

Boost up Your Certification Score

AAPC CGSC

AAPC Certified General Surgery Coder



For More Information – Visit link below:

<https://www.examsboost.com/>

Product Version

- ✓ Up to Date products, reliable and verified.
- ✓ Questions and Answers in PDF Format.

Visit us at: <https://www.examsboost.com/test/cgsc>

Latest Version: 6.0

Question: 1

A colonoscopy is attempted for evaluation of iron deficiency anemia. The physician advances the scope to an obstructing sigmoid mass but cannot traverse the lesion to examine the proximal colon. Biopsies of the mass are obtained, and the incomplete extent is documented. No stent placement or full colonoscopy is performed.

Which coding principle is most appropriate?

- A. Code complete colonoscopy because a mass was reached and sampled
- B. Code colectomy because the obstructing mass prevented full examination
- C. Code the endoscopic biopsy service with attention to incomplete examination rules
- D. Code diagnostic EGD because iron deficiency anemia can arise from upper bleeding

Answer: C

Question: 2

A patient is discharged after nonoperative treatment of diverticulitis and sees the general surgeon in the office four days later. The surgeon reconciles medications, reviews discharge imaging, assesses persistent symptoms, adjusts antibiotics, and confirms follow-up. No surgery was performed during the hospitalization.

Which coding concept is most important?

- A. Report modifier 78 because the visit occurred after inpatient management
- B. Report no service because discharge follow-up is always bundled into admission
- C. Report routine postoperative care because the patient recently left the hospital
- D. Evaluate whether transitional care or office E/M rules apply based on requirements

Answer: D

Question: 3

A procedure report states that the physician planned evaluation of rectal bleeding with flexible sigmoidoscopy. The scope was advanced to 55 cm, reaching the sigmoid colon but not the descending colon or splenic flexure. A small rectal polyp was removed with biopsy forceps. No full colonoscopy was attempted.

Which coding concept is most important?

- A. Report anoscopy because the abnormality was located in the rectal area

- B. Report diagnostic sigmoidoscopy only because biopsy forceps removed tissue
- C. Report flexible sigmoidoscopy with biopsy based on intended extent and work
- D. Report colonoscopy with biopsy because a polyp was removed from the rectum

Answer: C

Question: 4

A surgeon performs thyroid lobectomy for a suspicious right thyroid nodule. The preoperative diagnosis is "follicular neoplasm, rule out carcinoma." The final pathology is pending at the time the operative claim is prepared, and no confirmed thyroid malignancy is documented. Which diagnosis-coding approach is most appropriate?

- A. Code personal history of thyroid cancer because lobectomy was performed
- B. Code the documented thyroid nodule or neoplasm without assigning confirmed cancer
- C. Code thyroid cancer because carcinoma was included in the rule-out statement
- D. Code parathyroid disorder because thyroid nodules affect calcium regulation

Answer: B

Question: 5

An ERCP report documents cannulation of the common bile duct, cholangiogram showing choledocholithiasis, biliary sphincterotomy, and balloon extraction of two duct stones. No stent placement, biopsy, or lithotripsy is documented. Which coding consideration is most appropriate?

- A. Report ERCP with sphincterotomy and stone extraction based on the duct therapy
- B. Report EGD with biopsy because the endoscope passed through the upper GI tract
- C. Report diagnostic ERCP only because the cholangiogram confirmed the stones
- D. Report ERCP with stent placement because duct stones usually require drainage

Answer: A

Question: 6

A trauma patient develops abdominal compartment syndrome after massive resuscitation. The surgeon documents emergent reopening of the laparotomy incision, release of abdominal pressure, inspection of bowel viability, placement of temporary abdominal closure, and transfer back to the ICU. No bowel resection is performed. Which coding concept is most important?

- A. Code routine postoperative care because the patient already had laparotomy
- B. Code the documented decompressive reopening and temporary abdominal closure work
- C. Code bowel resection because compartment syndrome threatens intestinal viability
- D. Code diagnostic laparoscopy because bowel viability was inspected after entry

Answer: B

Question: 7

A surgeon evaluates a new patient with symptomatic gallstones in the office. The documentation states that the surgeon spent 48 minutes on the date of the encounter reviewing outside ultrasound results, obtaining history, examining the patient, counseling about laparoscopic cholecystectomy risks and alternatives, and documenting the plan. No separate procedure is performed that day. Which E/M coding principle is most appropriate?

- A. Time may support code selection when total time is documented for the encounter date
- B. Modifier 25 is required because counseling occurred during a surgical office visit
- C. Time cannot support office E/M selection when surgery is discussed with the patient
- D. Only examination bullet counting should determine the office E/M level in this case

Answer: A

Question: 8

A patient previously had sentinel lymph node biopsy showing metastatic melanoma. The surgeon now performs completion axillary lymph node dissection, removing level I and II axillary nodal tissue. No mastectomy, parotidectomy, or thyroid procedure is performed. Which coding distinction is most important?

- A. Code parotidectomy because melanoma can spread to head and neck nodes
- B. Distinguish completion axillary lymph node dissection from sentinel node biopsy
- C. Code sentinel node biopsy because melanoma initially spread to one node
- D. Code mastectomy because axillary dissection is performed near breast tissue

Answer: B

Question: 9

A gastroenterologist requests that a general surgeon evaluate a patient with a large symptomatic hiatal hernia and provide an opinion about surgical repair. The surgeon documents the request, performs a full evaluation, sends a written recommendation back to the gastroenterologist, and follows Medicare payer rules.

Which coding principle is most important?

- A. Always report consultation codes whenever another physician sends the patient
- B. Report postoperative care because the patient may later undergo surgery
- C. Follow payer policy because some payers do not recognize consultation codes
- D. Always report preventive codes because the surgeon gave an opinion only

Answer: C

Question: 10

A claim reports an office E/M service with modifier 25 on the same day as simple incision and drainage of a superficial abscess. The note only documents confirmation of the abscess, consent, local anesthesia, drainage, irrigation, and dressing. No separate history, exam, assessment, or management beyond the procedure is documented.

Which audit conclusion is most appropriate?

- A. Modifier 24 is required because abscess drainage includes postoperative care
- B. Modifier 25 is supported because consent is always a separate E/M service
- C. Modifier 57 is required because the drainage decision was made that day
- D. Modifier 25 is not supported because separate E/M work is not documented

Answer: D

Thank You for Trying Our Product

For More Information – **Visit link below:**

<https://www.examsboost.com/>

15 USD Discount Coupon Code:

G74JA8UF

FEATURES

- ✓ **90 Days Free Updates**
- ✓ **Money Back Pass Guarantee**
- ✓ **Instant Download or Email Attachment**
- ✓ **24/7 Live Chat Support**
- ✓ **PDF file could be used at any Platform**
- ✓ **50,000 Happy Customer**



Visit us at: <https://www.examsboost.com/test/cgsc>