

Chapter 1: Introduction to Coding

TRUE/FALSE

1. Computer skills are not necessary for coders to have if the record is not electronic.

ANS: T

Computer skills are necessary for coders who have electronic health records and/or electronic claims processing.

PTS: 1

2. Membership in a professional association is not beneficial since continuing education and bulletins are available via the Internet.

ANS: F

Membership in a professional association is beneficial for coding publications, networking, education, and certification.

PTS: 1

3. Fraud is defined as knowingly or willfully executing or attempting to execute a scheme to defraud a health care benefit program.

ANS: T

Fraud is defined as knowingly or willfully executing or attempting to execute a scheme to defraud a health care benefit program.

PTS: 1

4. Overcharging for services or equipment is considered fraud.

ANS: F

Overcharging for services or equipment is considered abuse.

PTS: 1

5. If physician X refers a patient to a pharmacy for prescription filling and receives compensation for this referral, this would be classified as insurance abuse.

ANS: F

If physician X refers a patient to a pharmacy for prescription filling and receives compensation for this referral, this would be classified as insurance fraud.

PTS: 1

6. With the HIPAA Act, penalties include a \$10,000 fine per claim form when an individual knowingly or unknowingly misrepresents information submitted on the claim form to increase payment.

ANS: F

With the HIPAA Act, penalties include a \$10,000 fine per claim form when an individual knowingly misrepresents information submitted on the claim form to increase payment.

PTS: 1

7. It is a coder's responsibility to code only what is documented in the medical record and to ask for clarification if necessary after assigning codes.

ANS: F

It is a coder's responsibility to code only what is documented in the medical record and to ask for clarification if necessary before assigning codes.

PTS: 1

8. An internal audit system is required as part of a compliance plan.

ANS: T

An internal audit system is required as part of a compliance plan.

PTS: 1

9. *CPT Assistant* is a monthly newsletter published by the American Hospital Association.

ANS: F

CPT Assistant is a monthly newsletter published by the American Medical Association.

PTS: 1

10. Level I HCPCS codes are alphanumeric national codes supplied by the federal government.

ANS: F

Level II HCPCS codes are alphanumeric national codes supplied by the federal government.

PTS: 1

MULTIPLE CHOICE

1. Which volume of ICD-9-CM is used to report inpatient procedures?
- a. Volume 1
 - b. Volume 2
 - c. Volume 3
 - d. Volume 4

ANS: C

	Feedback
A	Incorrect. This volume is tabular.
B	Incorrect. This is the disease index.
C	Correct
D	Incorrect. There is no Volume 4

PTS: 1

2. This is the condition that is indicated in the medical record as the reason the patient sought care in an outpatient setting.
- a. Principal diagnosis
 - b. Major diagnosis
 - c. Primary diagnosis
 - d. Secondary diagnosis

ANS: C

	Feedback
A	Incorrect. This applies to hospitals and not outpatient settings.
B	Incorrect. This is not a diagnosis category.
C	Correct.
D	Incorrect. This is not the condition for which the patient sought care.

PTS: 1

3. ICD-9-CM serves three major functions for insurance purposes. Of the choices below, which is NOT a function of ICD-9-CM?
- It justifies procedures and services by the physician.
 - To determine if the costs submitted are reasonable for services provided.
 - It assists in establishing medical necessity for services performed.
 - It serves as an indicator in measuring quality of health care delivered by the provider.

ANS: B

	Feedback
A	Incorrect. This is a function.
B	Correct.
C	Incorrect. This is a function.
D	Incorrect. This is a function.

PTS: 1

4. All health care facilities utilize ICD-9-CM. Which volume of ICD-9 is only used by hospitals?
- Volume 1
 - Volume 2
 - Volume 3
 - Volume 4

ANS: C

	Feedback
A	Incorrect. This is the tabular volume and used by all.
B	Incorrect. This is the index and used by all.
C	Correct.
D	Incorrect. There is no Volume 4.

PTS: 1

5. ICD-9-CM was created by the ____.
- AMA
 - AHA
 - WHO
 - CMS

ANS: C

	Feedback
A	Incorrect. This is the American Medical Association. The World Health Organization created ICD-9-CM.
B	Incorrect. This is the American Hospital Association. The World Health Organization created ICD-9-CM.
C	Correct.

D	Incorrect. CMS developed HCPCS. The World Health Organization created ICD-9-CM.
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PTS: 1

6. Which type of coding system is used to report procedures performed in physician offices and outpatient departments?
- a. CPT-4
 - b. ICD-10-PCS
 - c. ICD-9-CM
 - d. None of the above

ANS: A

	Feedback
A	Correct.
B	Incorrect. This has not been implemented yet.
C	Incorrect. This is for diagnostic coding
D	Incorrect.

PTS: 1

7. This credential is referred to as an entry-level certification.
- a. CCS-P
 - b. CPC
 - c. CCS
 - d. CPC-H

ANS: B

	Feedback
A	Incorrect. This credential is for experienced coders.
B	Correct.
C	Incorrect. This credential is for experienced coders.
D	Incorrect. This credential is for experienced coders.

PTS: 1

8. Computer systems, encounter forms, charge tickets, and code books should be updated ____.
- a. periodically
 - b. biannually
 - c. quarterly
 - d. annually

ANS: D

	Feedback
A	Incorrect. This is not often enough.
B	Incorrect. This is too often.
C	Incorrect. This is too often.
D	Correct.

PTS: 1

9. ICD-9-CM requires assignment of the most ____ code to represent the problem being treated by the provider.
- a. appropriate
 - b. often used
 - c. specific
 - d. logical

ANS: C

	Feedback
A	Incorrect. The term <i>appropriate</i> is subjective depending on interpretation of rules.
B	Incorrect. The most often used codes does not mean it is the best code.
C	Correct.
D	Incorrect. The term <i>logical</i> is subjective based on coder knowledge.

PTS: 1

COMPLETION

1. _____ is a process required to maintain a credential and certification status by achieving continuing education requirements mandated by the association.

ANS: Recertification

PTS: 1

2. There are four national organizations that offer coding credentialing: American Academy of Professional Coders (AAPC), The Board of Advanced Medical Coding (BAMC), The Association of Health Care Auditors and Educators (AHCAE), and The _____.

ANS:
American Health Information Management Association
AHIMA

PTS: 1

3. _____ is defined as the translation of diagnoses, procedures, services, and supplies into numeric and/or alphanumeric components for reporting and reimbursement.

ANS: Coding

PTS: 1

4. Diagnosis codes must be correctly linked to the _____ codes on the claim form to demonstrate medical necessity.

ANS: ICD-9-CM

PTS: 1

5. In addition to HIPAA, OBRA penalizes the health care provider for errors made by coders in the amount of \$2,000 per violation, an assessment of damages of up to twice the amount of the error, and exclusion from _____ and Medicaid for up to 5 years.

ANS: Medicare

PTS: 1

6. HITECH was created to govern development of _____.

ANS:

National Electronic Health Records
NEHR

PTS: 1

7. _____ and Management is a section of the CPT manual requiring practitioners to make a decision as to the level of service for offices, hospitals, nursing homes, etc.

ANS: Evaluation

PTS: 1

8. A _____ is a two-character code added to the main CPT code describing circumstances specific to that procedure. These are located in Appendix A of CPT.

ANS: modifier

PTS: 1