Chapter 2 Exam

True/False Questions

1. The ICD-10-CM has updated codes that allow up to seven alphanumeric digits, whereas ICD-9-CM only used up to five digits.

Answer: T

2. The Current Procedural Terminology (CPT®) is a systematic listing for coding the procedures or services performed by a physician. Within this text the word "physician" is used generically to apply to any provider of services including hospitals.

Answer: F

3. A procedure code is a five-digit numerical code used to designate medical services according to standardized, industry-accepted methods, usually reflected in the CPT® manual.

Answer: T

4. Modifier codes are three-digit numerical codes or alpha-numeric codes attached to a CPT® code to indicate special circumstances that affect reimbursement for that particular service.

Answer: F

5. *Physicians' Desk Reference* (PDR) is a manual that provides information on prescription drugs, including usage, dosage, appearance, prescription status, makeup, and other factors.

Answer: T

6. Claims examiners use the Product Information Section of the PDR the least.

Answer: F

7. As a rule, the medical dictionary should be used instead of the *Merck Manual* for verifying a diagnosis or affected body area or checking definitions and the spelling of terms.

Answer: F

8. The *Red Book* is primarily used by pharmacists for drug information and wholesale pricing,

and the *Blue Book* is used normally by providers and patients to compare pricing for their geographical area.

Answer: T

9. There are two types of forms most commonly used for billing claims: the CMS-1500 and the UB-04.

Answer: T

10. All injury claims (i.e., injury diagnosis) must have an injury, accident, or workers' compensation date.

Answer: T

Multiple Choice Questions

1. Which of the following describes one of the four sections of Volume II of the ICD-9-CM?
   a. An alphabetical index of diseases and injuries
   b. A table of weights and measures
   c. An alphabetical index of other codes
   d. A listing of factors affecting the health status of groups during hurricanes
2. Which of the following is NOT a body section contained in Volume III of the ICD-9-CM?
   a. Nervous System
   b. Endocrine System
   c. Hemic and Lymphatic System
   d. Digital System

3.How are values assigned using the payment methodology called the *Relative Value Scale* (RVS)?

a. By geographic region

b. By population density

c. By weather patterns

d. By rate of malpractice cases

4. Where can a medical practitioner find the location of the code for transplantation of the liver?

a. Transplantation and Spleen

b. Liver and Allotransplantation

c. Transplantation and Allotransplantation

d. Allotransplantation and Gallbladder

5. What is the standard means of interfacing HCPCS codes with English language?

a. If you have a code number, but need the English language equivalent, look in the front section of the HCPCS. HCPCS codes have a letter, then several numbers.

b. The codes are listed by the number, then the letters within that number.

c. Codes are assigned within groups. Therefore the items within a group will be found in several associated coding sections.

d. If you have an English language equivalent and need to look up the HCPCS code, look up the item in the dictionary found at the back of the manual.

6. What color is the Product Name Index in the PDR?

a. Green

b. White

c. Pink

d. Blue

7. How are pharmaceuticals described in the Product Information Section of the PDR?

a. Size and shape

b. Full-color reproductions

c. Time-lapse abilities

d. Indications and usage

8. How do medical dictionaries typically assist the examiner?

a. Identifying famous malpractice lawsuits

b. Identifying diagnoses, their symptoms, prognoses, and common treatment protocols

c. Assisting the medical biller in rewriting the physician's notes

d. Determining whether or not the diagnosis or services are authentic

9. The *Merck Manual* is relied on within the medical profession to assist in identifying which of the following?

a. Symptomatology

b. Date of birth

c. Diet and exercise protocols

d. ER protocols

10. What kinds of listings do the *Red* and *Blue Books* contain?

a. Patriotic paraphernalia

b. Wholesale prices of drugs

c. The addresses and telephone numbers of local pharmacies

d. Exchange rates between countries and the U.S.

11. What information would NOT be recorded on the CMS-1500 claim form?

a. Insured's ID number

b. Insured's name

c. Insured's weight

d. Insured's Policy Group or FECA number

12. What information is required in the Secondary Insurance blocks of the CMS-1500 form?

a. Other insured's automobile title

b. Other insured's date of birth

c. Other insured's number of children

d. Other insured's shoe size

13. When should the insured sign the CMS-1500 blocks?

a. When acknowledging that the patient's release of medical information form is on file

b. When acknowledging the patient's right to choose

c. When leaving the hospital

d. Upon entering the OR

14. Why are the five-digit procedure codes, as found in the CPT® and HCPCS manuals, important?

a. Six digits won't fit in the boxes provided.

b. By selecting the proper code, billers can describe the type of service performed with a few numbers.

c. Bureaucracies depend on codes.

d. Codes make it more difficult for outsiders to access sensitive information.

15. What is the correct term for the difference between the total charge and the amount paid by the patient or subscriber?

a. Easy money

b. Between payments option

c. Balance due

d. Separation of church and state

16. When should the degrees or credentials (i.e., M.D., D.O., etc.) follow the name of a

physician's signature?

a. With an electronic signature

b. Immediately following surgery

c. Before entering the OR

d. When paying a bill

17. What is the previous version of the CMS-1500 and UB-04 forms?

a. Medicare 2000

b. HIPAA X01

c. 4010/4010A

d. 3030/2424Z

18. Which of the following is NOT one of the changes of the Version 5010 form?

a. Increased field size for ICD codes from 5 spaces to 7 spaces

b. Added a one-digit version indicator to the ICD code to indicate Version 9 versus Version 10

c. Increased the number of insurance codes allowed on a claim

d. Added data modifications for the HIPAA standards including the standardization of the business information related to the transaction

19. How are the UB-04 forms intended for use?

a. For workers' compensation claims

b. By hospitals or other hospital-type facilities for inpatient and outpatient billing

c. To provide the basic data needed by most doctors to adjudicate a large majority of malpractice suits

d. To accommodate unusually specific needs while eliminating the need for attachments

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20. What does the form locator number do?

    a. Helps the coder find the form

    b. Assists the coder in assessing coworkers

    c. Ascertains claims fraud

    d. Helps the coder find the block in which to put the indicated information

21. What is a frequency code?

    a. A code that is used often

    b. The fourth digit in an alphanumeric code involving types of billing

    c. The precursor to a code

    d. The signal used when a patient is "coding" in the ER

22. What is a revenue code?

    a. The doctor's fee structure

    b. The typical cost of using an OR per hour

    c. A reference for the type of services provided

    d. A code used to access damages

23. Which of the following is NOT considered a quantitatively measurable unit of service?

    a. Days

    b. Miles

    c. Pints of blood

    d. Dollars

24. What is the intended use of the UB-04?

    a. As an interface between nurse practitioners and surgeons

    b. By hospitals or other hospital-type facilities for inpatient and outpatient billing

c. To provide the basic data most payers need to avoid lawsuits

d. To accommodate the need for attachments

25. The CDT is the equivalent of the CPT manual for which type of practice?

a. Dental

b. Dermatology

c. Dietetics

d. Drug manufacturing

Essay Questions

1. List and explain Volumes I, II, and III of the ICD-9-CM. Include examples of usage.

Answer:

- Volume I – A tabular listing of diseases.
- Volume II – An alphabetical listing of diseases by English language description.
- Volume III – A numerical and alphabetical listing of surgical or nonsurgical procedures that may be performed by a physician in a hospital or inpatient setting.

The order and degree of use varies for each volume.

The ICD-9-CM is used when:

- An ICD-9-CM code is provided, but there is no language description of the diagnosis.
- A language diagnosis is included, but an ICD-9-CM is not indicated and the terms used by the provider cannot be found in Volume II. If you can identify the body system, you may be able to locate an appropriate ICD-9-CM code. V codes and E codes are supplementary classifications found in Volume I. V codes deal with classification of factors influencing

health status and contact with health services. E codes are used for classification of external causes of injury and poisoning.

2. The ICD-10-CM/PCS codes are available for dual use starting October 1, 2012. The ICD-10-CM/PCS has two manuals. Name each and describe its function including coding and code procedures.

Answer:

a. Clinical Manual

The ICD-10-CM will be similar to the ICD-9-CM except the codes are more specific and expanded to allow for additional codes to be added in the future. Volumes I and II remain in this manual. All healthcare settings will utilize this portion.

b. Procedural Service Codes

This ICD-10-PCS manual has been drastically upgraded for inpatient hospital settings to code procedures. This manual contains Volume III. It is tentatively set to release in the summer of 2012 for available use in the fall of 2012. Full implementation is expected in 2014. The ICD-11 is in the works and will be implemented between 2014 and 2020.

3. The CPT® has six major sections:

a. Evaluation and Management 99201–99499

b. Anesthesiology 00100–01999, 99100–99150

c. Surgery 10021–69990

d. Radiology 70010–7999

e. Pathology & Laboratory 80047–89398

f. Medicine 90281–99189, 99500–99607

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Choose from two of the above sections, giving examples of proper coding procedures for each.

Answer:

To properly code using the CPT®, choose the number code associated with the English-language description of the procedure performed. Sometimes the procedure will be phrased in different terminology (i.e., testectomy is found under orchiectomy even though both are legitimate medical terms). Therefore, it is important to check all related codes and alternate terminology for a procedure. It may also be necessary to consult a medical dictionary for alternate terminology for a specified procedure.

Each section of the CPT® has specific instructions relating to that section prior to the first codes. It is important to read each of these instructions to properly code the procedures contained in that section or review the appropriateness of the codes (in the case of the claims examiner). Within each section there are instructions related to each body system as well, for example, in the surgery section there are instructions for musculoskeletal and then instructions for organs, etc.

Some descriptions in the CPT® are subprocedures of other descriptions. These subheading descriptions will be indented under the main procedure. To properly read an indented procedure, read the description of the main procedure (the one not indented) up to the semicolon. Then add the remaining description found in the indented wording.

For example, codes 21208 and 21209 read as follows:

21208 Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)

21209 reduction

Therefore, the correct description for 21209 is Osteoplasty, facial bones; reduction. It is important to carefully read the full description of all related procedures before choosing the one

which best describes the procedure performed. A slight change in the main description can significantly alter the meaning of the indented procedure.

4. The HCPCS codes are most often used for billing Medicare claims but may also be used for Medicaid claims and for some private insurance carriers. Identify and describe the three levels of coding used in this system.

Answer:

- Level I utilizes the current CPT® codes for most procedures.
- Level II utilizes the HCPCS codes listed in the HCPCS manual.
- Level III utilizes codes which are specific to the local Medicare/Medicaid carrier. Level III codes were discontinued on December 31, 2003.

One way to code using the HCPCS system is to check Level II codes first and then go to the CPT manual. Another way is to go to the CPT codes first and then the HCPCS; it depends on the type of coding being done.

5. Using the CMS-1500 form, examiners become familiar with the various blocks and start to know where to obtain the information required for completing and processing claim forms. Identify, explain, and describe in list form the various uses of the blocks followed by an in-depth description of the Information about the Patient block.

Answer:

Since it is easier to remember information in groups, the CMS-1500 is broken into sections for understanding. These sections include information about the patient, the insured, the secondary insurance, third party liability, authorization signature, the illness, the procedures performed, and

the provider of services.

Information about the Patient

These blocks contain information about the patient.

1. **Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, or Other.** Check the box of the organization to which you are submitting this claim for payment.
2. **Patient's Name.** Enter patient name.
3. **Patient's Birth Date and Sex.** All dates should be recorded as Month/Day/Year, i.e., 01/13/2012. Check the box for the appropriate sex.
5. **Patient's Address, City, State, ZIP Code, and Phone Number.** Enter address.
6. **Patient's Relationship to Insured.** Spouse, self, etc.
8. **Patient's Status.** Check applicable boxes.