AAPC

COBGC™

Certified Obstetrics Gynecology Coder

STUDY GUIDE

2026

2026

Specialty Study Guide: COBGC™

OBSTETRICS AND GYNECOLOGY

Contents

2026 Specialty Study Guide: COBGC™ Introduction

The *Specialty Study Guide: COBGC™* is designed to help obstetrics and gynecology coders, billers, and other medical office professionals prepare for the Certified Obstetrics Gynecology Coder (COBGC™) 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 obstetrics and gynecology.

Healthcare in the 21st century is complex and requires expertise in proper coding to obtain payment for procedures, services, equipment, and supplies. Becoming a COBGC™ shows your expertise in obstetrics and gynecology 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: COBGC™* 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 COBGC™ 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 code books are needed for the COBGC™ exam, as well.

ICD-10-CM Coding

Proper diagnosis 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 so you are prepared for that day.

We will discuss the major topics of diagnosis coding for obstetrics and gynecology. The examinee must become familiar with the ICD-10-CM Official Guidelines for Coding and Reporting, know how to select the appropriate ICD-10-CM codes, and be able to properly sequence 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 obstetrics and gynecology while underscoring 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 obstetrics and gynecology will be discussed in this section. Special attention will be paid 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 the COBGC™ certification exam. The list is not presented in any specific order. The information is determined after an evaluation by the AAPC exam department of the commonly missed questions on the exam.

Practice Exam

The practice exam and the exam were written by coders with extensive experience coding in obstetrics and gynecology. The practice exam mimics the format and structure of the COBGC™ certification exam.

AAPC has developed specialty credentials to enable coders to demonstrate superior levels of skill in their respective disciplines. Here is some information on the COBGC™ credential:

- COBGC™ stands alone as a certification with no prerequisite for the examinee to holds a CPC®, COC®, or CPC-P® credential.

- Exams aptly measure preparedness for "real world" coding by being entirely operative/patient-note based. These op notes are redacted from real obstetrics and gynecology practices.

The COBGC™ 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
- Shared/Split services
- HIPAA regulations
- Proper use of the (Advanced Beneficiary Notice (ABN)
- CMS drug wastage policy
- Clinical trial services
- ICD-10-CM coding
- E/M code selection using the AMA CPT® E/M guidelines
- CPT® coding for common procedures
  - 10000 Series
  - 40000 Series
  - 50000 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 coding 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: COBGC™* 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 COBGC™ certification examinations will receive recognition in AAPC's monthly magazine, *Healthcare Business Monthly* and receive a diploma.

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 NCHS, as well as the Centers for Medicare & Medicaid Services (CMS). 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 they 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 you 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 claim (individual dates of service must stand alone), and you must be mindful not to assume or extrapolate information from the medical record (for instance, coding a condition as acute when it is not 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, in addition to the principal diagnosis that affects 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, etc.

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 pre-existing conditions, make sure the assigned diagnosis code identifies the current reason for medical management. Do not report conditions that no longer exist or that 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 code character (which specifies location), a 6th code character (which specifies the laterality and whether the fracture is displaced or nondisplaced), and a 7th code character (which specifies the episode of care). If this information is not documented, appropriate code selection is impossible. Work with the provider to ensure 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, do 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.

For example, if a patient presents with complaint of a missed period and nausea, and she is confirmed as pregnant at the visit; the pregnancy caused the symptoms. In this case, you would report Z32.01 *Encounter for pregnancy test, result positive* not N92.5 *Other specified irregular menstruation* or N93.8 *Other specified abnormal uterine and vaginal bleeding*, and not R11.0 *Nausea*.

For example, if a patient presents with complaint of an irregular period and nausea. Last menstrual period was 45 days ago. A serum pregnancy test is ordered. In this case, because a pregnancy diagnosis is not confirmed at the conclusion of the encounter, you would report N92.5 or N92.6 *Irregular menstruation, unspecified*, R11.0 *Nausea*, and Z32.00 *Encounter for pregnancy test, result unknown.*

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, confirm the order for the physician's reason why 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, and the physician determines the patient has pneumonia, but the physician 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. You will select an appropriate code for acute or sub-acute (primary) versus chronic (secondary) conditions 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 to 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, 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. Codes 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

Evaluation and Management Coding for Obstetrics and Gynecology

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 COBGC™ 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.

In this chapter, we will review the following areas:

- Special evaluation and management (E/M) considerations in obstetrics/gynecology (OB/GYN) practice
- Medicare and CPT® rules for preventive services
- Reporting a procedure and E/M service on the same date
- Surgery guidelines (Medicare and CPT®)
- OB guidelines
  - Global package
  - Split billing
  - Twins
  - Ultrasound
  - Termination of pregnancy

The information in this chapter generally will follow official CPT® coding guidelines. Although the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine have published interpretations for using CPT® codes, these interpretations do not agree consistently with the guidelines established by the American Medical Association (AMA) CPT® Editorial Panel and the Centers for Medicare & Medicaid Services (CMS).

E/M Services

Most of the information you will need to report E/M services successfully in OB/GYN practice appears in the E/M services chapter of this guide. In this section, we will briefly review several concerns unique to E/M services for OB/GYN.

Prolonged Services

Prolonged service codes are an option, for instance, when the provider manages the patient during labor but does not perform the delivery, or when the provider provides a prolonged office service. Prolonged services may be reported only in addition to E/M services, and require face-to-face time with the patient for care, instructions, etc. When reporting prolonged services in addition to Office or Other Outpatient E/M Services, be sure to check AMA and Medicare guidelines.

Standby Services

Report standby services (for example, standby for cesarean delivery) only when the provider is dedicated to the patient and is precluded from doing anything else during the standby period. If the standby service results in a billable service, the stand-by service is not billable.

Observation Services

To report observation services, the provider must see the patient on the date of admission designating the patient is in observation status.

Preventive Services

A typical well-woman (preventive service) exam includes three components:

- General preventive examination that includes an age- and gender-appropriate examination
- Gynecological issues including a breast and pelvic exam
- Pap smear

The AMA's *CPT® Assistant*, July 1998, specifies:

> The comprehensive history obtained as part of the preventive medicine evaluation and management service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of pertinent risk factors.

In other words, the preventive service is not for a current complaint or problem. It is instead a "well woman" visit.

ACOG offers the following recommendations for what is included in the general preventive exam:

Age/Code	History	Exam	Counseling & Risk Factor Reduction
18-39 99385 or 99395	Complete or Interval ROS & PFSH	HT, WT & BP Neck & thyroid Breasts Abdomen Pelvic exam Skin	STDs Pregnancy Birth control Exercise & diet Psychosocial evaluation CV risk factors Smoking, skin exposure, injury prevention, general mental health
40-64 99386 or 99396	Same	Same plus oral cavity	Same plus Self breast exam
65+ 99387 or 99397	Same	Same plus oral cavity	Same plus HRT (hormone replacement therapy)

Note that recommended services vary slightly by patient age. In particular, the content of patient counseling will change as the patient ages, pregnancy is no longer an option, birth control is no longer relevant, etc.

For the general health check, assign a preventive medicine service code. The correct preventive medicine code depends on two factors:

- Patient's status (new or established)
- Patient's age

For instance, if the physician sees a new patient, select from among:

> 99385 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
>
> 99386 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years
>
> 99387 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older

If the patient is established, instead select from codes:

> 99395 Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
>
> 99396 Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient: 40-64 years
>
> 99397 Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient, 65 years and over

When reporting any of the above, the correct ICD-10-CM code is a code from subcategory Z01.4- *Encounter for routine gynecological examination*, which requires a 5th and 6th characters: Z01.411 *Encounter for gynecological examination (general) (routine) with abnormal findings* and Z01.419 *Encounter for gynecological examination (general) (routine) without abnormal findings.*

Medicare will not cover the general preventive exam (99385–99387 or 99395–99397) but will pay for the pelvic/breast exam (G0101 *Cervical or vaginal cancer screening; pelvic and*

Top 10 Missed Coding Concepts on COBGC™ Examination

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

1. **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.

2. **Proper ICD-10-CM code selection for suspected or probable diagnosis:** Conditions documented as suspected, ruled 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.

3. **Proper ICD-10-CM code selection for neoplasms:** Review the postoperative diagnosis and findings to determine if the histology of the neoplasm is identified. For example, the postoperative diagnosis states duodenum neoplasm. After review of the findings, the neoplasm is determined to be benign. Carefully review the entire operative note to make sure you report the most specific diagnosis.

4. **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, and/or lab culture) 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, e.g. urinary pregnancy test) 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.

5. **AMA E/M Guidelines for Selecting the Level for the Risk of Complications and/or Morbidity or Mortality of Patient Management:** Risk is measured based on the physician's determination of the patient's probability of becoming ill or diseased, having complications, or dying between this encounter and the next planned encounter. The E/M guidelines indicate that the risk of complications and/or morbidity or mortality of patient management is distinct from the risk of the condition itself. The risk is based on the management decisions for the patient made by the reporting provider as part of the encounter. For example, the patient is given a prescription (cream, oral medication, etc.) is a moderate level of risk for prescription drug management or a decision to admit the patient is a high level of risk.

6. **National Correct Coding Initiative (NCCI):** Each NCCI code-pair edit includes a correct coding modifier indicator of either 0 or 1. An indicator of 0 means that you may not unbundle the edit combination under any circumstances. An indicator of 1, means that you may use a modifier (usually modifier 59 *Distinct procedural service*) to override the edit if the two codes are mutually exclusive or bundled procedures that are separate and distinct from one another and the circumstances and documentation support the use of the modifier.

7. **Reporting code 99024 for Medicare:** Under Medicare's global surgery guidelines, postoperative complications that do not require a return to the operating room are included in the global package. A postoperative fever—even one requiring medication such as an IM antibiotic—does not justify separate reporting of an E/M service. Because the condition is related to the surgery and managed within the global period, the visit is reported with 99024

8. **Fecal Occult Blood Testing (FOBT):** Do not report CPT® 82274 unless documentation clearly states that an immunoassay-based fecal occult blood test (FIT/iFOBT) was performed. Pelvic exams may include a routine guaiac test for occult blood, but unless the provider specifies the method used, the immunoassay code 82274 is not supported.

9. **Modifier 25:** When reporting modifier 25 with an E/M code the E/M service must be "above and beyond" the minimal evaluation and management normally performed for a procedure. Documentation needs to support the medical necessity for both the E/M service and the other service or procedure. If the main reason for the visit is to perform a procedure (such as an IUD insertion) and there is a brief exam on just the body area where the procedure will be performed, only the procedure will be reported.
10. **Modifiers reported for ABN:** Advanced Beneficiary Notices (ABNs) are not required for services that are statutorily excluded. If the patient requests the claim to be sent, append modifier GY to the service to indicate that a denial is expected. Modifier GA is reported when an ABN is appropriately executed for a service that may not be covered. Modifier GZ is reported if an ABN is not signed and the provider determines after the service has been rendered that it will be denied.

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

CC: New 35-year-old female patient presents for annual gynecological exam.

HPI: Annual exam. Patient also needs OCP script for Alesse.

LMP: 4/29/xx. Menstrual periods typically last 4 days. Last Pap one year ago.

ROS: Denies fatigue, fever, weight gain, and unexplained weight loss. General health stated as good.

Denies double vision, spots before eyes, and any recent changes in visual acuity. Denies painful breathing, chest pain, dyspnea on exertion, palpitations, and swelling of legs. Denies chronic cough, coughing up blood, SOB, and wheezing. Denies constipation, diarrhea, nausea, bloody stools, and vomiting. Genital: denies dyspareunia, dysmenorrhea, and menorrhagia. Sexually active: yes. Urinary: denies frequency, hematuria, incontinence, retention, urgency, and pain on urination. Denies muscle weakness. Denies rash and ulcers. Denies breast discharge, masses, and pain. Performs BSE. Denies clumsiness, dizziness, numbness, and seizures. Denies anxiety, frequent crying, and depression. Denies dry skin, hot flashes, and excessive thirst. Denies allergic/immunologic symptoms.

Current Meds: Alesse-28–28.

Past Medical History

Irritable Bowel - Has to watch diet, dairy, etc. When under stress she gets diarrhea.

Surgeries:

Wisdom tooth extraction.

OB/GYN Hx: Gravidity: (0)

Reviewed, no changes.

Family History

Diabetes – grandmother.

Stroke – grandfather.

Deep Vein Thrombosis – maternal aunt.

Social History

Education: Currently attending 1st year of college.

Marital: Single.

Personal Habits:

Cigarette Use: NON-SMOKER.

Alcohol: Denies alcohol use.

Drug Use: Denies Drug Use.

Exercise Type: Exercises regularly.

Seat Belt Car: Always uses seat belt.

Examination:

Wt: 124 lbs. Wt Prior: 125 lbs. as of 04/09/0X Wt Dif: -1 lb. BP: 108/74 Ht: 62" 5'2" LMP: 04/29/0X.

Const: No signs of acute distress present. Speech is appropriate. Communicates normally using speech. Alert and oriented. Has normal facial hair. Has normal body hair.

Neck: Palpation reveals no nodes. Thyroid exhibits no palpable enlargement or nodules.

Resp: Lungs are clear bilaterally.

CV: Rate is within normal range. S1 is normal. S2 is normal. No heart murmur appreciated.

Extremities: Peripheral circulation is grossly normal.

Breasts: Breast exam was performed while patient was in a supine position. Breasts normal on inspection. Breasts normal to palpation. Nipples: Nipples are normal to palpation. Axillae: Axillae normal.

Abdomen: The abdomen is flat. No visible herniations. No abdominal scars. Abdomen is soft, nontender, and nondistended without guarding, rigidity or rebound tenderness. No abdominal masses.

GU: External genitalia: Normal. Pubic hair distribution normal for age. Urethral Meatus: Normal. Urethra: Urethra appears normal. Bladder: Nontender. Vagina: Blood is not noted in the vaginal vault. Vaginal wall: Pink, moist, well rugated, and without lesions. No prolapses noted. Cervix: normal, without lesions, posterior, and to patient's right.

Uterus: Normal size and shape. Anteverted. Adnexa: Structures palpate normally and without tenderness or masses. Pap smear was done. Perineum/Anus: Anus and perineum appear normal.

Lymph: No palpable lymphadenopathy in the subclavicular or supraclavicular regions.

Musculo: Normal muscle tone.

Skin: No rashes, lesions, or ecchymosis.

Assessment and Plan: Routine gyn examination. Ordered CBC and Chem 7, blood draw in office, counseled on calcium and vitamin D, as well as folic acid. Counseled on breast exams. Follow up in one year.

1. What is the evaluation and management (E/M) code?

   A. 99202

   B. 99203

   C. 99385

   D. 99395

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

CASE 1

CC: New 35-year-old [1] female patient presents for annual gynecological exam. [2]

HPI: Annual exam. Patient also needs OCP script for Alesse.

LMP: 4/29/xx. Menstrual periods typically last 4 days. Last Pap one year ago.

ROS: Denies fatigue, fever, weight gain, and unexplained weight loss. General health stated as good.

Denies double vision, spots before ¬¬¬eyes, and any recent changes in visual acuity. Denies painful breathing, chest pain, dyspnea on exertion, palpitations, and swelling of legs. Denies chronic cough, coughing up blood, SOB, and wheezing. Denies constipation, diarrhea, nausea, bloody stools, and vomiting. Genital: denies dyspareunia, dysmenorrhea, and menorrhagia. Sexually active: yes. Urinary: denies frequency, hematuria, incontinence, retention, urgency, and pain on urination. Denies muscle weakness. Denies rash and ulcers. Denies breast discharge, masses, and pain. Performs BSE. Denies clumsiness, dizziness, numbness, and seizures. Denies anxiety, frequent crying, and depression. Denies dry skin, hot flashes, and excessive thirst. Denies allergic/immunologic symptoms.

Current Meds: Alesse-28–28.

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Lymph: No palpable lymphadenopathy in the subclavicular or supraclavicular regions.

Musculo: Normal muscle tone.

Skin: No rashes, lesions, or ecchymosis.

Assessment and Plan: Routine gyn examination. [3] Ordered CBC and Chem 7, blood draw in office, [4] counseled on calcium and vitamin D, as well as folic acid. Counseled on breast exams. Follow up in one year.

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[1] New patient and age of patient.

[2] Reason for visit and indication to report a preventive service.

[3] Primary diagnosis.

[4] Venipuncture performed in the office.

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1. **Answer:** C. 99385

   Rationale: This new patient presents for a preventive visit with normal findings. A code from Preventive Medicine Services section is selected based on age and whether the patient is new or established.

2. **Answer:** B. 36415

   Rationale: Blood was obtained for lab work. It is appropriate to report the venipuncture. The laboratory performing the tests will report the lab codes associated with the CBC and Chem 7 tests.

3. **Answer:** B. Z01.419

   Rationale: The patient presents for a routine gynecological examination, which is reported with Z01.419. Look in the ICD-10-CM Alphabetic Index for Examination/gynecological. Refer to ICD-10-CM coding guidelines 1.C.21.c.13 for Routine and administrative examinations.

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