RHIA Practice Questions

1. In ICD-10-CM, which rate is used to describe "not included here"?

a. See
b. Excludes 1
c. Code also
d. Excludes 2

2. In assessing the length of time that a facility is required to maintain its records, which of the following should be the facility's first concern?

a. The most stringent state or federal regulation
b. The total number of records
c. The medium in which records will be retained
d. The cost associated with records retention

3. According to the Medicare Conditions of Participation, hospital records are required to have a _____-year retention period.

a. 10
b. 5
c. 3
d. 15

4. Which of the following is used to create and maintain standards for laboratory tests and results?

a. SNOWMED CT
b. MEDCIN
c. LOINC
d. NDC

5. Which type of data is entered into registries and databases and allows users to be able to conduct trend analyses, review and establish benchmarks, and execute long-term planning?

a. Secondary
b. Primary
c. Aggregate
d. Index

6. Pathological data characterizing site, stage of neoplasm, and type of treatment would be reported in which of the following registries?

a. Diabetes
b. Immunization
c. Cancer
d. Trauma

7. The _____ organization is responsible for the creation of standards to address health-care transactions between health partners.

a. ANSI
b. ASTM
c. OASIS
d. HL7

8. When a task requires data for detailed root cause analysis, which type of data is preferred?

a. Structured data
b. Unstructured data
c. Queries
d. Relational databases

9. A procedure involving the cutting out of solid matter is considered what root operation?

a. Extirpation
b. Release
c. Detachment
d. Destruction

10. The root operation destruction means _____.

a. Freeing a body part from an abnormal physical contract by cutting or force
b. Physical eradication of all or a portion of a body part by the direct use of energy, force, or destructive agent
c. Taking or cutting out solid matter from body part
d. Taking or letting out fluids and/or gases from a body part

11. The root operation release means _____.

a. Cutting off without replacement
b. Freeing a body part from an abnormal physical contract by cutting or force
c. Cutting off with replacement
d. Breaking solid matter into pieces

12. When destroying data in a paper format, which method is the most appropriate method?

a. Shredding
b. Encrypting
c. Burning
d. Placing information in a locked drawer away from patient access

13. If unforeseen scenarios occur such as power outages, fires, natural disasters, etc., what should facilities have in place to ensure that there are procedures to handle emergency response situations with respect to continuing operations?

a. Disaster recovery plan
b. Business continuity/contingency plan
c. Training
d. Risk and audit controls

14. Which act addressed issues with respect to the portability of health insurance after leaving employment?

a. Affordable Care Act
b. Omnibus Budget Reconciliation Act
c. Health Insurance Portability and Accountability Act
d. Health Information Technology for Economic and Clinical Health (HITECH) Act

15. All of the following are data security functions that require data governance EXCEPT _____.

a. Identifying and resolving quality issues
b. Establishing a risk-management program
c. Implementing security awareness for employees
d. Facility data security planning

16. The process of defining levels of data quality by establishing parameters to ensure that the data meet business needs is _____.

a. Data security management
b. Terminology and classification management
c. Content management
d. Data quality management

17. Qualitative analysis performed after a patient has been discharged and reviewed retrospectively is _____.

a. Open-record review
b. Closed-record review
c. Discharged-patient review
d. Retro-quality review

18. What is the standards development organization that develops messaging, data content, and document standards to improve the exchange of clinical information?

a. IEEE
b. HL7
c. ADA
d. ISO

19. Within entity relationship modeling, what is the process by which entity relationship diagrams are converted into tables?

a. Schema mapping
b. Cardinality
c. Attributes
d. Normalization

20. A discrepancy is found in which a patient's birthdate is listed as 07/12/2008 on one record and as 09/12/2008 on another record. Which characteristic of data quality does this discrepancy represent?

a. Precision
b. Granularity
c. Consistency
d. Timeliness

21. A pediatrician would report hydrocephalus in a newborn to which registry?

a. Diabetes
b. Immunization
c. Birth defect
d. Trauma

22. Creating and revising information within a patient's progress note is whose responsibility?

a. Administrator
b. Health information management (HIM) professional
c. Registration staff
d. Provider

23. What is the legal document that designates another person to act on behalf of the patient in the event that the patient becomes disabled and/or incapacitated?

a. Living will
b. Durable power of attorney
c. Informed consent
d. Health Insurance Portability and Accountability Act of 1996 (HIPAA) form

24. Where are guidelines for the retention and destruction of health-care information found?

a. Accreditation standards
b. HIPAA
c. HITECH Act
d. Articles of participation

25. The focus of a certified coder is geared toward which of the following?

a. Ensure maximum reimbursement
b. Avoid coding claim edits
c. Avoid write-offs due to claim rejections
d. Ensure that each claim is coded with accuracy

26. Data found in patient/disease registries are considered to be which of the following?

a. Financial data
b. Clinical data
c. Demographic data
d. Accreditation data

27. _____ typically occurs when there is a transfer of data between systems. This is most often seen when companies are implementing new systems.

a. Data dictionary analysis
b. Data mining
c. Data migration
d. Data analysis

28. Procedures that include the altering of a route of passage of contents of a tubular body part is which of the following root operations?

a. Dilation
b. Fragmentation
c. Occlusion
d. Bypass

29. What is the overall goal of documenting and maintaining medical records?

a. To ensure that clean claims are sent in order to provide maximum reimbursement
b. To provide data to avoid malpractice issues
c. To aid in the continuity of care
d. To adhere to guidelines set forth by the American Health Information Management Association (AHIMA)

30. Records arranged in strict chronological order are considered to be which of the following?

a. Source-oriented health records
b. Problem-oriented medical records
c. Integrated health records
d. Ascending health records

31. Which of the following is considered clinical data?

a. Medical history
b. Physical exam
c. Diagnostic orders
d. A patient's hospital unique identifier

32. Who is responsible for setting the strategic direction of the hospital?

a. Chief executive officer
b. Board of directors
c. Chief nursing officer
d. Chief information officer

33. Which law is considered "unwritten" law originating from previous court decisions?

a. Common law
b. Constitutional law
c. Administrative law
d. Statutory law

34. Who does ownership of health records ultimately belong to?

a. The patient
b. U.S. Department of Health and Human Services (HHS)
c. Office for Civil Rights (OCR)
d. The organization that created and maintained the physical record

Answer Key and Explanations

1. D: Excludes 2 means “not included here.” This means that the condition excluded is not a part of the condition represented by the code; however, a patient may have both conditions at the same time. The term see indicates that the coder must seek or refer to an alternate term. Excludes 1 means “not coded here.” This means that the excluded condition should never be coded at the same time as the condition represented by the code. The term code also means that two codes may be used to fully describe the condition.

2. A: Although the total number of records, how and where the records will be obtained (medium), and the cost associated with record retention all play a part in the decision-making process, the first and primary concern of record retention is to review state and federal laws and regulations to ensure that records are maintained for the longest time required.

3. B: According to 42 CFR § 482.24, the hospital must maintain a medical record for each inpatient and outpatient encounter. Medical records must be retained in their original or legally reproduced form for a period of at least 5 years.

4. C: SNOWMED CT is a standardized, multilingual vocabulary of clinical terminology used throughout the health-care providers for the exchange of clinical health information electronically. MEDCIN is a clinical terminology with a strong focus on the facilitation of documentation by providing choices that are in line with providers clinical though processes. The National Drug Code (NDC) is the universal product identifier for human drugs.

5. A: Primary data are data that were documented by the health-care professionals who provided care, treatment, and services for the patient. Aggregate data are data on groups of people that do not identity the patients individually. An index is a report from a database that allows for the location of diagnoses, procedures, physicians, etc. to be found within the database.

6. C: Based on the fact that the question mentions neoplasms as well as stage and site, cancer is the correct answer choice. Diabetes, immunization, and trauma registries do not address the criteria, nor do they serve the purpose of diagnosing and treating cancer.

7. A: The American National Standards Institute (ANSI) is responsible for creating standards to address health-care transactions between health partners. The American Society for Testing and Material (ASTM) is responsible for creating standards with regard to the EHR. Health Level-7 (HL7) is responsible for creating standards in regard to the content of the EHR. The Outcome and Assessment Information Set (OASIS) is a data set that is associated with the home health prospective payment system.

8. B: Unstructured data provide the user the opportunity to review detailed data in its granularity. This cannot be done with structured data. Relational databases are the digital form of organized tables, records, and columns. Queries are used for the questioning of databases to produce desired results.

9. A: Root operation release means “freeing a body part from an abnormal physical contract by cutting or force.” Detachment means “cutting off all or part of the upper or lower extremities." Destruction means “physical eradication of all or a portion of a body part by the direct use of energy, force, or a destructive agent.”

10. B: The freeing of a body part from an abnormal physical contract by cutting or force corresponding root operation is called release. The taking or cutting out of solid matter from a body part corresponding root operation is called extirpation. The taking or letting out of fluids and/or gases from a body part corresponding root operation is called drainage.

11. B: The cutting off without replacement corresponding root operation is excision. Cutting off with replacement has no root operation associated. The breaking solid matter into pieces corresponding root operation is fragmentation.

12. A: Encrypting is an appropriate format for electronic format. Burning is not a feasible way of destroying. Although burning could take place, it is not the most appropriate method. Placing information in a locked drawer away from patient access is not destroying data.

13. B: Disaster recovery plans usually involve getting systems up and running after a disaster takes place. Examples include information technology (IT) infrastructure and accessing files offsite. Training is conducted with employees on the business continuity plan itself. Risk and audit controls are not relevant to natural disaster situations; these processes are implemented and enforced regarding normal business practices.

14. C: The Affordable Care Act required most United States citizens to have health-care coverage. The Omnibus Budget Reconciliation Act mandated the development of a prospective system for hospital-based outpatient services to Medicare beneficiaries. The HITECH Act focused on adoption of IT in health care through economic incentives.

15. A: Identifying and resolving quality issues are functions of data governance for information intelligence. Establishing a risk management program, implementing security awareness for employees, and facility data security planning are all elements of data governance in relation to data quality management.

16. D: Data security management creates policies and procedures to protect security from a compliance and regulatory standpoint. Terminology and classification management involves health-care technologies, data sets, and classification systems that a facility may use. Content management includes managing structured and unstructured data.

17. B: Open-record review is the review of records while the patient is currently within the facility or while the patient is receiving active treatment. Discharged patient and retro-quality reviews are not terms used within HIM.

18. B: IEEE is an organization that developed the standards for abbreviated test language. ADA are those standards set for those with disabilities. ISO standards are international standards composed of various national standards organizations.

19. B: Schema mapping is the process by which entity relationship diagrams are converted into tables. Attributes are the characteristics within an entity relationship diagram. Normalization is the process that eliminates errors associated with updates, deletions etc., of data within a database.

20. C: The consistency principle is the need for data to be consistent and reliable. Precision speaks to how close to an actual numerical value a measurement is. Granularity consists of the individual data components that cannot be divided further. Timeliness is the concept around receiving information when needed in a timely manner.

21. C: Hydrocephalus in a newborn relates to a defect at birth. The other registries are not applicable in this case.

22. D: Progress notes should be completed by the provider. Administrators, HIM professionals, and registration staff should not have access to amend, delete, or alter a progress note in any way.

23. B: Although all of the answer choices are considered legal documents, only the durable power of attorney is able to act on behalf of the patient in the described circumstances.

24. A: Accreditation standards dictate those standards and rules in regard to the retention and destruction of health-care information.

25. D: Although the actions of coders may ultimately maximize reimbursement, result in decreased write-offs and claim edit hold-ups by issuing clean claims. The overall focus of certified coders is to ensure that each claim is coded with accuracy and precision.

26. B: Financial data includes information about the patient's insurance, occupation, and employer. Demographic data include data involving the patient's address, name, date of birth, etc. Accreditation data are not related to the patient but to the standards carried out by the organization. Patient/disease registries are considered clinical data.

27. C: Data mining includes finding patterns and trends within large data sets. Data analysis is modeling data with the intent of meeting a goal or to support decision making within an organization. A data dictionary analysis is a review of the standards and meanings of data within a system.

28. D: Dilation is the enlargement of a tubular body part or orifice. Fragmentation is a procedure that involves breaking solid matter into pieces. Occlusion is completely closing an orifice or the lumen of a tubular body part.

29. C: Although creating proper documentation and maintaining records can at times aid in the receipt of reimbursement, help to avoid malpractice issues, and help in following guidelines, the overall goal is to aid in the continuity of care for all patients.

30. C: Source-oriented records are recognized according to the source. Problem-oriented medical records involve the problem list being the focal point because it is the table of contents for the records. Ascending health records are not a part of HIM terminology.

31. D: Patient identifiers are considered to be part of the financial data category, whereas all of the other answer choices are considered to be clinical data.

32. B: The board of directors consists of elected members who work together with the chief executive officer to develop a hospital's strategic direction. The chief nursing officer and chief information officer serve as administrative staff in support of the chief executive officer.

33. A: Constitutional law is written law and is considered the highest law of the land and takes precedence over state and local laws. Administrative law is written law that controls a government agency or administrative operations. Statutory law is written law established by federal and state legislatures.

34. D: Although the patient has rights to their health records, the record itself actually belongs to the organization that created and maintained the physical record.