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AAPC Certified Obstetrics Gynecology Coder



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Question: 1

A high-risk pregnancy patient undergoes a fetal biophysical profile in the OB office. The report documents fetal breathing movements, gross body movements, fetal tone, amniotic fluid volume, and fetal nonstress testing. The physician documents the total score and interpretation.

Which coding approach is most appropriate?

- A. Report the biophysical profile code concept that includes the documented components
- B. Report routine prenatal care because the testing occurred during pregnancy
- C. Report only nonstress testing because the fetal heart tracing was included
- D. Report only a routine ultrasound because fetal movement was seen on imaging

Answer: A

Question: 2

A patient has a symptomatic paraurethral Skene gland cyst. The OB/Gyn excises the cyst in the operating room. The operative report documents paraurethral incision, complete cyst excision, protection of the urethra, layered closure, and specimen submission to pathology.

Which coding approach is most appropriate?

- A. Report Bartholin gland excision because all vulvar gland cysts use the same code family
- B. Report cystourethroscopy because the cyst is near the urethral opening
- C. Report excision of a paraurethral or Skene gland cyst based on the documented procedure
- D. Report incision and drainage only because cyst contents were accessed during excision

Answer: C

Question: 3

A payer requires a specific modifier for a mandated second surgical opinion before elective sterilization. The OB/Gyn documents that the encounter was performed solely because the payer required the independent opinion and includes the requested written report. No procedure is performed during the visit.

Which modifier concept should the coder evaluate when supported by payer policy?

- A. Modifier 59 because the opinion is distinct from the later sterilization procedure
- B. Modifier 78 because the opinion occurs before a related surgical procedure
- C. Modifier 22 because payer-required documentation always increases procedural work

D. Modifier 32 because the service was mandated by the payer requirement

Answer: D

Question: 4

A surgeon performs a laparoscopic hysterectomy. The operative report states only, "Procedure was difficult due to adhesions," but does not quantify additional time, describe unusual dissection, document altered anatomy in detail, or explain substantially increased work. The coder is considering modifier 22.

Which action is most appropriate?

- A. Append modifier 52 because difficult surgery means the service was reduced
- B. Do not append modifier 22 unless documentation supports substantially increased procedural work
- C. Append modifier 59 because adhesions make the hysterectomy distinct from routine surgery
- D. Append modifier 22 automatically because adhesions were mentioned in the operative report

Answer: B

Question: 5

An OB/Gyn admits a patient at 39 weeks' gestation for medically indicated induction of labor. The physician documents cervical ripening, oxytocin management, fetal monitoring review, and labor management for several hours. Before delivery occurs, the patient's care is transferred to another OB/Gyn, who performs the delivery and postpartum care.

Which coding consideration is most appropriate for the first OB/Gyn?

- A. Report delivery-only coding because labor management always equals completed delivery
- B. Report postpartum care-only coding because the first physician transferred care before delivery
- C. Report the full global delivery package because induction was initiated by the first physician
- D. Evaluate reporting of documented labor management services according to payer and maternity care rules

Answer: D

Question: 6

An OB/Gyn performs laparoscopic removal of the entire right ovary for a persistent complex ovarian mass. The operative report documents removal of the right ovary, preservation of the left ovary, and no removal of the uterus or fallopian tubes.

Which coding approach is most appropriate?

- A. Report hysterectomy because the ovarian mass was treated surgically
- B. Report ovarian cystectomy because the indication was an ovarian mass
- C. Report laparoscopic right oophorectomy based on removal of the entire ovary
- D. Report bilateral salpingo-oophorectomy because one ovary was removed

Answer: C

Question: 7

During one operative session, an OB/Gyn performs a laparoscopic ovarian cystectomy and a separately reportable hysteroscopic polypectomy for a different indication. The payer requests standard multiple-procedure reporting when more than one separately reportable procedure is billed.

Which modifier concept may need to be evaluated according to payer policy?

- A. Modifier TC because more than one procedure creates a technical component
- B. Modifier 25 because multiple procedures require an E/M modifier
- C. Modifier 57 because every operative session includes a surgical decision
- D. Modifier 51 for multiple procedures when payer policy requires it

Answer: D

Question: 8

The operative report states: "Total laparoscopic hysterectomy with removal of uterus and cervix, bilateral salpingectomy, ovaries preserved. Uterine weight 210 grams." The indication is symptomatic fibroids. No conversion to open surgery is documented.

Which coding detail is most important for selecting the appropriate CPT® hysterectomy code family?

- A. Number of skin incisions, suture type, antibiotic choice, and recovery room duration
- B. Laparoscopic approach, removal of uterus and cervix, adnexal structures removed, and uterine weight
- C. Patient age, fibroid symptoms, anesthesia time, and estimated blood loss
- D. Surgeon specialty, facility type, postoperative diagnosis, and pathology turnaround time

Answer: B

Question: 9

A postmenopausal patient presents with vaginal dryness, burning, and dyspareunia. The OB/Gyn documents "postmenopausal atrophic vaginitis" and prescribes local estrogen therapy. No infection, malignancy, or pregnancy is documented.

Which diagnosis coding approach is most appropriate?

- A. Report postmenopausal atrophic vaginitis based on the provider's documented diagnosis
- B. Report pregnancy complication because vaginal symptoms are reproductive system complaints
- C. Report dyspareunia only because atrophic vaginitis is part of normal aging
- D. Report candidal vulvovaginitis because burning and irritation indicate yeast infection

Answer: A

Question: 10

A gynecologic surgeon performs a complex abdominal hysterectomy and documents that an assistant surgeon actively assisted with exposure, vascular control, and closure due to dense pelvic adhesions. The payer allows assistant-at-surgery reporting when medically necessary and documented. Which coding issue should be evaluated for the assistant surgeon's claim?

- A. Whether the assistant should report the full primary surgeon's code without a modifier
- B. Whether modifier 25 should be appended because the assistant was present during surgery
- C. Whether an assistant-at-surgery modifier is supported by medical necessity and documentation
- D. Whether the service should be reported as diagnostic imaging because adhesions were visualized

Answer: C

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