Name:_____ Class:_____ Date:_____

Chapter 01

1. A coder acquires a working knowledge of coding systems, coding conventions and guidelines, government regulations, and third-party payer requirements to ensure that documented diagnoses, services, and procedures are coded accurately for _____, research, and statistical purposes.
   a. compliance
   b. continuity of care
   c. quality assurance
   d. reimbursement

   ANSWER: d

2. During internships (or professional practice experiences) at health care facilities, coding students receive _____ training.
   a. continuing education
   b. on-the-job
   c. paid
   d. virtual

   ANSWER: b

3. Which is the person to whom the student reports at the health care facility internship site?
   a. college instructor
   b. department manager
   c. internship supervisor
   d. volunteer coordinator

   ANSWER: c

4. Which is the most likely reason a student would be terminated from the internship site, fails internship course, or suspended and/or expelled from the academic program.
   a. arriving late due to weather conditions
   b. breaching patient confidentiality
   c. contacting the site about an absence
   d. dressing in a business casual style

   ANSWER: b

5. Coders also have the opportunity to work at home for employers who partner with an Internet-based organization called a(n) _____, which is a third-party entity that manages and distributes software-based services and solutions to customers using the Internet.
   a. application service provider (ASP)
   b. knowledge process outsourcing (KPO)
   c. third-party logistics (TPL)
   d. wide area network (WAN)

   ANSWER: a

Chapter 01

6. Which professional is employed by third-party payers to review health-related claims to determine whether the costs are reasonable and medically necessary based on the patient's diagnosis?
   a. health information technician
   b. insurance specialist
   c. liability underwriter
   d. medical assistant

   ANSWER: b

7. Students who join a professional association for a reduced membership fee often receive most of the same benefits as active members. Which is an example of a benefit of joining a professional association?
   a. guaranteed receipt of academic scholarship and grants
   b. opportunity to network with members of the association
   c. placement by the association at an internship facility
   d. waiver provided for certification examination fees

   ANSWER: b

8. Which represents an online professional network about a variety of topics and issues.
   a. application service provider
   b. listserv
   c. place-bound conference
   d. wide area network

   ANSWER: b

9. Which organizes a medical nomenclature according to similar conditions, diseases, procedures, and services, and it contains codes for each?
   a. classification system
   b. data dictionary
   c. hybrid record
   d. medical nomenclature

   ANSWER: a

10. Which is a vocabulary of clinical and medical terms used by health care providers to document patient care.
    a. classification system
    b. data dictionary
    c. hybrid record
    d. medical nomenclature

    ANSWER: d

Chapter 01

11. Which includes numeric and alphanumeric characters that are reported to health plans for health care reimbursement, to external agencies for data collection and internally for education and research.
    a. codes
    b. dictionary
    c. nomenclature
    d. placeholders

    ANSWER: a

12. Coding is the assignment of codes to diagnoses, services, and procedures based on _____.
    a. federal government regulations
    b. health information management
    c. patient record documentation
    d. third-party payer requirements

    ANSWER: c

13. Which is used to classify diagnoses in any health care setting?
    a. CPT
    b. HCPCS level II
    c. ICD-10-CM
    d. ICD-10-PCS

    ANSWER: c

14. Which is used to classify procedures in an inpatient hospital setting?
    a. CPT
    b. HCPCS level II
    c. ICD-10-CM
    d. ICD-10-PCS

    ANSWER: d

15. Which is published by the AMA and used to classify procedures and services in an outpatient setting?
    a. CPT
    b. HCPCS level II
    c. ICD-10-CM
    d. ICD-10-PCS

    ANSWER: a

Chapter 01

16. Which is managed by CMS and used to classify medical equipment injectable drugs, transportation services, and other services in an outpatient setting?
    a. CPT
    b. HCPCS level II
    c. ICD-10-CM
    d. ICD-10-PCS

    ANSWER: b

17. The Centers for Medicare & Medicaid Services (CMS) is a(n) _____ in the federal Department of Health and Human Services (DHHS).
    a. administrative agency
    b. compliance section
    c. private organization
    d. third-party payer

    ANSWER: a

18. Which is an example of a medical nomenclature?
    a. CPT
    b. DSM-5
    c. ICD-10-CM/PCS
    d. SNOMED CT

    ANSWER: d

19. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is federal legislation that amended the Internal Revenue Code of 1986 to _____.
    a. create privacy and security standards for health information
    b. eliminate standards for electronic health information transactions
    c. limit access to long-term care services and coverage
    d. produce waste, fraud, and abuse in health insurance and health care delivery

    ANSWER: a

20. The process of standardizing data by assigning alphanumeric values to text or other information is called _____.
    a. encoding
    b. mapping
    c. potentiating
    d. sequencing

    ANSWER: a

Chapter 01

21. The HIPAA small code set collects information concerning _____.
    a. actions taken to prevent, diagnose, treat, and manage diseases and injuries
    b. causes of injury, disease, impairment, or other health-related problems
    c. diseases, injuries, impairments, and other health-related problems
    d. race, ethnicity, type of facility, and type of unit

    ANSWER: d

22. The HIPAA large code set collects information concerning _____.
    a. actions taken to prevent, diagnose, treat, and manage diseases and injuries
    b. privacy and security standards for health information
    c. race, ethnicity, type of facility, and type of unit
    d. waste, fraud, and abuse in health insurance and health care delivery

    ANSWER: a

23. HIPAA requires health plans that do not accept standard code sets to modify their systems to accept all valid codes or to contract with a(n) _____.
    a. electronic data interchange
    b. health care clearinghouse
    c. insurance company
    d. third-party administrator

    ANSWER: b

24. Which is an insurance company that establishes a contract to reimburse health care facilities and patients for procedures and services provided?
    a. clearinghouse
    b. health plan
    c. provider
    d. third-party administrator

    ANSWER: b

25. Which is an example of a third-party payer?
    a. Blue Cross/Blue Shield
    b. Centers for Medicare and Medicaid Services
    c. Department of Health and Human Services
    d. Workers' compensation

    ANSWER: a

26. Which is an example of another health care professional who performs procedures or provides services to patients?
    a. clearinghouse staff
    b. health information technician
    c. medical assistant
    d. nurse practitioner

    ANSWER: d

27. Health plans that do not accept standard code sets are required to modify their systems to accept all valid codes or to contract with a _____ that does accept standard code sets.
    a. health care clearinghouse
    b. health care provider
    c. third-party administrator
    d. third-party payer

    ANSWER: a

28. Adopting HIPAA's standard code sets has improved data quality and simplified claims submission for health care providers who routinely deal with multiple _____.
    a. clearinghouses
    b. health plans
    c. markets
    d. physicians

    ANSWER: b

29. A third-party administrator (TPA) is an entity that _____ and may contract with a health care clearinghouse to standardize data for claims processing.
    a. combats waste, fraud, and abuse in health insurance and health care delivery
    b. improves portability and continuity of health insurance coverage in group/individual markets
    c. processes health care claims and performs related business functions for a health plan
    d. simplifies the administration of health insurance by creating unique identifiers

    ANSWER: c

30. The medical coding process requires the _____ of patient record documentation to identify diagnoses, procedures, and services for the purpose of assigning ICD-10-CM, ICD-10-PCS, HCPCS level II, and/or CPT codes.
    a. correction
    b. entry
    c. omission
    d. review

    ANSWER: d

Chapter 01

31. Professional associations establish a *code of ethics* to help members understand how to differentiate between "right" and "wrong" and apply that understanding to _____.
    a. credentialing
    b. decision making
    c. documentation
    d. focused review

    ANSWER: b

32. Concurrent coding is the review of records and/or use of encounter forms and chargemasters to assign codes _____.
    a. after the patient has been discharged from care
    b. during an inpatient stay or outpatient encounter
    c. following the submission of health insurance claims
    d. that results in continuity of the patient's health care

    ANSWER: b

33. Which is used to record data about office procedures and services provided to patients?
    a. chargemaster
    b. encounter form
    c. insurance claim
    d. uniform bill

    ANSWER: b

34. Which contains a computer-generated list of procedures, services, and supplies and corresponding revenue codes along with charges for each.
    a. chargemaster
    b. encounter form
    c. insurance claim
    d. uniform bill

    ANSWER: a

35. Coders are prohibited from performing *assumption coding*, which is the assignment of codes based on assuming, from a review of clinical evidence in the patient's record, that the patient has certain diagnoses or received certain procedures/services even though the _____.
    a. a responsible physician was contacted to confirm diagnoses, procedures, and services
    b. physician query process was not implemented by the health care facility or physician
    c. provider did not specifically document those diagnoses or procedures and services
    d. risk for health care fraud and abuse is assumed by the health care facility or physician

    ANSWER: c

36. When coders have questions about documented diagnoses or procedures/services, they use a *physician query process* to contact the responsible physician to _____.
    a. confirm diagnoses, procedures, and services already documented in the record
    b. eliminate the risk for fraud and abuse even though assumed by the facility or physician
    c. request clarification about documentation and the code(s) to be assigned
    d. to document diagnoses, procedures, or services that will increase reimbursement

    ANSWER: c

37. Integrating the _____ physician query process with the electronic health record allows physicians to more easily receive and reply to queries, which results in better and timely responses from physicians.
    a. automated
    b. complete
    c. legible
    d. precise

    ANSWER: a

38. A physician lists "viral pneumonia" as the final diagnosis. However, the coder notes that laboratory results state "gram-negative bacteria." There is also documentation of chest pain, fever, and dyspnea due to pneumonia. What should the coder do?
    a. Assign a code to the final diagnosis of viral pneumonia
    b. Code bacterial pneumonia, chest pain, fever, and dyspnea
    c. Query the physician regarding the diagnosis of pneumonia
    d. Report symptom codes for chest pain, fever, and dyspnea

    ANSWER: c

39. The purpose of a *clinical documentation improvement (CDI) program* is to help health care facilities comply with government programs and other initiatives with the goal of improving health care quality. Thus, a CDI specialist initiates concurrent and retrospective reviews of inpatient records to identify _____ provider documentation.
    a. abusive and fraudulent
    b. conflicting, incomplete, or nonspecific
    c. illegible physician queries and
    d. redacted health insurance claims

    ANSWER: b

40. A *coding compliance program* ensures that the assignment of codes to diagnoses, procedures, and services follows established coding guidelines, and health care organizations write *policies* and *procedures* to assist in implementing the coding compliance stages of _____.
    a. detection, correction, prevention, verification, and comparison
    b. portability, continuity, and combating waste, fraud, and abuse
    c. legibility, completeness, clarify, consistency, and precision
    d. unbundling, upcoding, overcoding, jamming, and downcoding

    ANSWER: a

41. An effective *coding compliance program* monitors coding processes for _____.
    a. completeness, reliability, validity, and timeliness
    b. diagnostic/management, therapeutic, and education plans
    c. record formats, whether automated or manual
    d. reporting hospital data for health data collection

    ANSWER: a

42. *Computer assisted coding* uses software to automatically generate _____ by "reading" transcribed clinical documentation provided by health care practitioners.
    a. data entry
    b. insurance claims
    c. medical codes
    d. validation/audit reviews

    ANSWER: c

43. A patient record is the business record for a patient encounter that documents _____.
    a. encounter forms data sent to third-party payers
    b. inaccurate information that cannot be altered
    c. health care services provided to a patient
    d. insurance claims submitted to health care plans

    ANSWER: c

44. Demographic data is patient identification information that is collected according to facility policy and includes information such as the _____.
    a. insurance claim submitted
    b. medical codes reported
    c. patient's date of birth
    d. quality of patient care

    ANSWER: c

Chapter 01

45. The primary purpose of the record is to provide for _____.
    a. facility medicolegal interests
    b. health care reimbursement
    c. patient continuity of care
    d. quality review studies

    ANSWER: c

46. A secondary purpose of the patient record is to _____.
    a. assist in planning patient care
    b. evaluate patient quality of care
    c. provide patient continuity of care
    d. serve as a communication method

    ANSWER: b

47. Patient record documentation must be _____.
    a. dated and authenticated by the responsible provider
    b. evaluated prior to patient discharge from the facility
    c. provided to third-party payers for reimbursement
    d. stored using an automated electronic record format

    ANSWER: a

48. A teaching hospital is engaged in an approved graduate medical education _____ program in medicine, osteopathy, dentistry, or podiatry.
    a. health care
    b. medicolegal
    c. residency
    d. third-party

    ANSWER: c

49. Residents are supervised by a(n) _____ physician during patient care?
    a. admitting
    b. attending
    c. responsible
    d. teaching

    ANSWER: d

50. Which type of physician participates in an approved GME program?
    a. attending
    b. emergency
    c. resident
    d. teaching

    ANSWER: c

51. A *hospitalist* is a physician whose practice emphasizes providing care for hospital _____, and they are often internal medicine specialists who handle a patient's entire admission process.
    a. clinic patients
    b. ED patients
    c. inpatients
    d. outpatients

    ANSWER: c

52. For medical necessity purposes, the patient record must support codes submitted for third-party payer reimbursement, and patient diagnoses must _____.
    a. evaluate the quality of patient care received in the health care facility
    b. justify diagnostic and/or therapeutic procedures or services provided
    c. provide clinical evidence for a higher degree of specificity or severity
    d. serve the medicolegal interests of the patient, facility, and providers of care

    ANSWER: b

53. Which type of record is paper based?
    a. automated
    b. hybrid
    c. manual
    d. systematized

    ANSWER: c

54. Which type of record uses computer technology?
    a. automated
    b. hybrid
    c. manual
    d. systematized

    ANSWER: a

55. Patient records that consist of handwritten progress notes and automated laboratory results are and example of _____ records.
    a. automated
    b. hybrid
    c. manual
    d. systematized

    ANSWER: b

56. In a source-oriented record, reports are organized according to _____ in labeled sections.
    a. documentation source
    b. health care provider
    c. procedures and services
    d. reimbursement type

    ANSWER: a

57. The problem-oriented record is a(n) _____ method of documentation that consists of four components: database, initial plan, problem list, and progress notes.
    a. automated
    b. data source
    c. manual
    d. systematic

    ANSWER: b

58. Chief complaint, social data, and past medical history are considered part of the problem-oriented record _____.
    a. database
    b. initial plan
    c. problem list
    d. progress note

    ANSWER: a

59. The table of contents for the problem-oriented record is called the _____, and it is filed at the beginning of the record and contains a numbered list of the patient's problems, which helps to index documentation throughout the record.
    a. database
    b. initial plan
    c. problem list
    d. progress note

    ANSWER: c

60. The problem-oriented record _____ contains the strategy for managing patient care and any actions taken to investigate the patient's condition and to treat and educate the patient.
    a. database
    b. initial plan
    c. problem list
    d. progress note

    ANSWER: b

61. Which is documented about each problem assigned to the patient, using the SOAP structure of the problem-oriented record?
    a. database
    b. initial plan
    c. problem list
    d. progress note

    ANSWER: d

62. To learn more about the patient's condition and the management of the conditions, review the _____ plans in the problem-oriented record.
    a. diagnostic/management
    b. follow-up
    c. patient education
    d. therapeutic

    ANSWER: a

63. To determine how the patient will be informed about conditions for which he or she is being treated, review the _____ plans in the problem-oriented record.
    a. diagnostic/management
    b. follow-up
    c. patient education
    d. therapeutic

    ANSWER: c

64. To learn more about specific medications, goals, procedures, therapies, and treatments used to treat the patient, review the _____ plans in the problem-oriented record.
    a. diagnostic/management
    b. follow-up
    c. patient education
    d. therapeutic

    ANSWER: d

65. Observations about the patient's physical findings or lab results would be found in the _____ portion of a problem-oriented SOAP note.
    a. assessment
    b. objective
    c. plan
    d. subjective

    ANSWER: b

66. The patient's statement about how he or she feels would be found in the _____ portion of a problem-oriented SOAP note.
    a. assessment
    b. objective
    c. plan
    d. subjective

    ANSWER: d

67. The judgment, opinion, or evaluation made by the health care provider would be found in the _____ portion of a problem-oriented SOAP note.
    a. assessment
    b. objective
    c. plan
    d. subjective

    ANSWER: a

68. Diagnostic, therapeutic, and education plans to resolve the problems would be found in the _____ portion of a problem-oriented SOAP note.
    a. assessment
    b. objective
    c. plan
    d. subjective

    ANSWER: c

69. The progress notes section of the POR contains a(n) _____ note to summarize the patient's care, treatment, response to care, and condition on release from the facility.
    a. discharge
    b. emergency
    c. follow-up
    d. transfer

    ANSWER: a

70. The progress notes section of the POR contains a(n) _____ note when the patient is relocated to another facility, and it summarizes the reason for admission, current diagnoses and medical information, and reason for relocation.
    a. discharge
    b. emergency
    c. follow-up
    d. transfer

    ANSWER: d

71. *Integrated record* reports are arranged in strict chronological date order (or in reverse date order), which allows for _____, and many facilities integrate only physician and ancillary services progress notes, which require entries to be identified by appropriate authentication.
    a. collection of information by a number of providers at different facilities about a patient
    b. linking of information created at different locations using a unique patient identifier
    c. observation about how the patient responds to treatment based on test results
    d. summarization of patient care, treatment, response to care, condition on discharge

    ANSWER: c

72. The *electronic health record* is a(n) _____.
    a. collection of information by a number of providers at different facilities about a patient
    b. linking of information created at different locations using a unique patient identifier
    c. observation about how the patient responds to treatment based on test results
    d. summarization of patient care, treatment, response to care, condition on discharge

    ANSWER: a

73. The *electronic medical record* is a(n) _____.
    a. created using vendor software, which also assists in provider decision making
    b. linking of information generated at different locations using a unique patient identifier
    c. observation about how the patient responds to treatment based on test results
    d. practice management software solution for acute and long-term care hospitals

    ANSWER: a

74. Optical disk imaging provides an alternative to traditional microfilm or remote storage systems because patient records are _____.
    a. converted to an electronic image and saved on storage media
    b. linked using a unique patient identifier assigned by the government
    c. paper-based solutions for facilities that cannot afford automated records
    d. stored on computers at regional health care centers in each state

    ANSWER: a

75. Which is used during the document imaging process to create images of patient reports?
    a. index
    b. jukebox
    c. optical disk
    d. scanner

    ANSWER: d

76. During the optical disk imaging process, each patient report is _____ with a unique identification number assigned by the facility.
    a. documented
    b. indexed
    c. scanned
    d. tabulated

    ANSWER: b

77. Which is used in conjunction with the document imaging process to store optical disks?
    a. clearinghouse
    b. database
    c. jukebox
    d. scanner

    ANSWER: c

78. Which is performed by health care facilities and providers for the purpose of administrative planning, submitting statistics to state and federal government agencies, and reporting health claims data to third-party payers?
    a. health data collection
    b. provider documentation
    c. reimbursement processing
    d. statistical analysis

    ANSWER: a

79. Automated case abstracting software is used by hospitals to _____.
    a. collect data for statistical analysis
    b. generate accounting aging reports
    c. register patients for encounters
    d. schedule patient appointments

    ANSWER: a

Chapter 01

80. The UB-04 claim is submitted by _____ to health plans for reimbursement purposes.
    a. departments of health
    b. hospitals
    c. physician offices
    d. third-party payers

    ANSWER: b

81. The CMS-1500 claim is submitted by _____ to third-party payers for processing.
    a. departments of health
    b. government agencies
    c. physician offices
    d. third-party payers

    ANSWER: c

82. Medical management software is used to _____.
    a. automate physician office workflow
    b. collect hospital data for analysis
    c. generate patient satisfaction surveys
    d. process UB-04 outpatient claims

    ANSWER: a

    Match each statement of purpose with the reference/resource listed below.
    a. *Conditions of Participation* and *Conditions for Coverage*
    b. *CPT Assistant* and *HCPCS Assistant*
    c. National Correct Coding Initiative
    d. Outpatient Code Editor with APCs
    e. *Coding Clinic for HCPCS Level II*

83. Medicare regulations (Centers for Medicare and Medicaid Services)

    ANSWER: a

84. Software used by hospitals to help identify CPT/HCPCS coding errors

    ANSWER: d

85. Monthly newsletter published by AMA as an official coding resource

    ANSWER: b

86. Quarterly newsletter published by AHA as an official coding resource

    ANSWER: e

87. “Code edits pairs” that cannot be reported on the same claim for payment

    ANSWER: c

Chapter 01

Match each illegal coding practice with the correct term listed below.

a. Downcoding
b. Jamming
c. Overcoding
d. Unbundling
e. Upcoding

88. Reporting multiple CPT codes to increase reimbursement when a combination code should be reported

ANSWER: d

89. Reporting codes for associated signs and symptoms in addition to an established diagnosis

ANSWER: c

90. Routinely assigning lower-level CPT codes as a convenience instead of reviewing documentation and the coding manual to determine the proper code to be reported

ANSWER: a

91. Routinely assigning a 0 or 9 as the fourth- or fifth-digit position of an ICD-9-CM disease code instead of reviewing the coding manual to select the appropriate code number

ANSWER: b

92. Reporting codes that are not supported by documentation in the patient record for the purpose of increasing reimbursement

ANSWER: e

Chapter 01

Match each credential with the corresponding credentialing organization listed below.

a. AAMA
b. AAPC
c. AHIMA
d. AMBA
e. NEBA

93. CCS

ANSWER: c

94. CHRS

ANSWER: e

95. CMA

ANSWER: a

96. CPC

ANSWER: b

97. CRMS

ANSWER: d

Match each description with the type of code set listed below.

a. large code set
b. small code set

98. Actions related to disease impairment management, prevention, and treatment

ANSWER: a

99. Causes of injury, disease, impairment, or other health-related problems

ANSWER: a

100. Diseases, injuries, impairments, other health-related problems and their manifestations

ANSWER: a

101. Race, ethnicity, type of facility, and type of unit

ANSWER: b

102. Substances, equipment, supplies, or other items

ANSWER: a