Student name:_____

1) What is *abstracting*?

A) When the physician summarizes the patient's history in his or her notes
B) Items that are used in the care and treatment of a patient
C) A form preprinted with the diagnosis codes and procedure codes most frequently used in a particular facility
D) The process of identifying the key words or terms in health care documentation in order to determine the best, most appropriate code

2) _____ is to suppose to be the case, without proof; guess the intended details.

A) Abstracting
B) Assume
C) Interpret
D) Demographic

3) _____ is to explain the meaning of; convert a meaning from one language to another.

A) Abstracting
B) Assume
C) Interpret
D) Demographic

4) The _____ will have a coder to report for any heart problems.

A) anesthesiologist
B) radiologist
C) cardiologist
D) pathologist

5) Explains who is provided with care:

A) Patient
B) Physician
C) Facility
D) Diagnosis

6) Explains why the provider is caring for this individual during this encounter:

A) Procedure
B) Diagnosis
C) Facility
D) Physician

7) Explains how and where the patient became injured:

A) Patient
B) Diagnosis
C) Procedure
D) External Cause

8) Explains what the provider did for the individual:

A) Patient
B) Diagnosis
C) Procedure
D) External Cause

9) Identifies where the services were provided:

A) Procedure
B) Diagnosis
C) Facility
D) Physician

10) For coding purposes, why are diagnosis codes important?

A) They explain what the physician did for the patient.
B) They establish the case for medical necessity.
C) They indicate where the patient was treated.
D) They describe which insurance policy the patient has.

11) _____ details include the patient's name, address, date of birth, and other personal details, not specifically related to health.

A) Abstracting
B) Superbill
C) Face sheet
D) Demographic

12) A condition that caused or developed from the existence of another condition is called a:

A) co-morbidity.
B) complication.
C) manifestation.
D) sequela.

13) A separate diagnosis existing in the same patient at the same time as an unrelated diagnosis is known as a:

A) co-morbidity.
B) complication.
C) manifestation.
D) sequela.

14) _____ is to ask; an official request to the attending physician for more specific information related to a patient's condition or treatment:

A) Summary report
B) Remittance Advise
C) Query
D) Sequela

15) When should a coder query the physician?

A) When there is unclear or missing information necessary to code an encounter
B) When the supporting documentation is in the progress note
C) When the chart has been updated
D) When the chart is missing

16) A cause-and-effect relationship between an original condition that has been resolved with a current condition is known as a _____.

A) Manifestation
B) Symptom
C) Sequela
D) Sign

17) Measurable indicators of a patient's health status is known as a:

A) manifestation.
B) symptom.
C) sequela.
D) sign.

18) A patient's subjective description of feeling is known as a:

A) manifestation.
B) symptom.
C) sequela.
D) sign.

19) This document or section includes the patient's demographic information, as well as health insurance policy numbers and the name of the individual who will be financially responsible for the patient's care.

A) Physician's Notes/Operative Reports
B) Referral Authorization Form
C) Patient's Registration Form
D) Discharge Summary

20) If another physician or health care provider referred this patient for a consultation, you will need to have a _____ to determine the correct evaluation and management code.

A) Physician's Notes/Operative Reports
B) Referral Authorization Form
C) Patient's Registration Form
D) Discharge Summary

21) Results of testing performed on blood, tissue, and other specimens hold important keys to the patient's condition. The results can provide you with important details necessary for you to determine a specific, accurate code. You can locate this information in the:

A) Physician's Notes/Operative Reports.
B) Imaging Reports.
C) Pathology and Laboratory Reports.
D) Medication Logs.

22) Essentially, this document, written by the admitting physician, explains the background and current issues used to make the decision to admit the patient into the hospital.

A) History and Physical
B) Referral Authorization Form
C) Patient's Registration Form
D) Discharge Summary

23) When a specialist is asked by an attending physician to evaluate a patient's condition, a report is written and sent over to be included in the patient's medical record in the requesting physician's files, as well as those belonging to the consulting physician. You can locate this information in the:

A) Physician's Notes/Operative Reports.
B) Imaging Reports.
C) Pathology and Laboratory Reports.
D) Consultations Reports.

24) At the time a patient is released from a facility, such as a hospital,

this document provides the conclusions and results of the patient's stay in the facility in addition to follow-up advice.

A) History and Physical
B) Discharge Summary
C) Referral Authorization Form
D) Patient's Registration Form

25) The documentation of each patient encounter should include which of the following?

A) the date
B) the reason for the encounter
C) appropriate history and physical exam in relationship to the chief complaint
D) a plan of care
E) all of these

26) The written plan of care should include which of the following?

A) the date
B) the reason for the encounter
C) appropriate history and physical exam in relationship to the chief complaint
D) treatments and medications, specifying frequency and dosage

27) The suffix -phobia means:

A) fear
B) repair
C) crush
D) remove

28) The suffix -ectomy means:

A) to dissolve
B) to repair
C) to crush
D) to remove

29) Which ICD-10-CM official guideline is concerned with signs and symptoms?

A) Section I.B.4
B) Section I.B.5
C) Section I.B.6
D) Section I.B.7

30) An external cause code explains which of the following?

A) How
B) Where
C) The details of the accident
D) All of these

31) Which ICD-10-CM official guideline is concerned with sequela?

A) Section I.B.7
B) Section I.B.8
C) Section I.B.9
D) Section I.B.10

32) The underlying condition is known as the _____, the original source or cause for the development of a disease or condition.

A) manifestation
B) etiology
C) sequela
D) idiopathic

33) The abbreviation GTT stands for

A) glass tolerance test.
B) gutta drops.
C) glucose tolerance test.
D) Google translator toolkit.

34) Thrombolysis means:

A) nerve repair
B) dissolve dangerous clots in blood vessels
C) low blood platelet count
D) high blood platelet count

35) In diagnostic coding NOS stands for:

A) network operating systems
B) nitrous oxide system
C) not otherwise specified
D) national occupational standards

36) Which of the following would be an example of an external causes code?

A) D48.1
B) M05.631
C) T50.903A
D) X17.XXXA

37) Rosetta is having a screening colonoscopy because of her ulcerative colitis. In the CPT book, which term will you look up in the Alphabetic index?

A) screening
B) colonoscopy
C) ulcerative
D) colitis

38) Which of the following would be an example of an external cause code?

A) 99050
B) L0468
C) Y35.001A
D) 0T140K8

39) What is the main term in the following procedural statement? Repair of an abdominal hernia.

A) repair
B) abdominal
C) hernia
D) none of these

40) George's broken foot did not heal properly. Today's encounter for the malunion is coded as a(n):

A) current condition.
B) injury.
C) sequela.
D) adverse reaction.

41) A biopsy is an example of a(n):

A) symptom.
B) eponym.
C) procedure.
D) diagnosis.

42) A fever is an example of a(n) _____.

A) sign
B) objective
C) sensation
D) symptom

43) Laminectomy is an example of a _____.

A) symptom
B) diagnosis
C) procedure
D) complaint

A) Section I.C.9.
B) Section I.C.15.
C) Section I.C.19.
D) Section I.C.20.

45) When querying a provider, what is the best approach in asking the questions?

A) Open-ended
B) Multiple choice
C) Direct the provider to a specific code
D) Either open-ended or multiple choice

46) Which ICD-10-CM official guideline is concerned with acute and chronic conditions?

A) Section I.B.5
B) Section I.B.8
C) Section I.B.13
D) Section I.B.18

47) The _____ will have a coder to report for any administration of anesthesia.

A) anesthesiologist
B) radiologist
C) cardiologist
D) pathologist

48) Which code represents an ICD-10-PCS code?

A) N13.5
B) 77333
C) 07PK4CZ
D) E0118

49) Which of the following are pathways to query a provider?

chart.

A) Electronic health record software programs.
B) Encrypted email system.
C) Charts with query notes attached to the front of the
D) All of these.

50) When an inpatient is being discharged without a confirmed diagnosis, you will

A) code the suspected conditions listed on the discharge summary.
B) code the signs.
C) code the symptoms.
D) wait until a confirmed diagnosis is reached.

Answer Key

Test name: CH 2: Test Bank (2020)

1) D

2) B

3) C

4) C

5) A

6) B

7) D

8) C

9) C

10) B

11) D

12) C

13) A

14) C

15) A

16) C

17) D

18) B

19) C

20) B

21) C

22) A

23) D

24) B

25) E

26) D

27) A

28) D

29) A

30) D

31) D

32) B

33) C

34) B

35) C

36) D

37) B

38) C

39) A

40) C

41) C

42) A

43) C

44) A

45) D

46) B

47) A

48) C

49) D

50) A