPPs) to bill for their services.

The E/M documentation requirements chapter is designed to provide a detailed approach to the accurate identification of documentation elements as they are defined by the American Medical Association (AMA) Guidelines for E/M services. The goal of this material is to offer the necessary insight to develop proficiency and correct technique to accurately select levels of E/M services for the exam. This material is not meant to influence policy, rather to refer to as coding guidelines for the CGIC™ exam.

This chapter should be reviewed with the CPT® guidelines for E/M services found in the current CPT® code book. This guide is a general summary that explains commonly accepted aspects of selecting E/M codes. The goal is that, after completing your training, you will be confident that you will not under or over code a visit.

An Introduction to the Documentation Requirements Associated with E/M Services

The E/M Documentation Guidelines (DGs) have perhaps inspired more discussion than any other non-clinical topic based in the industry. In an ever-increasing effort to ensure that correct payments are made for visits and consultations, Medicare and the AMA have been working together for well over a decade. In 1992, Medicare transitioned to the Resource-Based Relative Value Scale (RBRVS) physician payment system and the AMA introduced E/M codes in CPT® to report visits and consultations.

By 1994, in response to confusion and the inaccurate interpretation of the codes, the Office of Management and Budget mandated that Medicare adopt DGs to expand the definition that was, at that time, only provided by CPT®. Medicare and the AMA jointly developed this initial set of E/M DGs which were deployed in 1995 and became known as the 1995 Documentation Guidelines or DGs. As auditing showed a pattern of continued misuse of the E/M Codes, the 1995 DGs were criticized as unfair to specialists because they seem to account for extended single system examinations with as much weight as limited multiple system exams.

Within two years, the E/M DGs were revised to improve physician and provider understanding and payment accuracy by extending the definitions to include specialty specific guidance. This set of DGs was scheduled to replace the 1995 DGs and became known as the 1997 DGs. The only problem was that the physician community loudly objected to the 1997 DGs. They were criticized as burdensome with documentation requirements that were too detailed and very difficult to achieve. Medicare decided to not replace the 1995 DGs but to instead allow physicians and providers to choose between the 1995 and the 1997 DGs.

In 2021, in an attempt to simplify the guidelines, the AMA changed the descriptions of the Office or Other Outpatient E/M Services codes 99202-99215. In addition, guidelines for the use of these codes were printed in the CPT® code book. The guidelines added in the 2021 CPT® code book were specific to Office or Other Outpatient E/M Services. In 2023, the AMA expanded the use of the guidelines introduced in 2021 to other E/M categories, eliminating the need for the 1995 and 1997 DGs.

Documentation Guidelines

There are three general principles regarding documentation to ensure credit can be thoroughly verified. It is important to follow these rules of thumb:

1. Documentation should be legible to someone other than the documenting physician or provider and their staff.
2. The date of service, name of the patient, and the name of the provider of service should be easily demonstrated by the documentation.
3. The documentation should support the nature of the visit and the medical necessity of the services rendered.

For most E/M visits, the provider performs three main components: history, exam, and medical decision making (MDM). The history directs the provider to troubleshoot the chief complaint based on an interview with the patient. The exam portion is the provider's physical exam and evaluation of the patient. The MDM includes the provider's assessment and plan.

The guidelines for E/M Services, along with the code descriptors, indicate that a "medically appropriate history and/or physical examination, when performed" is included in the service. While the history and exam should be documented, they are not used in the determination of the level of the code.

The guidelines also include pertinent definitions for terms necessary to understand when determining the level of MDM. You should read through the definitions provided in your CPT®

code book and refer back to them as we go through the MDM components below.

The E/M guidelines provide instructions for selecting the appropriate level of service based on either of the following:

1. The level of the MDM as defined for each service; or
2. The total time for E/M services performed on the date of the encounter.

The provider can determine to support the E/M level of the visit based on MDM or time on a case-by-case basis. Regardless of which element is used to determine the level of visit, documentation should support the medical necessity of the visit. Payers may also have regulations on when MDM or total time is used.

Determining the Medical Decision Making (MDM)

The MDM most accurately reflects the amount of work a provider performs during an E/M service. Four levels of MDM are recognized: straightforward, low, moderate, and high. The level of MDM directly correlates to a level of service.

EXAMPLE: OFFICE VISIT MDM TO CODE CORRELATION

New Patient Code	Established Patient Code	Level of MDM
	99211	N/A 99211 is reported for services that typically do not require the presence of a provider. As such, the concept of MDM does not apply to code 99211.
99202	99212	Straightforward
99203	99213	Low
99204	99214	Moderate
99205	99215	High

To adequately determine the level of visit, the MDM is selected based on three components:

1. The number and complexity of problems addressed at the encounter;
2. The amount and complexity of data to be reviewed and analyzed; and
3. The risk of complications and/or morbidity or mortality of patient management.

To determine the levels of these components appropriately, the definitions provided in your CPT® code book must be understood. Using a grid method, we will discuss each component. Be sure to refer back to the definitions listed in the E/M Guidelines as needed.

Number and Complexity of Problems

The number and complexity of problems identifies the nature of the presenting problem and is based on the relative difficulty level in making a diagnosis. For the problem to be considered in the number of problems, the problem must be addressed within that encounter.

Per CPT®, symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Multiple problems of lower severity may, in aggregate, create higher risk due to interaction.

The final diagnosis alone does not determine the complexity or risk to the patient. The documentation should be reviewed for comorbidities or underlying diseases that are addressed that increase the level of risk to the patient. Simply listing a chronic illness in the documentation is not sufficient. The documentation should indicate that the provider addressed the conditions during the encounter or that the condition contributed to the severity of the case.

When a patient sees multiple providers for different aspects of their care, you may see a physician document the condition is being managed by another provider. When the documentation only states that the patient has the condition and that it is being treated by another provider, it is not considered for the leveling of the visit. If there is additional documentation showing assessment or care coordination regarding that diagnosis, other than the statement of the condition being treated by another provider, it is then considered toward the level of service.

TESTING TECHNIQUE

Read through the entire note to get an understanding of the conditions that are addressed and analyzed during the visit. Simply relying on the chief complaint will not always give an accurate description of the number and complexity of problems for the encounter.

There are four levels identified under the number and complexity of problems addressed; minimal, low, moderate, and high. As demonstrated by the table below, the level of Number/Complexity of Problems Addressed increases as the difficulty of the patient's health increases.

Top 10 Missed Coding Concepts on CGIC™ Exam

The concepts discussed are not in a particular order. The tips provided below are based on the AAPC exam department observations of the most missed coding concepts.

1. **Sequencing CPT® codes:** When multiple procedures are performed during the same encounter, the codes should be listed in Relative Value Unit (RVU) order, with the procedure assigned the highest RVUs reported first. For example, if a provider performs an ERCP for destruction of calculi and also performs a biopsy, the correct codes are 43265 (12.73 RVUs) and 43261 (9.97 RVUs). Code 43265 is reported first because it carries the higher RVU value. Modifier 51 is then appended to 43261 to indicate an additional, non-bundled procedure. An RVU calculator will be provided as a resource for you to use on the online GCIC™ exam.
2. **Colonoscopy with polyp removal:** Codes for polyp removal are selected based on the technique used to remove the polyp(s). If more than one polyp is removed using the same technique, report only one CPT® code. If multiple polyps are removed using different techniques, report a CPT® for each technique. For example, the provider removes a polyp using hot forceps and a second polyp using cold biopsy. The correct codes are 45384, 45380-59. Report 45380 when the polyp is removed for cold biopsy.
3. **Proper ICD-10-CM code selection for NOS versus NEC:** Not Otherwise Specified (NOS) is selected when there is not enough documentation to select a more specific code. Not Elsewhere Classifiable (NEC) is selected when specific information is documented for the diagnosis, but there is not an existing ICD-10-CM code to report it. For example, dilation of the bile duct is reported with K83.8 *Other specified diseases of biliary tract*, not K83.9 *Disease of biliary tract, unspecified*.
4. **ICD-10-CM coding for postoperative pain:** Coding postoperative pain is based on the provider's documentation. Routine or expected postoperative pain immediately after a surgery is not coded. Postoperative pain not specified as acute or chronic is coded as acute. Sometimes postoperative pain is associated with a specific complication. When the pain is associated with a specific complication, the code for the complication is primary with a code from category G89 reported secondarily.
5. **Proper ICD-10-CM code selection for neoplasms:** Review the postoperative diagnosis and operative findings to determine if the histology of the neoplasm is specified. For example, the postoperative diagnosis states duodenum neoplasm, but the findings may clarify that the neoplasm is benign. Carefully review the entire operative note to ensure you are reporting the most specific and accurate diagnosis.
6. **Proper ICD-10-CM code selection for a complication of a transplant:** When a patient has a transplant and there is a complication that is related to the transplant, the primary code will be from codes listed for category code T86.
7. **AMA E/M Guidelines for Selecting the Level for the Amount and/or Complexity of Data to be Reviewed:** For Amount and/or Complexity of Data, determining when to count a test ordered towards data is dependent upon whether or not the test/study is separately reportable. The ordering and actual performance and/or interpretation of diagnostic tests/studied during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests/studies is reported separately by the physician. When a provider orders a test that includes a separate interpretation (X-ray, ECG) in the office and it is performed in the office it is presumed that the provider will bill for the test and ordering of a unique test is not counted Tests that do not require separate interpretation (tests that are results only - labs) and are analyzed as part of MDM can be counted as ordered or reviewed. On a follow-up visit if a test is reviewed with a patient that was ordered in a previous visit you do not count review of the result of each unique test because it is included in the ordering of the test from the previous visit.
8. **Colonoscopy Decision Tree:** When a diagnostic colonoscopy is attempted but the colonoscope cannot be advanced to the cecum, the CPT® code book includes a decision tree that outlines the appropriate code selection and indicates when a modifier is or is not required, based on the extent of the colonoscope's advancement.
9. **Modifier use with HCPCS Level II codes:** It is appropriate to append CPT® modifiers on HCPCS Level II codes. For example, modifier 51 can be appended to G0121. If an operative note indicates the patient has Medicare report the HCPCS Level II G code.

10. **Proper ICD-10-CM code selection for category code Z09:** ICD-10-CM codes Z08 and Z09 are used to identify follow-up encounters after a patient has completed treatment for a prior condition. Code Z08 is assigned when the visit is specifically for follow-up after completed treatment for a malignant neoplasm, such as routine surveillance colonoscopy after colon cancer surgery. Code Z09, on the other hand, is used for follow-up after completed treatment for conditions other than malignant neoplasms, such as monitoring after treatment of infections, fractures, or benign conditions. These follow-up codes are reported **first,** followed by the appropriate personal history code to describe the resolved condition being monitored, unless the condition is found to have recurred

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 57-year-old female patient presents for an inpatient Sigmoidoscopy.

Indications: The patient has complained of passing large volumes of blood and clots per rectum. Recent colonoscopies at Anytown General show positive only for hemorrhoids. I am bringing this patient in for an unprepped flexible sigmoidoscopy.

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

Procedure: The endoscope was passed with ease through the anus under direct visualization and advanced to the mid sigmoid colon at 26 cm. The quality of the preparation was mediocre with some brown formed stools at mid sigmoid. The views were excellent. The patient's toleration of the procedure was excellent.

Findings: There is no blood in the colon on examination to the mid sigmoid. No colitis. The rectum is free of blood or bleeding site. The anal verge has some mild hemorrhoids.

Summary: There is no blood in the colon on examination to the mid sigmoid. No colitis. The rectum is free of blood or bleeding site. The anal verge has some mild hemorrhoids. In face of patient complaints of gross rectal bleeding there is no blood in the colon, normal brown stool in the sigmoid. The only possibility is an anal verge vascular abnormality resulting in the reported "blood and clots" passed per rectum. There is no colonic lesion/blood on a scoped examination obtained within hours of her purported passage of blood per rectum.

1. What is the first listed CPT® code for this patient encounter?
   A. 45378
   B. 45331
   C. 45300
   D. 45330

2. What is the first listed ICD-10-CM diagnosis code for this encounter?

   A. K64.8
   B. K64.4
   C. K64.9
   D. K64.0

3. What does a sigmoidoscopy procedure include?

   A. Examination of the rectum and sigmoid colon only
   B. Examination of the entire rectum, sigmoid colon and may include examination of a portion of the descending colon
   C. Examination of the entire rectum, sigmoid colon, descending colon, and a portion of the transverse colon
   D. Examination of the entire colon

4. What is a polyp?

   A. A fluid filled sac found only in the large intestine
   B. A sac which grows from membranes containing excess fatty deposits on their surface
   C. A mass of tissue that bulges outward or upward from membranes that line structures and organs
   D. A blood blister found along the digestive tract lining

CASE 2

Indications:

This esophagogastroduodenoscopy (EGD) is done this morning because of bleeding and abdominal pain.

Procedure:

The patient was placed in the left lateral decubitus position and was given sedation with Versed and Demerol. Oxygen was monitored and when the blood oxygen was at the appropriate level, the Olympus GIF-XQ fiber endoscope was gently inserted into the oropharynx. The scope was then passed down the esophagus into the stomach and duodenal bulb.

There is noted to be a duodenal bulbar ulceration with duodenitis present. The scope was then pulled back into the antrum. There are irregular folds noted there. CLO test biopsy was taken. There was an AV malformation in the body of the stomach. Photographs were taken. This was oozing. Then using the BICAP coagulator multiple coaptations were undertaken until finally the areas were coagulated fully. The scope was gently withdrawn up the esophagus. No intraluminal mass and no varices. The scope was gently withdrawn. The patient tolerated the procedure well.

Impression:

1. Bleeding arteriovenous malformation proximal stomach.
2. BICAP probe coagulation of arteriovenous malformation.
3. Duodenal ulceration.
4. Duodenitis.

CGIC™ Practice Examination –Answers and Rationales

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

CASE 1

Introduction: A 57-year-old female patient presents for an inpatient sigmoidoscopy.

Indications: The patient has complained of passing large volumes of blood and clots per rectum. Recent colonoscopies at Anytown General show positive only for hemorrhoids. I am bringing this patient in for an unprepped flexible sigmoidoscopy. [1]

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

Procedure: The endoscope was passed with ease through the anus under direct visualization and advanced to the mid sigmoid colon at 26 cm. The quality of the preparation was mediocre with some brown formed stools at mid sigmoid. [2] The views were excellent. The patient's toleration of the procedure was excellent.

Findings: There is no blood in the colon on examination to the mid sigmoid. No colitis. The rectum is free of blood or bleeding site. The anal verge has some mild hemorrhoids. [3]

Summary: There is no blood in the colon on examination to the mid sigmoid. No colitis. The rectum is free of blood or bleeding site. The anal verge has some mild hemorrhoids. In face of patient complaints of gross rectal bleeding there is no blood in the colon, normal brown stool in the sigmoid. The only possibility is an anal verge vascular abnormality resulting in the reported "blood and clots" passed per rectum. There is no colonic lesion/blood on a scoped examination obtained within hours of her purported passage of blood per rectum.

[1] Indication of type of procedure being performed.

[2] Diagnostic sigmoidoscopy in only viewing the sigmoid colon and rectum.

[3] Diagnosis to report.

1. **Answer:** D. 45330

   Rationale: CPT® code 45330 appropriately describes the flexible sigmoidoscopy for only a diagnostic examination.

2. **Answer:** B. K64.4

   Rationale: Operative note documents that "the anal verge has some mild hemorrhoids." Look in the ICD-10-CM Alphabetic Index for Hemorrhoids/external referring you to K64.4. Verify code selection in the Tabular List.

3. **Answer:** B. Examination of the entire rectum, sigmoid colon and may include examination of a portion of the descending colon

   Rationale: According to the CPT® code book, under the Digestive System section in the Endoscopy subsection, sigmoidoscopy is defined as an examination of the entire rectum and sigmoid colon, and may also include visualization of a portion of the descending colon.

4. **Answer:** C. A mass of tissue that bulges outward or upward from membranes that line structures and organs

   Rationale: Medical dictionary will confirm a polyp is a growth or mass protruding from a mucous membrane.

   See Stedman's Medical Dictionary.

CASE 2

Indications:

This esophagogastroduodenoscopy (EGD) is done this morning because of bleeding and abdominal pain.

Procedure:

The patient was placed in the left lateral decubitus position and was given sedation with Versed and Demerol. Oxygen was monitored and when the blood oxygen was at the appropriate level, the Olympus GIF-XQ fiber endoscope was gently inserted into the oropharynx. The scope was then passed down the esophagus into the stomach and duodenal bulb. [1]

There is noted to be a duodenal bulbar ulceration with duodenitis present. [4] The scope was then pulled back into the antrum. There are irregular folds noted there. CLO test biopsy was taken. [1] There was an AV malformation in the body of the stomach. [3] Photographs were taken. This was oozing. Then using the BICAP coagulator multiple coaptations were undertaken until finally the areas were coagulated fully. [2] The scope was gently withdrawn up the esophagus. No intraluminal mass and no varices. The scope was gently withdrawn. The patient tolerated the procedure well.

Impression:

1. Bleeding arteriovenous malformation proximal stomach. [3]
2. BICAP probe coagulation of arteriovenous malformation. [3]
3. Duodenal ulceration. [4]
4. Duodenitis. [4]

Recommendations:

1. Treat the patient with proton-pump inhibitor.
2. Follow anti-reflux regimen.
3. Await: histology.
4. Close follow-up.

---

[1] Esophagogastroduodenoscopy performed with biopsy.

[2] Bleeding controlled in the stomach.

[3] Primary diagnosis.

[4] Additional diagnosis to report.

Join the biggest team in healthcare information management.

As an AAPC member, you'll be part of a global network of 250,000+ career learners and working professionals. Our credentials are among the most highly sought after in the industry — in part because AAPC members are trained for more than passing an exam. They are trained to succeed on the job from day one.

"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

Whether you're just getting started or a seasoned pro, AAPC membership will give you the support, training, tools, and resources to help you launch and advance your career successfully,

Learn more at **aapc.com**

AAPC