Practice Paper

Domain 1Coding Knowledge and Skills

1. The patient is seen in the pain clinic for chronic neoplasm-related pain that was known to be caused by the metastatic bone carcinoma of the vertebra that has spread from carcinoma of the left main bronchus of the lung. How should this be coded?

a. C34.02, Malignant neoplasm of left main bronchus

b. G89.3, Neoplasm related pain (acute) (chronic)

c. G89.3, Neoplasm related pain (acute) (chronic); C79.51, Secondary malignant neoplasm of bone; C34.02, Malignant neoplasm of left main bronchus

d. C79.51, Secondary malignant neoplasm of bone; G89.3, Neoplasm related pain (acute) (chronic)

2. A child is seen in the emergency department for second- and third-degree burns of the left lower leg and second- and third-degree burns of the lower back, for a total of 16 percent of body surface area burned, 9 percent of which are third-degree burns. What is the correct code assignment?

a. T24.301A, T21.34XA, T31.10

b. T24.302D, T21.34XD, T31.10

c. T24.302A, T21.34XA, T31.10

d. T24.301D, T21.34XD, T31.10

3. A patient underwent excision of a malignant lesion of the skin of the chest that measured 1.0 cm, and there was a 0.2-cm margin on both sides. Based on the 2022 CPT codes, which code would be used for the procedure?

a. 11401, Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm

b. 11601, Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm

c. 11602, Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm

d. 11402, Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm

4. A laparoscopic tubal ligation with Falope ring is completed. What is the correct CPT code assignment?

a. 58662

b. 58670

c. 58671

d. 49321

5. A patient is admitted to the hospital for pain due to displacement of pacemaker electrode. The patient also has hypothyroidism due to partial thyroidectomy seven years ago and a breast cyst. Using a guide wire, the pacemaker electrode was relocated and Synthroid was given during hospitalization. The codes (excluding External Cause codes) that should be assigned are:

a. T82.110A, E89.0, 02WA3MZ

b. T82.110D, E89.0, N60.09, 02WA4MZ

c. T82.120A, E89.0, 02WA3MZ

d. T82.120S, E89.0, N60.09, 02WA0MZ

6. A maternity patient is admitted in labor at 43 weeks. She has a spontaneous delivery with vacuum extraction to facilitate the baby's delivery. Which of the following would be the principal diagnosis?

a. O48.0

b. O48.1

c. O80

d. O66.5

7. A patient is admitted to the hospital due to a fracture of the right hip and is scheduled for an open reduction with internal fixation. The patient developed cardiac arrhythmia that results in an inability to do the planned surgery. What is the principal diagnosis?

a. Status post fracture

b. Cardiac arrhythmia

c. Right hip fracture

d. Cancelled procedure

8. A 45-year-old man with known AIDS is admitted to the hospital for treatment of HIV-related Pneumocystis carinii pneumonia. What is the principal diagnosis code?

a. B20

b. J18.9

c. B59

d. Any of the above

9. Patient admitted with hemorrhage due to placenta previa with twin pregnancy. This patient had two prior (cesarean section) deliveries. Emergency C-section was performed due to the hemorrhage. The appropriate principal diagnosis would be:

a. Prior cesarean sections

b. Placenta previa without hemorrhage

c. Twin gestation

d. Placenta previa with hemorrhage

10. A patient presents to a facility with a history of prostate cancer and mental confusion on admission. The patient completed radiation therapy for prostatic carcinoma three years ago and is status post a radical resection of the prostate. A CT scan of the brain reveals metastatic carcinoma of the brain. The correct coding and sequencing of this patient's record is:

a. Metastatic carcinoma of the brain, carcinoma of the prostate, mental confusion

b. Mental confusion, history of carcinoma of the prostate, metastatic carcinoma of the brain

c. Metastatic carcinoma of the brain, history of carcinoma of the prostate

d. Carcinoma of the prostate, metastatic carcinoma to the brain

11. A patient with GERD presents to a facility for upper endoscopy submucosal injection of material near the lower esophageal sphincter. The correct coding and sequencing of this patient's record is:

a. K20.90, 43257

b. K21.00, 43235, 43236

c. K21.9, 43236

d. K21.9, K20.90, 43270-58, 43236-59

12. According to CPT, an endoscopy that is undertaken to the level of the midtransverse colon would be coded as a:

a. Proctosigmoidoscopy

b. Sigmoidoscopy

c. Colonoscopy

d. Proctoscopy

13. If a patient is admitted with pneumococcal pneumonia and severe pneumococcal sepsis, the coding professional should:

a. Assign codes for sepsis and pneumonia

b. Assign codes for sepsis, pneumonia, and severe sepsis

c. Assign only a code for pneumococcal pneumonia

d. Review the chart to determine if septic shock could be coded first

14. A female patient with terminal carcinoma of the breast, metastatic to the liver, brain, and intrahepatic and extrahepatic bile ducts, was admitted with dehydration. Patient was rehydrated with IVs and discharged, with no treatment given to the cancer. What are the codes assigned?

a. E86.0, C50.919, C78.7, C79.31, C78.89

b. C50.919, E86.0, C78.7, C79.31

c. C50.919, E86.9, C78.7, C79.31

d. E86.9, C50.919, C78.7, C79.31, C78.89

15. A 45-year-old patient is admitted with insulin-dependent diabetes. The type of diabetes is not specified in the health record. How should this be coded?

a. E11.9, Z79.4

b. E11.8, Z79.4

c. E10.9, Z79.4

d. Query the provider for the type of diabetes

16. A patient was admitted to the hospital with unstable angina and congestive heart failure. The unstable angina is treated with nitrates, and intravenous Lasix is given to manage the heart failure. What is the appropriate coding action?

a. Assign only the code for the congestive heart failure.

b. Assign the codes for the unstable angina and congestive heart failure, sequence either first.

c. Query the physician about which diagnoses to code.

d. Assign only the code for the unstable angina.

17. A patient presents to the outpatient surgical area for a cystoscopy with multiple biopsies of the bladder. The patient's presenting symptom is hematuria. What is the correct facility code assignment for this procedure?

a. 52000

b. 52000-22

c. 52204

d. 52204, 52204-22

18. A patient has blepharoplasty of the left upper eyelid. What modifier should be used with the procedure?

a. LT

b. TA

c. E1

d. F2

19. Facilities may use X modifiers in place of which modifier?

a. 25

b. 27

c. 52

d. 59

20. A sigmoidectomy takes the physician more time than originally planned. The reason was extensive lysis of adhesions, which took over two hours. What modifier can the physician use to indicate this procedure required increased time?

a. 22

b. 26

c. 52

d. 59

21. A patient is admitted to the hospital with shortness of breath and congestive heart failure and subsequently develops respiratory failure. The patient undergoes intubation with ventilator management. The correct sequencing of the diagnoses in this case would be:

a. Congestive heart failure and respiratory failure

b. Respiratory failure

c. Respiratory failure and congestive heart failure

d. Shortness of breath, congestive heart failure, and respiratory failure

22. A patient was admitted with end stage renal disease (ESRD) following kidney transplant. The patient undergoes dialysis during admission. The patient's angina and chronic obstructive pulmonary disease are managed with medication while admitted. The diagnoses would be sequenced as:

a. Status post kidney transplant; ESRD, chronic obstructive pulmonary disease; angina

b. ESRD; status post kidney transplant; chronic obstructive pulmonary disease; angina

c. Angina; ESRD, status post kidney transplant; chronic obstructive pulmonary disease

d. Chronic obstructive pulmonary disease; ESRD; status post kidney transplant; angina

23. This patient was admitted for chemotherapy due to a primary hepatocellular carcinoma of the transplanted liver. What codes are assigned?

a. C80.2, T86.49, Z51.11, C22.0

b. C22.0, C80.2, Z51.11, T86.49

c. Z51.11, T86.49, C80.2, C22.0

d. T86.49, C80.2, C22.0, Z51.11

24. A patient comes to the ER with chest pain and shortness of breath. An EKG was performed, and the patient's history of COPD was noted. Unstable angina was diagnosed as the chest pain came on while the patient was at rest and did not resolve with nitroglycerin. The patient was admitted for a left heart catheterization, coronary arteriography using two catheters, and left ventricular angiography. The patient was found to have arteriosclerotic heart disease. The patient has no history of cardiac surgery. The appropriate sequencing of ICD-10-CM and CPT codes would be:

a. R07.9, R06.02, I25.119, 93452, 93458

b. J44.9, I20.0, I25.110, 93454, 93453

c. I20.9, J44.9, 93453

d. I25.110, J44.9, 93458

25. An obstetric patient is admitted with vaginal spotting and fever. She is found to have been treated for a miscarriage (spontaneous abortion), which was resolved two weeks prior to this admission. She is treated with aspiration dilation and curettage and products of conception are found. She is found to be septic. Which of the following is the correct sequencing of the diagnoses for this case?

a. A41.9, O03.37

b. O26.859, R50.9

c. R50.9, O26.859

d. O03.37, A41.9

26. A patient was admitted with pneumonia. Sputum cultures on day three of admission indicate a Klebsiella pneumonia. What is the POA status for the Klebsiella pneumonia and why?

a. Y, because the pneumonia was present on admission, even though the organism was not verified until days later

b. N, because the type of pneumonia was not verified until after admission

c. U, because the coding professional must query the physician for POA status in this case

d. W, because the physician cannot tell if the reason for the pneumonia at the time of admission was the Klebsiella or not

27. A patient has a hernia repair done as an outpatient. In recovery, the patient develops tachycardia and shortness of breath, is diagnosed with postoperative atrial fibrillation, and is subsequently admitted. What is the POA indicator for the postoperative atrial fibrillation?

a. Y

b. N

c. U

d. W

28. A patient is admitted with acute gastritis. On the second day of admission, the patient has hematemesis. The patient is also being treated for long-standing hypertension and diabetes, along with recently diagnosed hypothyroidism. Which of the patient's diagnoses will have a POA indicator of N?

a. Diabetes

b. Hypothyroidism

c. Hypertension

d. Acute gastritis

29. Which type of conditions are always considered present on admission?

a. Obstetrical

b. Congenital

c. Those with an acute exacerbation

d. Those that represent an injury

30. A patient is admitted for seizures. What is the appropriate POA for the external cause code of W06.XXXA assigned because the patient fell out of bed during a seizure in the emergency department?

a. Y

b. N

c. U

d. W

31. The outpatient code editor (OCE) has all of the following types of edits except:

a. Sex and procedure edits

b. Valid diagnosis code edits

c. Invalid revenue code edits

d. Diagnosis and age edits

32. Determining medical necessity for outpatient services includes all the following except:

a. Local coverage determinations (LCDs)

b. National coverage determinations (NCDs)

c. Diagnoses linked to procedures by claims-processing software tests ensuring that the procedure is cross-referenced, or linked, correctly to an acceptable diagnosis code for that service

d. Requiring new HCPCS codes be developed to replace codes in the CPT code book

33. The National Correct Coding Initiative (NCCI) Edits apply to services billed by:

a. The same provider, for same beneficiary, on same date of service

b. All providers, for the same beneficiary, on the same date of service

c. The same provider, for the same beneficiary, for all dates of service related to the encounter

d. All providers, for the same beneficiary, for all dates of service related to the encounter

34. If the principal diagnosis is an initial anterior wall myocardial infarction, which procedure will result in the highest MS-DRG assignment?

a. Mechanical ventilator

b. Insertion central venous catheter

c. Right heart cardiac catheterization

d. Transbronchial lung biopsy via bronchoscopy

35. Medicare payment to healthcare providers for services rendered is made under the:

a. Outpatient Prospective Payment System

b. Resource-based Relative Value Scale

c. Ambulatory Payment Classification

d. Conditions of Participation

36. Inpatient procedures are coded with:

a. HCPCS

b. CPT

c. ICD-10-PCS

d. ICD-O

37. Under the Inpatient Prospective Payment System (IPPS), what can be used to measure the cost of care for inpatients?

a. MS-DRG assignment

b. RBRVS

c. Case-mix index

d. SOI-ROM

38. The abstracting of this data element has an impact on the DRG reimbursement.

a. Date of service

b. Discharge disposition

c. Admission source

d. Medical record number

39. Which of the following is a data element that coding professionals typically are tasked with abstracting?

a. Blood type

b. Date of admission

c. Sex

d. Date of surgery

40. Dr. Jones is the attending physician for a patient admitted with aspiration of a ballpoint pen cap. Dr. Westwood is the provider who performed a direct laryngoscopy with foreign body removal on the patient the afternoon of admission. Monitoring of the patient's respiratory status continued for 36

hours after the procedure as severe swelling of the larynx was noted during the laryngoscopy. On the morning of discharge, the patient was noted to have acute, suppurative otitis media of the right ear and Dr. Phillips performed a myringotomy with tube insertion under general anesthesia with assistance from Dr. Johannsen, the resident.

Upon discharge, which physician will be assigned to the principal procedure that was performed?

a. Dr. Jones

b. Dr. Westwood

c. Dr. Johannsen

d. Dr. Phillips

41. When a patient leaves an acute inpatient prospective payment system (IPPS) facility against medical advice, and is then admitted into a different IPPS facility on the same day, the initial facility should categorize this as a(n):

a. Discharge

b. Transfer

c. Readmission

d. Outlier

42. A patient is admitted with an acute inferior myocardial infarction and discharged alive. Which condition would increase the MS-DRG weight?

a. Respiratory failure

b. Atrial fibrillation

c. Hypertension

d. History of myocardial infarction

43. Documentation in the health record reveals that a patient is admitted with an acute exacerbation of COPD (MS-DRG 192). Which of the following could potentially result in a higher weighted MS-DRG if documented as an associated diagnosis at the time of admission?

a. Angina and treated with nitroglycerin prn

b. Atrial fibrillation and underwent a cardioversion

c. Respiratory failure treated with intubation and mechanical ventilation for 23 hours

d. Anemia and was given a blood transfusion

44. A female patient is diagnosed with congestive heart failure. Which of the following will increase the MS-DRG weight if present on admission?

a. Atrial fibrillation

b. Stage III pressure ulcer of coccyx

c. Blood loss anemia

d. Coronary artery disease

45. Major complications and comorbidities (MCCs) are determined to require the greatest degree of resources with a payment group and also reflect the greatest _____.

a. ROM

b. ROI

c. SOI

d. SNF

46. Which of the following diagnoses qualifies as MCC?

a. Coronary artery disease

b. Aortic stenosis

c. Type 2 myocardial infarction

d. Unspecified atrial fibrillation

Domain 2Coding Documentation

47. A 7-year-old patient was admitted to the emergency department for treatment of shortness of breath. The patient is given epinephrine and nebulizer treatments. The shortness of breath and wheezing are unabated following treatment. What diagnosis should be suspected?

a. Acute bronchitis

b. Acute bronchitis with chronic obstructive pulmonary disease

c. Asthma with status asthmaticus

d. Chronic obstructive asthma

48. A 23-year-old female is admitted for shock following treatment of an ectopic pregnancy. This encounter would be coded as:

a. O03.81, Spontaneous abortion complicated by shock

b. O08.3, Complication following ectopic and molar pregnancies

c. R57.9, Shock NOS

d. T81.10XA, Postoperative shock

49. A patient is discharged with a diagnosis of acute pulmonary edema due to congestive heart failure. What condition(s) should be coded?

a. Acute pulmonary edema

b. Congestive heart failure

c. Acute pulmonary edema and congestive heart failure

d. Unable to determine based on the information provided

50. A 65-year-old male patient is being assessed for possible colon cancer and treated in the special procedure unit of the hospital. He undergoes a colonoscopy with biopsy of a suspicious area in the transverse colon using the cold biopsy forceps. In addition, a colonic ultrasound is performed, with transmural biopsy of an area of the mesentery adjacent to the transverse colon. Assign the appropriate CPT codes.

a. 45384, 45342

b. 45380, 45391

c. 45384, 45392

d. 45380, 45392

51. FNA and core biopsies are done on the same breast lesion, in the same session, on the same day, both performed with fluoroscopic guidance. What codes would be assigned?

a. 19100, 10007-59

b. 10007 ×2, 19100 ×2, 77002

c. 10007, 10008, 19100 ×2

d. 19100, 10007-59, 77002

52. The physician removes all of a right thyroid lobe without isthmusectomy. The physician exposes the thyroid via a transverse cervical incision in the skin line. The platysmas are divided and the strap muscles separated in the midline. The thyroid lobe to be excised is isolated and superior and inferior thyroid vessels serving that lobe are ligated. Parathyroid glands are preserved. The thyroid gland is divided in the midline of the isthmus over the anterior trachea. The thyroid lobe is resected. The platysmas and skin are closed. What code should be assigned?

a. 0GTH4ZZ

b. 0GTL0ZZ

c. 0GTH0ZZ

d. 0GTL4ZZ

53. The physician inserts a speculum into the vagina to view the cervix. The cervix was dilated. The endometrial lining of the uterus is scraped on all sides for therapeutic purposes. What code should be assigned?

a. 0UDB7ZX

b. 0UDB7ZZ

c. 0UDB8ZZ

d. 0U5B7ZZ

54. A 28-year-old male with a history of IV heroin dependence is admitted for pneumonia. A pulmonologist is consulted to assist with the patient's treatment and an antibiotic for Pneumocystis carinii pneumonia is administered. Low potassium is treated as well. The final diagnoses were coded as: B20, B59, E87.6, and F11.21. What is the discrepancy noted between the coding and the documentation?

a. The "history of" code reflects abuse rather than dependence

b. The correct code for the pneumonia should be J18.9

c. The assignment of B20 has no supportive documentation

d. The hypokalemia should not be coded as that is integral to the pneumonia

55. A patient is admitted post–back surgery with uncontrolled pain and leakage at the surgical site. Vitals show a fever of 101 with some tachycardia noted as well. The attending physician documents inflammation, with an infectious disease consultant documenting Staphylococcus aureus infection based on the lab culture. How should the coding professional resolve the discrepancy between the diagnoses documented?

a. Code the inflammation since that is what the attending physician documented

b. Code the infection since the consultant was specific regarding the type of infection

c. Code the infection based on the lab culture results

d. Query the attending physician to clarify the conflicting documentation

56. A coding professional has noted that a particular nurse practitioner is sending orders for outpatient testing with the diagnosis listed as "possible" or "rule out" without any accompanying signs or symptoms or abnormal findings suggestive of the possible diagnosis. What action should the coding professional take?

a. Nothing, code the diagnosis as if it exists since this is an outpatient

b. Use an observation code for the encounter

c. Ask for outpatient CDI specialist to educate the NP on the guidelines for outpatient coding which do not permit the use of "possible" or "rule out" diagnoses

d. Report the nurse practitioner to quality management and billing as this practice is causing billing delays and increase in the discharge not final billed metric

57. An operative report indicates the physician performed metatarsal surgery but all other information in the health record points to need for metacarpal surgery. What step should the coding professional take upon this discovery?

a. Code the metatarsal surgery as that is what is documented in the operative report

b. Code the metacarpal surgery since the op report was clearly an error

c. Query the physician to determine which body area the surgery involved

d. Suspend the chart and contact the coding supervisor as to which procedure to code

58. A patient is seen in the ED with leg edema and headache. The patient denies shortness of breath, chest pain, and chills. The patient has a chest x-ray, CT of the head, and lab work. A doppler scan was done to evaluate for a DVT, which was negative. Final diagnoses in the ED were swelling of leg, migraine, and chest pain. What is the discrepancy in this documentation?

a. Swelling is not documented outside the final diagnosis

b. There was no chest pain by patient report

c. Possible DVT should have been listed as final diagnosis

d. No testing was provided to assess migraine

Domain 3Provider Queries

59. The most challenging type of provider query is issued for:

a. Determining cause and effect

b. Establishing clinical validation

c. Resolving documentation conflict

d. Clarifying acuity or specificity

60. When creating a compliant query to clarify conflicting information from the surgeon and the attending physician, to whom should the query be directed?

a. Surgeon

b. Attending physician

c. Medical staff director

d. Medical records committee chairperson

61. When a compliant query remains unanswered, what is the next step for the coding professional?

a. Ask the HIM director to place the physician on suspension until the query is answered.

b. Alert the CEO that the query is outstanding, requesting a fine until the query is answered.

c. Refer to the internal escalation policy and follow the process outlined therein.

d. Report the physician to the peer review committee for disciplinary measures.

62. When creating compliant queries coding professionals should:

a. Query once without further follow up

b. Query multiple times until the desired diagnosis is provided

c. Query once with additional follow up if necessary

d. Query unlimited times until every discrepancy is resolved

63. Verbal queries:

a. Are not permissible in any circumstance

b. Must have a written response in the health record for coding purposes

c. Have different rules or criteria than written queries

d. Are not required to be documented as long as the healthcare provider responds verbally

64. A patient is admitted with a high temperature, lethargy, hypotension, tachycardia, oliguria, and elevated WBC. The patient also has more than 100,000 organisms of Escherichia coli per cc of urine. The attending physician documents “urosepsis.” What is the next step for the coding professional?

a. Code sepsis as the principal with a secondary diagnosis of urinary tract infection due to E. coli.

b. Code urinary tract infection with sepsis as a secondary diagnosis.

c. Query the physician to determine if the patient is being treated for sepsis, highlighting the clinical signs and symptoms.

d. Ask the physician whether the patient had septic shock so that this may be used as the principal diagnosis.

65. A patient has findings suggestive of chronic obstructive pulmonary disease (COPD) on chest x-ray. The attending physician mentions the x-ray finding in one progress note but no medication, treatment, or further evaluation is provided. The coding professional should:

a. Query the attending physician regarding the x-ray finding

b. Code the condition because the documentation reflects it

c. Question the radiologist regarding whether to code this condition

d. Use a code from abnormal findings to reflect the condition

66. If a patient undergoes an inpatient procedure and the final summary diagnosis is different from the diagnosis on the pathology report, the coding professional should:

a. Code only from the discharge diagnoses

b. Code the diagnosis reflected on the pathology report

c. Code the most severe symptom

d. Query the attending physician as to the final diagnosis

67. A 56-year-old woman is admitted to an acute-care facility from a skilled nursing facility. The patient has multiple sclerosis and hypertension. During the course of hospitalization, a decubitus ulcer is found and debrided at the bedside by a physician. There is no typed operative report and no pathology report. The coding professional should:

a. Use an excisional debridement code as these charts are rarely reviewed to verify the excisional debridement.

b. Code with a non-excisional debridement procedure code.

c. Query the healthcare provider who performed the procedure to determine if the debridement was excisional.

d. Eliminate the procedure code all together.

68. Patient presents with lower left quadrant abdominal pain with normal white cell count. X-ray showed sigmoid diverticulitis. Patient underwent a resection of sigmoid colon with anastomosis, developing a postoperative ileus after surgery. Nausea abated after resolution of the ileus. What is the query opportunity for this case?

a. Was the diverticulitis perforated?

b. Was the nausea postoperative?

c. Was there an associated abscess with the diverticulitis?

d. Was the postoperative ileus a complication?

69. A 64-year-old female is admitted to the hospital with nausea, vomiting, and edema. The patient has a history of diabetes and takes Metformin and Lisinopril as prescribed. Blood sugar and blood pressure are monitored while admitted. On the discharge summary, the final diagnoses of acute renal failure and diabetes are documented. What is the query opportunity for this record?

a. Is the acute renal failure linked to the diabetes?

b. Does the patient have hypertension?

c. Does the patient have chronic renal failure?

d. Is the diabetes out of control?

Domain 4Regulatory Compliance

70. Most hospitals require a medical record to be completed within:

a. 5 days

b. 10 days

c. 7 days

d. 30 days

71. To correct an entry in a paper-based medical record, the provider should:

a. Draw a single line through the error, add a note explaining the error, initial and date, add the correct information in chronological order

b. Draw a double line through the error, initial and date, add the reason for the correction

c. Draw a single line through the error, and add the correct information in chronological order

d. Draw several lines through the error, obliterate the documentation as much as possible, initial and date, add the correct information in chronological order

72. After a patient is discharged from the hospital, the medical record must be reviewed for:

a. Inclusion of all incident reports

b. Certain basic reports (for example, history and physical, discharge summary)

c. Voided prescription pads

d. Personal case notes from all mental health providers

73. A completed and signed operative report needs clarification of the size of the skin lesions that were removed. What process is used for that clarification?

a. Amendment

b. Addendum

c. Update

d. Revision

74. The information in the table represents all the CPT/HCPCS codes and associated information pertinent to a patient's encounter for care. From the information provided, how many APCs would impact this patient's total reimbursement?

a. 1

b. 5

c. 4

d. Unable to determine

75. What percentage will the facility be paid for procedure code 25500?

a. 50%

b. 75%

c. 0%

d. 100%

76. If another status T procedure were performed, how much would the facility receive for the second status T procedure?

a. 50%

b. 75%

c. 0%

d. 100%

77. Which of the following would be considered a hospital-acquired condition when the POA indicator is N?

a. DVT following a gastric procedure

b. Diabetes with neuropathy

c. Catheter-associated urinary tract infection

d. Foreign body in the thumb

78. A patient is admitted with abdominal pain and is found to have a perforation due to large intestine diverticulitis. A colectomy is performed. Following the procedure, there was fever, and elevated white count with peritonitis suspected. An x-ray shows a metallic object in the area of the previous surgery. A

return to the OR with reopening of the wound shows that a piece of a surgical blade had broken off and been left in the wound. Which of the following diagnoses is a hospital-acquired condition and will bear the POA indicator of N?

a. R50.9

b. K57.20

c. D72.829

d. T81.590A

79. When a POA indicator for a HAC that is the only CC/MCC condition on the record is listed as N, what happens to the reimbursement for that account?

a. Nothing, the reimbursement is not impacted as this is an internal quality monitoring code

b. The reimbursement increases, since the condition was not present on admission and more resources were needed to care for the patient

c. The reimbursement is not eligible for increase, since the condition was not present on admission and should have been prevented using best practices

d. The reimbursement is placed on hold until the physician clarifies why the patient did not have the condition on admission

80. Which of the following conditions is on the hospital-acquired condition list?

a. Diabetic foot ulcer

b. Stage 2 coccyx pressure ulcer

c. Calf ulcer, left leg, with muscle necrosis

d. Right elbow pressure ulcer, stage 4

81. Which of the following statements best describes how the retention of records should be determined?

a. Unless state law requires longer periods of time, specific patient health information should be retained for HIPAA-established minimum time periods.

b. AHIMA has published specific guidelines for retention of health information and these guidelines should be followed for records retention.

c. The Joint Commission has developed standards for retention of health information that must be followed to maintain accreditation and these standards should be adhered to with regard to time frames.

d. Health records should be retained according to their use in a healthcare entity and the state and federal laws do not apply to the retention of this health information.

82. The form that must be completed in order to permit a specific disclosure of protected health information is called a(n):

a. Authorization

b. Consent

c. Access

d. Redisclosure

83. The minimum necessary requirement would apply in which of the following scenarios?

a. When disclosure is to the secretary of HHS for investigation

b. When disclosure is required by law

c. When disclosure is for payment

d. When disclosure is made to the personal representative of the individual

84. What is the term used when protected health information has been disclosed inappropriately?

a. Exposure

b. Breach

c. Violation

d. Infraction

85. What is the term used for applying the HIPAA Privacy Rule over state rule(s) that are less strict?

a. Exception

b. Preemption

c. Exclusion

d. Predominance

86. A contract coding professional works for a hospital and, in the course of daily work, routinely accesses protected patient health information. Under HIPAA, what should be in place to permit access and protect patient privacy?

a. AHIMA credential

b. Business associate agreement

c. Vendor license

d. Patient authorization

87. Based on the AHIMA Code of Ethics, which of the following is not considered an ethical activity?

a. Coding audits

b. Using health records for educational purposes within the department

c. Reviewing the history and physical of a coworker when not part of work assignment

d. Completion of code assignment

88. After consulting with a physician, a coding supervisor has issued an internal policy stating that all bedside debridement be coded as excisional. Is this an ethical practice for a coding professional to follow? Why or why not?

a. Yes, physician guidance provided basis for the policy.

b. Yes, coding professionals must follow internal policies of the facilities where they are employed.

c. No, coding supervisors cannot make internal policies without approval of administration

d. No, internal policies cannot conflict with requirements provided in coding guidelines, conventions, and so on.

89. It is unethical for a coding professional to query:

a. Retrospectively

b. When the response will impact reimbursement

c. Based on information in a previous encounter

d. Multiple times on the same patient record

90. A patient came in for surgery and developed a post-operative infection. The patient had multiple comorbid conditions, which provided several CC and MCC conditions that were captured in coding. However, the coding professional left off the post-op infection code knowing it would impact the physician's quality of care score. Is this acceptable, ethical practice? Why or why not?

a. Yes; since it will not impact reimbursement, there is no issue.

b. Yes; coding professionals have discretion in which codes to assign on every case.

c. No; the coding of the post-op infection would have impacted reimbursement.

d. No; coding professionals cannot intentionally omit codes in order to affect quality scores.

91. Which of the following is an ethical way to handle an internal coding policy that conflicts with coding guidelines?

a. Report the concern through the organization's compliance hotline

b. Talk with fellow coding professionals to develop your own plan

c. Ignore the internal policy and follow coding guidelines

d. Wait six months to see if the policy gets changed and then report your concern

92. In addition to credentialed coding professionals, AHIMA's Standards of Ethical Coding apply to which of the following groups?

a. Noncredentialed coding professionals and students

b. Students and attorneys

c. Attorneys and auditors

d. Case managers and noncredentialed coding professionals

93. A diabetic patient was admitted for treatment of a pressure ulcer. The patient also has a history of diabetic neuropathy and retinopathy. The patient is blind and additional nursing care and extended time with the patient was required. Which conditions should be coded at discharge?

a. Pressure ulcer, history of neurologic condition, history of retinal condition, diabetes

b. Pressure ulcer, diabetic neuropathy and diabetic retinopathy, and blindness

c. Pressure ulcer, diabetic neuropathy

d. Pressure ulcer, diabetic retinopathy, and blindness

94. A patient admitted with shoulder pain has an inpatient discharge with principal diagnosis of either peptic ulcer or cholecystitis documented on the history and physical. Both are equally treated and well documented. A coding professional should:

a. Code based on the circumstances of admission and if both are equally treated, code either as principal

b. Use a code from the abnormal findings category

c. Code to the most severe symptom only

d. Code shoulder pain followed by both peptic ulcer, cholecystitis

95. During an admission for congestive heart failure (CHF), a chest x-ray was done to evaluate the severity of the CHF. An asymptomatic hernia was also found for which no treatment or evaluation was done. What is the reason that the hernia should not be coded?

a. The patient’s primary condition of interest is the CHF.

b. The hernia is an incidental finding and does not meet the UHDDS requirements.

c. The patient is asymptomatic.

d. The condition does not impact the reimbursement.

96. According to the UHDDS, section III, the definition of other diagnoses is all conditions that:

a. Coexist at the time of admission, that develop subsequently, or that affect the treatment received or the length of stay

b. Receive evaluation and are documented by the physician

c. Receive clinical evaluation, therapeutic treatment, further evaluation, extend the length of stay, increase nursing monitoring/care

d. Are considered to be essential by the physicians involved and are reflected in the record

97. Which patient-specific UHDDS items also have the potential to have an impact on MS-DRG assignment?

a. Race and residence

b. Residence and sex

c. Sex and discharge disposition

d. Discharge disposition and race