Total Question: 140 QAs

1. **Which of the following is NOT a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?**

   a. The Centers for Disease Control and Prevention Correct

   b. Employer-sponsored health plan

   c. Third-party billing agency

   d. Healthcare provider

A covered entity is any person or organization that provides treatment or payment in the healthcare field. These include healthcare providers, healthcare clearinghouses, business associates such as third-party billing companies or consulting agencies, and any individual or group health plan. Public health authorities, which include state and local health departments and the Centers for Disease Control and Prevention, are not considered covered entities.

2. **Which of the following is a risk adjustment model used by Medicare to predict health care costs and resource consumption of specific patient populations over time?**

   a. Risk adjustment factor (RAF)

   b. Diagnosis-related groups

   c. Outcome and Assessment Information Set

   d. Hierarchical condition category (HCC) coding Correct

Hierarchical condition category (HCC) coding is a risk adjustment model established in 2004 to predict health care costs and resource consumption of a specific patient population over time. Costs and consumption are calculated using a risk adjustment factor (RAF) score assigned to more than 9,500 ICD-10-CM codes associated to one of the 79 HCCs. The Outcome and Assessment Information Set is a quality measurement tool used to report and improve the quality of care delivered to Medicare and Medicaid patients in the home health setting. Diagnosis-related groups (DRGs) refer to a classification system that factors in the age, gender, diagnosis, and procedures performed during a patient's inpatient hospital stay to determine how much the hospital should be paid.

3. **Current Procedural Terminology (CPT) code 21805 is a column 2 code that has a National Correct Coding Initiative (NCCI) edit of 1 when paired with CPT code 21813. How would this be interpreted?**

a. The two codes are inclusive of each other and can never be billed together.

b. If being billed together, only report one unit of each.

c. The two codes are exclusive of each other and can never be billed together.

d. The two codes can be billed together with an appropriate modifier. Correct

Column one represents a correct code when listed next to column two. There are three edits listed with the combination of the two columns: 0, 1, and 9. Edit 0 means that the two codes should never, under any circumstance, be reported together. Edit 1 means that the procedures may be coded together with the use of a modifier. Edit 9 means that the edit does not apply.

4. **Based on the following documentation, what would the overall medical decision making (MDM) be?**
Number of diagnosis or management options: Minimal
Amount and complexity of data: Moderate
Level of risk: Moderate

a. Straightforward

b. Low complexity

c. Moderate complexity Correct

d. High complexity

Two of the highest three components should be used to determine the level of complexity. In this case, because the complexity of data and level of risk are moderate, the MDM is considered moderate. If the highest two components fall into different categories, the lower of the two would determine the score. This scoring method is the same for the 1995 and 1997 documentation guidelines.

5. **A patient was seen by her gynecologist to remove her intrauterine device. The removal was attempted but terminated due to excessive bleeding. How should the gynecologist report the encounter?**

a. 58301-53 Correct

b. 58301-52

c. 99212-25, 58301

d. 99212, 58301-59

Modifier 53 is used when a procedure has been discontinued, perhaps for the patient's own health. Keywords such as "terminated" and "aborted" are clear indicators of a discontinued procedure. Modifier 52 describes services that are rendered but reduced. Key phrases such as "part of procedure eliminated" are clear indicators of a reduced service. Additionally, there is not enough medical evidence to support a separately billed evaluation and management (E/M) code because the patient was only seen for the removal of an intrauterine device.

6. **A technician performs an ultrasound of a patient's thyroid at a privately owned family practice immediately following her annual health screening. The primary care physician determines that the images are normal and advises the patient to return in one year. How should the primary care physician report the ultrasound?**

a. 76536-26

b. 76536-TC

c. 76536 Correct

d. 76536-TC, 26

Modifier 26 is used to indicate that only the professional component of a service was rendered. In this scenario, modifier 26 would be appended if the primary care physician only interpreted the images of the ultrasound that was done off site. Modifier TC is used to indicate that only the technical component of a service was rendered. In this scenario, modifier TC would be appended if the family practice performed the ultrasound but then forwarded the images to another practice for interpretation. On the other hand, when a physician either owns or is employed by an entity that owns the equipment and interprets the results, only the procedure should be billed without any modifier.

7. **Which type of edit identifies the maximum number of units that may be reported for a CPT/HCPCS code that relates to an individual patient?**

a. Medically unlikely edits Correct

b. Add-on-code edits

c. Correspondence edits

d. Procedure-to-procedure coding edits

Add-on code edits are used when a service or procedure follows another primary CPT/HCPCS code. Procedure-to-procedure coding edits alert the provider of two procedures that are mutually exclusive to each other, meaning it would be unreasonable to have performed these two procedures or services during the same session.

8. **Which statement best describes a comorbidity?**

a. Two or more life-threatening illnesses occurring at the same time

b. Three or more minor injuries occurring at the same time

c. Three or more chronic illnesses occurring at the same time

d. Two or more unrelated diseases occurring at the same time Correct

A comorbidity occurs when a patient has two or more unrelated diseases or disorders occurring at the same time.

9. **A healthcare employee happens to meet a well-known actor during a lunch break. The employee takes a photo and shares it with his coworkers and social media. Which AHIMA Standard(s) of Ethical Coding has been violated?**

a. Protect privacy and confidentiality; protect personal health information; and use technology, data, and information resources in the way they are intended. Correct

b. Respect the dignity of every person, put the welfare of persons before self-interest.

c. Refuse to participate in unethical practices, privacy and confidentiality, respect the dignity of every person.

d. None, the act was unintentional.

Even though the act may have been unintentional, the following principles were violated:

- AHIMA principle 1: *Advocate, uphold, and defend the consumer's right to privacy and the doctrine of confidentiality in the use and disclosure of information.* The employee did not respect the patient's right to privacy by sharing the photo to social media and with other coworkers.
- AHIMA principle 3: *Preserve, protect, and secure personal health information in any form or medium and hold in the highest regard health information and other information of a confidential nature obtained in an official capacity, taking into account the applicable statutes and regulations*. The employee did not protect the patient's health information (e.g., where they are receiving treatment) by sharing the photo to social media.
- AHIMA principle 5: *Use technology, data, and information resources in the way they are intended to be used*. By sharing a picture to social media, the employee is using secure data outside the scope of their job.

10. **The smoking status of a patient should generally be found in which section of a medical record?**

a. Chief complaint

b. Plan

c. Examination

d. Social history Correct

Although documentation methods vary for each physician, the medical record will generally begin with the patient's chief complaint, which is the reason for the visit. Following that would be a patient's past, social, and family history, including whether or not the patient smokes or drinks, and other risk factors that he or she may be susceptible to. Next is a physical exam, usually focused on the patient's chief complaint. Once the physician has collected an intake and has examined the patient, a diagnosis and plan can be made as to how to address the patient's concerns, illness, and/or injury.

11. Which of the following is not a data element required by the Uniform Hospital Discharge Data Set (UHDDS)?

a. Location of residence

b. Provider name

c. Family history Correct

d. Total charges for services rendered

The UHDDS requires certain data elements to be abstracted from the patient record and reported for review. These include:

- Patient identification
  - Medical record number
  - Name
  - Date of birth
  - Gender
  - Location of residence
  - Race
  - Ethnicity
- Provider information
  - Provider name
  - Hospital identification number
- Clinical information surrounding the patient's admission and discharge
  - Principal and other diagnoses
  - Procedures
  - Where the patient was discharged to
  - Dates of service
- Financial information
  - Healthcare payer
- Total charges for services provided

12. A hospital director repeatedly refuses to accept residents due to a tight budget that limits training time for students. Which AHIMA Standard(s) of Ethical Coding has been violated?

a. Put the welfare of persons before self-interest.

b. Mentor colleagues to strengthen the professional workforce. Correct

c. Respect the worth of every person.

d. Represent the profession to the public in a positive manner.

The seventh principle includes providing "directed practice opportunities for students" (AHIMA Standard of Ethical Coding 7.1), which the hospital director is refusing to be a part of.

13. A physician performs a coronary artery bypass grafting using the left internal mammary artery to the right coronary, and a saphenous vein graft to the circumflex. Which CPT code(s) would be reported?

a. 33533, 33510

b. 33534

c. 33533, 33517 Correct

d. 35600, 33517

Arterial grafts are reported with CPT codes 33533–33536. Because only the internal mammary artery was used, the appropriate option would be the single arterial graft (CPT code 33533). Additionally, CPT code 33517 should be reported as an add-on code to report the obtaining and grafting of the saphenous vein graft.

14. A patient is seen in the emergency room with second- and third-degree burns on the right hand, and second-degree burns on the left hand after being exposed to paint thinner. After a comprehensive physical examination reveals that approximately 4% of the body is affected, the physician begins preventative treatment by debriding the nonviable tissue, cleansing the areas, and applying gauze. The patient is discharged and advised to return if experiencing symptoms that indicate an infection. What CPT and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes should be reported for this encounter?

a. 99283-25, 16020, T23.701A, T23.601A, T23.602A, T65.6X4A

b. 99283-25, 16020, T23.701A, T23.602A, T65.6X1A Correct

c. 99283, T23.701A, T23.601A, T23.602A, T65.6X4A

d. 16020, T23.701A, T23.602A, T65.6X1A

When billing for physician services in the emergency room, it is appropriate to also report a stand-alone E/M when the documentation supports its necessity in determining the need for appropriate treatment. Additionally, when multiple burns on the same anatomic location and laterality are being treated, identify and code only the highest degree of burn recorded in the assessment. In this scenario, only the third-degree burns on the right hand and second-degree burns on the left hand would be reported. Finally, like poisoning codes, toxic effect codes specify the intent (accidental, self-harm, assault, or undetermined). When the intent is not documented, ICD-10-CM guidelines stipulate that “accidental” should be used as the default, which in this scenario would be T65.6X1A (Toxic effect of paints and dyes, not elsewhere classified, accidental, initial encounter).

15. The UHDDS defines a principal diagnosis as _____.

a. the condition established after study to be the foremost reason for which the patient was admitted Correct

b. the condition, sign, and/or symptom with which the patient presented and was admitted

c. the admitting physician's initial diagnosis of the patient

d. the condition that has the highest rate of mortality for the patient upon admission

A principal diagnosis is the condition or disease that, after study, is determined to be the foremost reason for which the patient was admitted into the hospital or other long-term-care facility. A principal diagnosis is a required element within the UHDDS because it has a significant contribution to quality assurance and monitoring, risk-adjusted outcome studies, and reimbursement policies.

16. A 62-year-old patient is admitted into observational care after a comprehensive history and exam confirms tuberculosis. He has a medical history of being human immunodeficiency virus (HIV)-positive. How should this be reported?

a. 99236, A15.9, B20

b. 99236, B20, A15.9 Correct

c. 99235, B20, A15.9

d. 99235, A15.9, B20

All observation codes (99234–99236) include a comprehensive history and exam. The MDM of this condition is considered high (the number of diagnoses and risk of complication), making the CPT code 99236, as opposed to CPT code 99235. Even though tuberculosis is the reason for the admission, ICD-10-CM guidelines stipulate that a confirmed HIV diagnosis takes precedence in sequencing when the reason for admission is HIV-related. HIV-related conditions are identified in the ICD-10-CM manual with a black "HIV" symbol.

17. **Hospital-acquired conditions (HACs) may appear up to _____ hours after a person is discharged from an inpatient hospital or facility stay.**

a. 72 hours Correct

b. 24 hours

c. 48 hours

d. 120 hours

Hospital-acquired conditions (HACs) may appear up to 72 hours after a patient has been discharged or within 30 days of an operation. Patients cannot be billed for care related to an HAC, and most health insurance plans will not pay for their treatment.

18. **Which of the following ICD-10-CM codes are exempt from present on admission (POA) indicators?**

a. I69.120 Correct

b. E05.21

c. K92.2

d. O12.03

Conditions arising as a sequela of another disease, newborns affected by maternal illnesses and/or injuries, and congenital malformations are all exempt from POA indicators because they may occur some time after a patient's admission but are usually not preventable by hospital staff and physicians.

19. A patient is admitted to the hospital due to uncontrolled seizures, but diagnostic images later determine that the cause is a malignant neoplasm within the brain tissue. How should the discharge be reported if 30 minutes were spent counseling and coordinating the care of the patient?

a. 99217, C71.9, G40.909

b. 99217, R56.9, C71.9

c. 99238, G40.909, C71.9

d. 99238, C71.9 Correct

The appropriate CPT codes for a hospital discharge following an inpatient admission are 99238–99239. CPT code 99217 describes discharge services from outpatient hospital observation status. The principal diagnosis code should always be the underlying illness and/or disease that necessitated the treatment. In this scenario, the brain malignancy is the underlying reason for the seizures and should therefore be reported as the primary code. Because seizures are a common symptom of a brain malignancy, R56.9 (Unspecified convulsions) should not be reported.

20. Which admission indicator was created so that chronic and comorbid conditions could be differentiated from those that developed during a patient's hospital stay?

a. HCC

b. DRG

c. IPPS

d. POA Correct

Present-on-admission (POA) indicators were created so that hospitals could differentiate chronic and comorbid conditions from those that developed during an inpatient admission. These indicators were created in lieu of the implementation of HACs, which affected payment and quality ratings.

21. As of April 1, 2020, CPT code 69990 (Microsurgical techniques, requiring use of operating microscope) may be reported in conjunction with CPT code 61304 (Craniectomy or craniotomy, exploratory; supratentorial). This is an example of which type of edit?

a. Medically unlikely edits

b. Add-on code edits Correct

c. Correspondence edits

d. Procedure-to-procedure coding edits

The first step is to locate CPT code 69990 in the CPT manual. The description of the code indicates that the procedure is an add-on code; therefore, the type of edit that would encompass it is an add-on code edit. Medically unlikely edits are used to identify the maximum number of units that may be reported for a CPT/HCPCS code, whereas procedure-to-procedure coding edits are applied when two procedures are mutually exclusive to each other.

22. Coded clinical data are used for all of the following, EXCEPT:

a. Predict potential health diseases Correct

b. Identify fraudulent habits

c. Track public health and risks

d. Measure the quality, safety, and efficacy of care

Coded clinical data are used to

- Set health policy
- Identify fraudulent habits within the healthcare system
- Monitor utilization of resources and design the way it is distributed
- Perform research, studies, and trials
- Design payment systems
- Provide data regarding the costs and quality of treatment options to the public
- Follow public health
- Measure the quality, safety, and efficacy of the care being given
- Assist in improving clinical performance

23. An 88-year-old male patient is seen in the emergency room with complaints of pain and bleeding on his lower back. The patient reports little to no physical activity throughout the day because he gets tired easily. A physical exam reveals a deep tissue ulcer on the coccyx. The patient is admitted and given antibiotics intravenously. Should the physician be queried?

a. No, report ICD-10-CM code L98.498.

b. No, report ICD-10-CM code K27.4.

c. Yes, the physician should be queried on whether the coccyx should be coded to the buttock.

d. Yes, the physician should be queried if the ulcer is due to constant pressure. Correct

In order to select the most specific and accurate diagnosis, further specification is needed to determine the type of ulcer that the patient has. Because the physician documented "little to no physical activity" and bedsores are the leading cause of ulcers in elderly people, a query asking the physician if the ulcer is due to constant pressure is nonleading and clinically relevant.

24. All of the following are common comorbidities to hypertension EXCEPT which of the following?

a. Cataracts Correct

b. Congestive heart failure

c. Chronic kidney disease

d. Dyslipidemia

Hypertension in a condition in which the body cannot control its high blood pressure. This damages the artery walls, leading to conditions such as heart disease, heart failure, kidney disease, and dyslipidemia, all of which rely on consistent blood flow.

25. **Which of the following is NOT considered a global surgical package postoperative period under the Medicare Physician Fee Schedule Look-Up Tool?**

- a. Zero days
- b. Ten days
- c. Thirty days **Correct**
- d. Ninety days

CMS has created three types of global surgical packages built on the duration of the postoperative period. These are a zero-day post-operative period for endoscopies and some minor procedures, a 10-day postoperative period for other minor procedures, and a 90-day postoperative period for major procedures.

26. **Which law prohibits physicians and entities from offering expensive hotel stays in return for patient referrals?**

- a. The Physician Self-Referral Law
- b. The Stark Law
- c. The False Claims Act
- d. The Anti-Kickback Statute **Correct**

Because the Anti-Kickback Statute prohibits physicians and entities from obtaining healthcare business by means of incentives or money, it reduces corruption; overutilization of services, durable medical equipment, or prescriptions; and unnecessary costs to CMS. The Stark Law, otherwise known as the Physician Self-Referral Law, prohibits physicians from referring certain designated health services that are payable by Medicare or Medicaid to which they, or their immediate family, have a financial relationship with. The False Claims Act prohibits any person(s) or entity from knowingly reporting a false or fraudulent claim to CMS to obtain payment.

27. Which one of the following forms is sent to the provider by an insurance plan to identify the allowable amount of a claim?

a. Remittance advice Correct

b. Explanation of benefits

c. Summary of reimbursement

d. Statement of receivables

The remittance advice and explanation of benefits forms identify the allowable amount of a claim, the beneficiary responsibility, and the reasons for any charges that were denied or not paid. The difference between the two forms is that a remittance advice form is sent to the medical entity where the services were rendered, whereas an explanation of benefits form is sent directly to the beneficiary.

28. How often is the NCCI policy manual updated?

a. Annually

b. Biannually

c. Quarterly Correct

d. Semiannually

The Centers for Medicare & Medicaid Services (CMS) update the NCCI policy manual every quarter; it can be found by visiting the following website:

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd

29. A patient requires additional surgery within the 90-day postoperative period of a knee replacement to treat an infection that has developed at the incision site. Which modifier should be appended on the procedure?

a. 24

b. 78 Correct

c. 58

d. 52

Modifier 78 is for an unexpected return to the operating room by the same physician during the postoperative period to address a complication that has developed as a result from the initial procedure. It should be noted that the billing of a new procedure with the use of modifier 78 does not extend the original postoperative period. Modifier 24 is for use on unrelated E/M services rendered by the same physician during the postoperative period. Modifier 58 is used for a procedure that is planned to take place during the 0-, 10-, or 90-day postoperative period of the first procedure.

30. A 61-year-old established patient with a history of type 2 diabetes presents to his primary care physician with complaints of changes in vision and bilateral eye pain. A comprehensive eye examination reveals that the patient has cataracts. Should the physician be queried?

a. No, report ICD-10-CM code E11.36. Correct

b. No, report ICD-10-CM code H26.9.

c. Yes, the physician should be queried if the cataracts are due to the type 2 diabetes.

d. Yes, the physician should be queried to specify what type of cataracts the patient has.

As a result of a chemical imbalance and accumulation of excess sorbitol in the lens, patients who have diabetes are at a higher risk of developing eye complications, such as cataracts. Because of this, a causal relationship is presumed between the two conditions, as seen in the verbiage of E11.36 (Type 2 diabetes mellitus with diabetic cataract), and the physician does not need to be queried.