AAPC

CGSC™

Certified General Surgery Coder

STUDY GUIDE

2026

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Specialty Study Guide: CGSC™

GENERAL SURGERY

Contents

Specialty Study Guide: CGSC™ Introduction

The *Specialty Study Guide: CGSC™* is designed to help general surgery coders, billers, and other medical office professionals prepare for the CGSC™ 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 general 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 CGSC™ shows your expertise in general surgery coding and helps your employer recoup proper payment. 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: CGSC™* 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 CGSC™ examination.

We will review the importance of using the coding guidelines in 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 code books you will need for your CGSC™ 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 general surgery. The examinee must become 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 general surgery 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 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 general 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. 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 Relative Value Units (RVUs) are sequenced first.

Top 10 Missed Coding Concepts

We will review the Top 10 Missed Coding Concepts for CGSC™ certification exam in this chapter. 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 general surgery. The practice exam mimics the format and structure of the CGSC™ 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 CGSC™ credential:

- CGSC™ 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 general surgery practices.

The CGSC™ 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, 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
- Shared/Split services
- HIPAA regulations
- Proper use of an Advance Beneficiary Notice (ABN)
- ICD-10-CM coding
- E/M code selection using the AMA CPT® E/M guidelines
- CPT® coding for common procedures
  - 10000 Series
  - 20000 Series
  - 30000 Series
  - 40000 Series
  - 50000 Series
  - 60000 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: CGSC™* 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 CGSC™ 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

ICD-10-CM coding guidelines are developed by CMS and the National Center for Health Statistics. Healthcare providers must begin using the most recent ICD-10-CM code revisions on Oct. 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 Alphabetic Index and Tabular List 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 diagnosis coding. 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 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. When coding for surgical services, the first listed diagnosis will reflect the reason for surgery. If the postoperative diagnosis is different from the preoperative diagnosis, select the postoperative diagnosis since it is the most definitive. Read the entire operative report. Do not code from the preoperative and postoperative lines in the operative note. The body of the note will often include additional information needed to select a more specific diagnosis.

EXAMPLE

Preoperative Diagnosis: Bladder tumor

Postoperative Diagnosis: Bladder tumor

In the body of the report, the physician documents "I removed a 1 cm tumor from the trigone of the bladder."

In order to select the appropriate diagnosis, go to the main term Tumor in the ICD-10-CM Alphabetic Index. There is a notation to see also Neoplasm, unspecified behavior, by site. Go to the Table of Neoplasms and look for Neoplasm, neoplastic/bladder (urinary)/trigone/Unspecified Behavior column. You are referred to D49.4. Be sure to verify the code accuracy in the Tabular List.

Relevant coexisting 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 many of the injury codes require 6th and 7th characters that indicate laterality (right, left, or bilateral) and type of encounter (initial, subsequent, or sequela). 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," "consistent with," "compatible 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 for diagnostic tests that have been 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 diagnosis. 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 for the physician's reason(s) that the test was ordered.

When you are provided with both a preoperative and postoperative diagnosis, always report the postoperative diagnoses codes 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. In such a case, you may still report the shortness of breath as a sign and symptom with pneumonia because the physician has 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) vs. "chronic" (secondary) 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 that 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 General Surgery

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 CGSC™ 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.

CPT® arranges surgical procedure codes by organ system, as follows:

- General 10004–10021
- Integumentary 10030–19499
- Musculoskeletal 20100–29999
- Respiratory 30000–32999
- Cardiovascular 33016–37799
- Hemic and Lymphatic 38100–38999
- Mediastinum & Diaphragm 39000–39599
- Digestive 40490–49999
- Urinary 50010–53899
- Male Genital 54000–55899
- Intersex Surgery 55970–55980
- Female Genital 56405–58999
- Maternity Care and Delivery 59000–59899
- Endocrine 60000–60699
- Nervous 61000–64999
- Eye and Ocular Adnexa 65091–68899
- Auditory 69000–69979
- Operating Microscope 69990

The Global Surgical Package

All surgical procedure codes describe a "package" of services, including the procedure itself, as well as:

- Local infiltration, metacarpal/metatarsal/digital block, or topical anesthesia;
- Evaluation and Management (E/M) service(s) subsequent to the decision for surgery on the day before and/or day of surgery (including history and physical);
- Immediate postoperative care, including dictating operative notes; talking with the family and other physicians or other healthcare professionals;
- Writing orders;
- Evaluating the patient in the post-anesthesia recovery area;
- Typical postoperative follow-up care.

CPT® code 99024 is a non-payment code reported to indicate an E/M service was provided for a related post-operative visit during the global period of a procedure. Since this code is included in the surgical package, it is used by providers as a tracking mechanism to indicate in their records that the E/M visit is related to the procedure that was performed. Some payers may not require submission of code 99024.

The Global Period

The Medicare National Physician Fee Schedule Relative Value File contains the "global period" for all CPT® codes, which describes the length, in days, of the postoperative period. During this period, follow-up care related to the surgery is included in the fee for the surgery itself (that is, follow-up care is part of the surgical package, as described above).

Procedures with a 90-day global period (090) are considered "major" procedures. Procedures with zero (000) or 10 (010) day global period are typically minor procedures or endoscopies.

Codes with a "YYY" global period are carrier-priced procedures, for which the carrier also determines the global period. Not all carrier-priced codes have a "YYY" global surgical indicator, however—sometimes the global period is specified as 000, 010, 090.

The "ZZZ" global period applies only to add-on procedure codes. Because add-on codes are billed only in addition to a primary procedure code, they have no global period of their own. Rather, the primary procedure code specifies the global period.

Surgical Complications

Treating complications during surgery generally is not reported separately, except with unusually difficult circumstances. For example, control of hemorrhage is a usual and necessary component of a surgical procedure in the operating room; and, therefore, it is not separately reportable. For an exceptional case that raises the difficulty level of the surgery considerably (for instance, the patient loses a great deal more blood than is typical), you might consider appending modifier 22 *Increased Procedural Services* to the surgical procedure code. Usually, the surgeon will document in a separate paragraph why the procedure supports modifier 22.

Under CMS/Medicare rules, post-operative care—including treatment for complications—during the global period is not separately reportable unless a return to the operating room is required. For example, control of post-operative hemorrhage treated in the office is not separately reportable. If the surgeon must return the patient to the operating room to control the

bleeding, he may report the service separately by appending modifier 78 *Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period* to the appropriate CPT® code.

Intra-Service or Post-Procedure Care Only

The global package for all surgical procedures includes minor, pre-procedure evaluation and management, the procedure itself, and typical post-operative care, as described above. When a different physician performs a portion of the overall service (that is, the operating surgeon and another physician agree to a transfer of care during the global period), you may separate the components from one another using an appropriate modifier.

- Modifier 54 Surgical Care Only
- Modifier 55 Postoperative Management Only

The Medicare National Physician Fee Schedule Relative Value File contains a specific value for each portion of the overall service, based on a percentage of the total Relative Value Units (RVUs) assigned to that code.

For example, an emergency department physician reduces a fracture and places a cast and instructs the patient to follow up with his family physician. In this case, the ED physician reports the appropriate fracture care code(s) with modifier 54 appended. The family physician reports the same code(s), but with modifier 55 appended, for post-operative care.

The *Medicare Claims Processing Manual* specifies that when transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until he or she has provided at least one service. When the physician has seen the patient, that physician may bill for the period beginning with the date on which the physician assumes the care of the patient.

Add-on Codes

CPT® uses an "add-on" designation to identify services or procedures that always occur in addition to other services or procedures. To identify add-on codes in CPT®, you should look for a "+" symbol to the left of the code. Also, all add-on codes contain a variation of the phrase "List separately in addition to code for primary procedure" in their CPT® descriptors. An example of the use of an add-on code is provided in the "Global Period" explanation, above.

In most cases, the primary code(s) for a given add-on code immediately precede the add-on code in the CPT® listings. CPT® does not list all add-on codes in proximity to their primary procedure codes. In most cases, when CPT® does not list the add-on code and primary codes together, the code book provides instructions on which codes should accompany the add-on code. Do not append modifier 51 to add-on codes.

Separate Procedures

CPT® uses a "separate procedure" designation in code descriptors to identify procedures that the physician normally performs as a part of another, more extensive procedure, but which may, on occasion, be performed independently.

Don't make the mistake of thinking that a "separate procedure" designation means you can always report the code separately if the physician provides the service. In fact, a separate procedure designation means that the procedure is bundled—and therefore not separately reportable—any time the physician provides a more extensive, related service.

The National Correct Coding Initiative

CMS designed the NCCI "to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims," according to the agency's own introduction to NCCI. The NCCI lists thousands of "edits"—code combinations that you should not, in most circumstances, report together during the same patient encounter. You must apply these edits when reporting services to all Medicare (and many private) payers.

The NCCI divides its edits into two categories: mutually exclusive and "Correct Coding" edits. Mutually exclusive edits pair procedures or services the physician would not reasonably perform at the same session at the same anatomic location on the same beneficiary. Correct Coding edits describe bundled procedures. That is, CMS considers one code in each pair to be a lesser service, which is included as a component of (and, therefore, not separately payable with) the more extensive procedure.

CMS guidelines allow you to override NCCI edits and achieve separate reimbursement for bundled codes. Before attempting to unbundle an NCCI edit, you must determine two points:

- Is the override possible? Each NCCI code pair edit includes a correct coding modifier indicator of either 0 or 1. The correct coding modifier indicator appears as a superscript to the right of each "column 2" code. A "0" indicator means that you may not unbundle the edit combination under any circumstances, according to NCCI guidelines. An indicator of "1," however, means that you may use a modifier to override the edit if the two usually mutually exclusive or bundled procedures are separate and distinct from one another, and the circumstances and documentation support the use of the modifier.
- Are the procedures truly distinct? You should only attempt to override NCCI code pair edits if the paired procedures are separate and unrelated. For instance, the physician may have provided the services/procedures at different sessions, at different anatomic locations, or for different diagnoses.

Top 10 Missed Coding Concepts on CGSC™ 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, the codes should be sequenced in Relative Value Unit (RVU) order. For example, if a provider excises a malignant lesion from the forehead with an excised diameter of 1.5 cm and performs an intermediate repair measuring 1.8 cm, the correct codes are 11642 (8.05 RVUs) and 12051 (8.43 RVUs). Because 12051 has the higher RVU value, it is reported first. Modifier 51 is then appended to 11642 to indicate that a multiple procedure was performed. A RVU calculator will be provided as a resource in the online CGSC™ exam.

2. **Consultation rules according to CPT® and CMS:** According to CPT® guidelines, a consultation requires three elements: (1) a documented request from a physician or other qualified source, (2) an evaluation performed to provide an opinion or recommendation for a specific problem or to determine whether to assume ongoing management, and (3) a written report sent back to the requesting provider. If any of these requirements are missing—such as the absence of a written report—the service cannot be billed as a consultation. CMS no longer reimburses consultation codes, so when a case involves a Medicare patient, office/outpatient or hospital care codes must be used instead. Coders should not assume a patient has Medicare based solely on age; exam questions or case notes will clearly indicate Medicare coverage when it applies.

3. **Proper ICD-10-CM code selection for suspected or probable diagnosis:** Conditions documented as suspected, rule out, or probable are not coded. This information is pertinent in the documentation but is not coded as an ICD-10-CM code. Instead, code the sign or symptom. If a definite diagnosis is determined, report the definitive diagnosis. Signs and symptoms consistent with the definitive diagnosis are not reported. For example, a patient presents with right side abdominal pain and vomiting. The physician suspects appendicitis and orders tests, which confirm gastritis. The diagnosis reported is K29.70 *Gastritis, unspecified, without bleeding.*

4. **Proper ICD-10-CM code selection for malignancy:** When coding for malignancy, select a code from the primary malignant column in the Table of Neoplasms unless the provider documents the cancer has spread or metastasized. Only cancer documented as a metastasis is reported as a secondary cancer. Cancer in two sites does not automatically mean one of them is a secondary cancer. Both sites are coded as primary cancer unless metastasis is documented.

5. **CPT® codes designated as a Separate Procedure:** There are codes in the CPT® code book that are designated as a separate procedure. When performed alone, the separate procedure is reported; however, when reported with another procedure or service on the same patient, during the same encounter, and is related, it may be considered inclusive to that procedure and not reported separately.

   EXAMPLE

   11755 Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)

   11765 Wedge excision of skin of nail fold (eg, for ingrown toenail)

   When a provider performs a wedge excision of the skin of the nail fold (11765) and sent it for biopsy (11755) the biopsy is considered inclusive to the wedge excision and only 11765 is reported. If the provider only performs a biopsy of the nail unit, 11755 is reported.

6. **Modifier 52 and 53:** Modifier 52 is reported if a procedure is reduced. For example, if the ileum is not visualized during capsule endoscopy, report 91110-52. If the physician has to stop the surgery due to the patient's condition without completing the procedure in its entirety, append modifier 53. If prior to stopping the procedure, the provider is able to reduce the service instead of stopping in the middle of it, append modifier 52.

7. **AMA E/M Guidelines in Selecting the Level for the Number and Complexity of Problems Addressed at the Encounter:** An undiagnosed new problem with uncertain prognosis refers to signs or symptoms—such as pain or a mass—that the provider evaluates during the visit but cannot assign a definitive diagnosis for. Because the underlying cause remains unclear, the provider must order additional testing or workup to determine the source of the problem.

8. **Modifier 59 with multiple lesion excisions:** When multiple lesions are excised from the same anatomic site, append modifier 59 to report the procedure was performed on different lesions. For example, the provider excises a 2.8 cm malignant lesion and a 2.1 cm malignant lesion on the patient's back. The correct codes are 11603, 11603-59.

9. **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.

10. **CPT® Code 10160:** Report 10160 when a physician accesses an existing fluid collection—such as a seroma—and inserts a drain without performing an incision and drainage (I&D). Codes 10140 and 10180 require documentation of an I&D procedure, so they should not be used unless an actual I&D is performed.

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

Reason for Referral:

Gentleman referred for evaluation of GI bleeding source with known anemia

Procedure Data:

Gastric passage time: 0h, 6m. Small bowel passage time: 4h, 1m

Procedure Info & Findings:

Capsule passed uneventfully through the stomach in approximately seven minutes and into the colon to the ileum in a little over 4 hours. Multiple angiodysplastic lesions were seen which probably accounts for heme-positive stools, but full-blown anemic state is doubtful. Also noted was a gastric polyp with bleeding as well.

Summary & Recommendations:

Multiple angiodysplastic lesions throughout the small bowel and a bleeding gastric polyp that could undoubtedly be seen on endoscopy.

1. Select the phrase that best describes an angiodysplastic lesion.

   A. Malformation of the heart
   B. Lesion in the blood vessel
   C. Polyp in the small intestine
   D. A small vascular malformation

2. What is the correct sequencing of the diagnosis codes?

   A. K31.7, K92.2
   B. K55.20, K31.7
   C. K55.21, K31.7
   D. K55.21, D13.9

3. How would this service be reported?

   A. 91110
   B. 91111
   C. 44376
   D. 74261

4. Which modifier should be assigned to this case?

   A. 22
   B. 78
   C. 58
   D. No modifier is appropriate

CASE 2

Sex: F

Age: 32-years-old

Subjective:

CC: Patient is seen at the request of Dr. W and presents for evaluation of GERD and evaluation of possible hiatal hernia.

HPI: GERD and hiatal hernia. Present for years. Onset was gradual. Progressive. Rated as moderate. Interferes with activities of daily life. Aggravated by eating. Symptoms not alleviated by Nexium prescribed a few months ago. Has had an upper GI series within the last two months. Reports associated heartburn and indigestion, but denies associated dysphagia, flatulence, globus, hoarseness, recurrent pneumonia, sleeping difficulty, and shortness of breath.

ROS:

Const: Denies anorexia, change in appetite, chills, fatigue, fever, and weight change,

ENMT: Denies discharge from the ears and ear pain. Denies rhinorrhea. Denies hoarseness, voice change, and sore throat.

CV: Denies arrhythmia, chest pain, and tightness.

Resp: Denies cough, dyspnea, sputum production and recent URI.

GI: Denies symptoms other than stated above.

GU: Urinary: denies dysuria, frequency, and urgency.

Musculo: Denies limitations of movement.

Skin: Denies skin changes, pruritus, and rashes.

Breast: Denies discharge, lumps, masses, pain, and tenderness.

Neuro: Denies dizziness, lightheadedness, and syncope.

Endocrine: Denies intolerance to cold, intolerance to heat, night sweats, polyuria, excessive thirst, and excessive urination.

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

CASE 1

Reason for Referral:

Gentleman referred for evaluation of GI bleeding source with known anemia [1]

Procedure Data:

Gastric passage time: 0h, 6m. Small bowel passage time: 4h, 1m

Procedure Info & Findings:

Capsule passed [2] uneventfully through the stomach [2] in approximately seven minutes and into the colon to the ileum [2] in a little over 4 hours. Multiple angiodysplastic lesions were seen which probably accounts for heme-positive stools but full-blown anemic state is doubtful. Also noted was a gastric polyp with bleeding as well.

Summary & Recommendations:

Multiple angiodysplastic lesions [3] throughout the small bowel and a bleeding gastric polyp [4] that could undoubtedly be seen on endoscopy.

[1] Indication for the procedure

[2] Indication of a capsule endoscopy going through the GI system to the ileum

[3] Primary Diagnosis

[4] Second Diagnosis

1. **Answer:** D. A small vascular malformation

   Rationale: The definition for angiodysplastic lesion can be found in *Stedman's Medical Dictionary*. Angi/o is a Greek root referring to a vessel, typically a blood vessel. Dys- is a Greek root referring to bad, and –plastic is Greek for tissue growth.

2. **Answer:** B. K55.20, K31.7

   Rationale: The patient has multiple angiodysplastic lesions. Look in the ICD-10-CM Alphabet Index for Angiodysplasia (cecum) (colon) referring you to K55.20. There is no mention of bleeding from the angiodysplastic lesions. Next, the patient has a bleeding gastric polyp. Look in the Alphabetic Index for Polyp, polypus/stomach referring you to K31.7. Verify code selection in the Tabular List.

3. **Answer:** A. 91110

   Rationale: The procedure performed is "GI tract imaging, intraluminal (capsule endoscopy), esophagus through ileum, with physician interpretation and report." Look in the CPT® Index for Gastrointestinal Tract/Imaging/Endoscopic/Esophagus. This procedure is reported with CPT® code 91110.

4. **Answer:** D. No modifier is appropriate

   Rationale: A modifier is not needed with the procedure performed. Modifier 52 only needed when the ileum was not visualized. A description for all modifiers is located in Appendix A of the CPT® code book.

CASE 2

Sex: F

Age: 32 years-old

Subjective:

CC: Patient is seen at the request of Dr. W and presents for evaluation of GERD and evaluation of possible hiatal hernia. [1]

HPI: GERD and hiatal hernia. Present for years. Onset was gradual. Progressive. Rated as moderate. Interferes with activities of daily life. Aggravated by eating. Symptoms not alleviated by Nexium prescribed a few months ago. [2] Has had an upper GI series within the last two months. Reports associated heartburn and indigestion, but denies associated dysphagia, flatulence, globus, hoarseness, recurrent pneumonia, sleeping difficulty, and shortness of breath.

ROS:

Const: Denies - anorexia, change in appetite, chills, fatigue, fever, and weight change,

ENMT: Denies discharge from the ears and ear pain. Denies rhinorrhea. Denies hoarseness, voice change, and sore throat.

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Musculo: Denies limitations of movement.

Skin: Denies skin changes, pruritus, and rashes.

Breast: Denies discharge, lumps, masses, pain, and tenderness.

Neuro: Denies dizziness, lightheadedness, and syncope.

Endocrine: Denies intolerance to cold, intolerance to heat, night sweats, polyuria, excessive thirst, and excessive urination.

Hema/Lymph: Denies easy bleeding, easy bruising, and lymphadenopathy.

Current Meds: Nexium Allegra-D 24 Hour, Advair Diskus

Allergies: NKDA

PMH:

Surgeries: Cholecystectomy. Reviewed and updated. Barium swallow 2 months ago.

FH: Alcoholism, Asthma, Pancreatic Cancer, Cancer - bone, Hypertension, Heart Problems, Diabetes. Reviewed and updated.

SH: Marital: married.

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