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AAPC CASCC

AAPC Certified Ambulatory Surgery Center Coder



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Question: 1

During the same ASC session, a surgeon excises a benign lesion from the right forearm and performs incision and drainage of an abscess on the left thigh. An NCCI edit exists between the procedure codes, but payer policy allows a distinct procedural service modifier when separate anatomical sites and clinical purposes are documented. Which coding action is most appropriate?

- A. Remove the incision and drainage code because all skin procedures bundle together
- B. Append the appropriate distinct procedural service modifier if documentation supports separate sites and separate clinical purposes
- C. Append modifier 22 because two unrelated procedures were performed
- D. Bill both codes without a modifier because the operative note mentions different sites

Answer: B

Question: 2

An ASC procedure note documents transrectal ultrasound-guided needle biopsy of the prostate for elevated PSA. The physician obtains 12 core samples from mapped prostate regions. No cystoscopy, transurethral resection, or prostatectomy is documented. Which coding approach is most appropriate?

- A. Report transurethral resection of prostate because prostate tissue was removed
- B. Report radical prostatectomy because biopsy was performed for suspected malignancy
- C. Report prostate needle biopsy with ultrasound guidance according to CPT® and payer rules
- D. Report cystoscopy because the prostate is part of the urinary system

Answer: C

Question: 3

An ASC operative report documents removal of a buried plate and screws from the left clavicle through an incision over the prior surgical scar. The surgeon dissects through deep tissue to expose the plate on bone and removes the plate and screws. The hardware was not palpable through the skin and was not removed by simple traction. Which coding distinction is most important?

- A. Determine that the documentation supports removal of deep implant hardware rather than superficial foreign body removal
- B. Code simple foreign body removal because screws are objects removed from the body
- C. Code fracture repair because the hardware was originally placed for a fracture

D. Code incision and drainage because the surgeon reopened the prior scar

Answer: A

Question: 4

An ASC internal audit finds that a separately billed implant line was paid twice due to a duplicate corrected claim submission. The facility confirms the duplicate payment is not supported by documentation. Compliance policy requires timely refund of identified overpayments. What is the best action?

- A. Keep the payment because both claims were processed by the payer
- B. Follow the payer and facility overpayment refund process for the unsupported duplicate payment
- C. Add a late modifier to the medical record to justify both payments
- D. Apply the duplicate payment to a different patient account with an unpaid balance

Answer: B

Question: 5

An ASC coder considers using an unlisted CPT® code because the surgeon performed an unusual endoscopic technique not specifically described by available codes. Facility policy requires documentation review and payer-specific submission materials for unlisted codes, including an operative report and comparison to a similar listed procedure. What is the best action?

- A. Add modifier 22 to a similar code instead of using an unlisted code
- B. Split the unusual service into several component codes that approximate the work
- C. Follow the facility and payer unlisted-code process with required documentation and comparison support
- D. Select the closest listed code even if its descriptor does not match the procedure performed

Answer: C

Question: 6

An ASC cataract surgery record documents phacoemulsification with IOL insertion in the right eye. The provider's preoperative diagnosis states age-related nuclear cataract, right eye. The patient also has type 2 diabetes listed in the medical history, but the surgeon does not link the cataract to diabetes. Which diagnosis-coding approach is most appropriate?

- A. Code diabetes only because it is the chronic condition affecting surgical risk
- B. Code diabetic cataract because the patient has diabetes and cataract in the same record

- C. Code unspecified cataract because diabetes makes the cataract etiology unclear
- D. Code the documented age-related nuclear cataract of the right eye and do not assume a diabetic cataract relationship without provider linkage when required

Answer: D

Question: 7

A pre-bill audit finds that a claim for an ASC facility procedure was accidentally assigned a physician office place of service on the facility claim file. The operative note, facility record, and scheduling system all show the service occurred in the licensed ASC. What is the best corrective action?

- A. Remove the facility claim and bill only the professional claim
- B. Correct the place-of-service or facility claim setting before submission to match the licensed ASC documentation
- C. Leave the office place of service because the surgeon owns the ASC
- D. Add modifier 59 to show that the service was distinct from an office procedure

Answer: B

Question: 8

A billing audit identifies that the ASC facility and the surgeon's professional practice both billed the same HCPCS Level II implant supply code for a device used during an ASC procedure. The payer policy allows the device to be billed by the facility only when documentation supports it. The operative note and invoice are in the ASC record. What is the most appropriate corrective action?

- A. Leave both claims unchanged because both the surgeon and facility participated in the case
- B. Add modifier 59 to both device lines to show separate facility and professional involvement
- C. Coordinate correction so the device is billed only by the allowed billing entity according to payer policy
- D. Remove the procedure code from the ASC claim and bill only the device

Answer: C

Question: 9

An ASC procedure note documents endoscopic retrograde cholangiopancreatography for choledocholithiasis. The physician cannulates the common bile duct, performs biliary sphincterotomy, and removes two common bile duct stones using a balloon sweep. No biliary stent is placed, and no pancreatic duct intervention is documented. Which coding approach is most appropriate?

- A. Report ERCP with removal of biliary stones, including the documented sphincterotomy when represented by the selected code descriptor and payer rules
- B. Report pancreatic duct stent placement because ERCP always includes pancreatic duct treatment
- C. Report diagnostic ERCP only because the stones were removed endoscopically rather than surgically
- D. Report laparoscopic cholecystectomy because common bile duct stones usually originate from the gallbladder

Answer: A

Question: 10

A patient presents to an ASC for a scheduled minor surgical procedure. Before the procedure, the surgeon evaluates a new unrelated complaint of acute left ankle swelling, documents a separate history and exam, orders imaging, and decides to proceed with the scheduled procedure on the right hand. The payer allows a separately identifiable E/M service when documentation supports it. Which modifier concept is most relevant to the professional claim?

- A. No E/M can ever be reported on the same day as a procedure
- B. Modifier 25 may be appropriate for the separately identifiable E/M service when documentation and payer rules support it
- C. Modifier 22 should be appended because evaluating a new complaint takes extra time
- D. Modifier 59 should be appended to the E/M service because a procedure occurred on the same day

Answer: B

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