Student name:_____

1) ICD stands for

A) Internal Coding Determinations
B) International Classification of Diseases
C) International Coding Determinations
D) Intentional Coding of Diseases

2) Coding and billing language is used to assist _____ in understanding why the patient was seen and what services, procedures, or supplies were provided for the patient.

A) third-party administrators and customer service representatives
B) collection agencies and hospitals
C) patients and collection agencies
D) physician offices and patients

3) Accounts receivable, denials, and modifiers are examples of _____ language.

A) Provider
B) Billing
C) Compliance
D) Payer

4) Any diagnosis, condition, procedure, or service that is documented in the patient record as having been treated or medically managed demonstrates:

A) medical support
B) medical documentation
C) medical management
D) medical necessity

5) The Certified Professional Coder (CPC) exam tests the coder's skill in translating data from the patient's medical record accurately and completely so that the provider is:

A) Reimbursed

correctly and fairly
B) Able to hire additional staff
C) Exempt from audits
D) Reimbursed regardless of compliance guidelines

6) The organization that administers the CPC exam and confers the Certified Professional Coder credential is called:

A) American Health Information Association
B) American Health Information Management Association
C) American Academy of Professional Coders
D) American Federation of Professional Coders

7) Medical coding is defined as:

A) The process of translating provider documentation into codes
B) Identifying noncovered services
C) Verifying services are covered by a payer prior to providing the services
D) The process of reporting patient index information to payer auditors

8) An ICD-10-CM (tenth revision) code represents:

A) the diagnosis
B) the demographics
C) the service
D) the procedure

9) The CPC exam is an "open code-book" exam. All of the following are approved coding manuals for use during the exam except:

A) ICD
B) HCPCS
C) CPT
D) DSM-5

10) The _____ exam is a 150-question exam that thoroughly tests the coder's ability within a medical coding subset.

A) Certified Coding Specialist
B) National Billing and Insurance Specialist
C) Certified Professional Coder
D) Certified Coding Associate

11) Revenue included in the accounts receivable cycle may be due to the provider from all of the following except:

A) workers' compensation
B) recovery audit contractors
C) health insurance coverage
D) the patient

12) Approximately _____ percent of members of the American Academy of Professional Coders are credentialed as Certified Professional Coders.

A) 50
B) 60
C) 80
D) 70

13) A diagnosis which may not receive direct treatment during an encounter but which the provider has to consider when determining treatment for other conditions is called a:

A) Medically managed diagnosis
B) Concurrent diagnosis
C) Additional diagnosis
D) Secondary diagnosis

14) The flow of a practice's revenue, which

begins when charges for services, procedures, or supplies are incurred and continues until those charges are paid in full or adjusted off the account is called:

A) revenue cycle
B) contractual adjustment cycle
C) accounts payable cycle
D) accounts receivable cycle

15) The CPC exam tests the coder's ability and understanding of which content areas?

A) Radiology, DRGs, Advanced Beneficiary Notices, and Anesthesia
B) DRGs, HCPCS Level II, and Anesthesia
C) HCPCS Level II, Radiology, and DRGs
D) Radiology, Anesthesia, and HCPCS Level II

16) Selection of ICD, CPT, and HCPCS codes is based on _____ language.

A) provider
B) payer
C) billing
D) compliance

17) The demographic portion of the CMS 1500 form:

A) Contains information such as the services provided on a date of service
B) Is found at the top of the form
C) Is found at the bottom of the form
D) Contains information such as the patient's medical condition

18) The foundation of a coder's role is to:

A) Determine each patient's chief complaint and communicate this to the physician
B) Follow office guidelines and procedures when scheduling patients

C) Make each patient feel comfortable while obtaining vital signs
D) Interpret different languages and correctly translate them into data for the CMS 1500 form

19) Creating a clean claim requires that all involved in its creation have all of the following except:

A) A good working knowledge of each of the patient's medically managed conditions
B) A good working knowledge of government regulations
C) A good working knowledge of payer policies
D) A good working knowledge of the practice/provider-payer contract limitations

20) To be of value to the practices or organizations they work for, medical coders should:

A) Memorize all procedure codes
B) Consistently audit the use of ICD-10 codes
C) Demonstrate strong organizational skills
D) Be diligent in maintaining and updating their knowledge of medical coding and billing policies

21) One of the more common reasons for a coder performing poorly on the exam when he/she knows the material well is:

A) The coder experiences test anxiety
B) The coder forgot to bring No. 2 pencils
C) The coder forgot to bring headphones
D) The coder brought all permitted coding manuals

22) Certified coders, on average, earn _____ percent more than noncertified coders.

A) 30

B) 20
C) 15
D) 10

23) The CPC exam tests the coder's ability and understanding of which content areas?

A) Digestive, Psychology, and Musculoskeletal
B) Respiratory, Musculoskeletal, and Digestive
C) Respiratory, Psychology, and Digestive
D) Psychology, Respiratory, and Musculoskeletal

24) The CPC exam tests the coder's ability and understanding of all of the following except:

A) Practice management
B) ICD-10-PCS
C) Evaluation and management
D) Medical terminology

25) The CPC exam tests the coder's ability and understanding of which content areas?

A) Hemic and Lymphatic, Laboratory, and ICD-10-CM
B) MCCs/CCs, Laboratory, and ICD-10-CM
C) Hemic and Lymphatic, Laboratory, and MCCs/CCs
D) MCCs/CCs, Hemic and Lymphatic, and ICD-10-CM

26) The CPC exam tests the coder's ability and understanding of all of the following except:

A) Male/female genital
B) Pharmacology
C) Eye and ocular adnexa
D) Anatomy and physiology

27) The CPC exam tests the coder's ability and understanding of all of the following body systems except:

A) Digestive
B) Psychology
C) Musculoskeletal
D) Respiratory

28) A complete and current list of non-approved manuals for use during certification testing can be found at:

A) www.cpc.com
B) www.aapc.com
C) www.ahima.org
D) www.cms.gov

29) A Certified Professional Coder is an individual who has demonstrated his or her knowledge of medical coding by successfully completing the _____ exam:

A) PAC
B) CPA
C) CPC
D) APC

30) The CPC exam tests the coder's ability and understanding of all of the following except:

A) Maternity and delivery
B) Coding guidelines
C) Revenue cycle
D) Pathology

31) The CPC exam has _____ questions.

A) 175
B) 100
C) 150
D) 200

A) Moves to the submission phase of the cycle
B) Begins
C) Moves to the charge phase of the cycle
D) Concludes

33) ABN stands for

A) advanced billing notice
B) advanced beneficiary notice
C) adjudication benefit notice
D) alternate beneficiary notice

34) The CPC exam tests the coder's ability and understanding of which content areas?

A) Risk adjustment, Pathology, and Maternity and Delivery
B) Maternity and Delivery, Pathology, and general coding guidelines
C) General coding guidelines, Maternity and Delivery, and risk adjustment
D) Pathology, general coding guidelines, and risk adjustment

35) A clean claim:

A) Slows the reimbursement process
B) Results in accurate and timely reimbursement
C) Releases the payer from the contractual adjudication time frame
D) Guarantees the provider will receive payment

36) Medical practices contract with multiple insurance payers for all of the following reasons except:

A) To ensure the uninsured receive services
B) Facilitate payment for patients covered by diverse insurance plans
C) To maintain the

number of patients they serve

D) To increase the number of patients they serve

37) The process of translating provider documentation and medical terminology into codes that illustrate the procedures and services performed by medical professionals is:

A) medical coding
B) provider language
C) payer language
D) medical management

38) The CPC exam is an "open code-book" exam. Approved books to use during the exam include:

A) DSM IV, HCPCS, and ICD
B) HCPCS, CPT, and DSM IV
C) CPT, HCPCS, and ICD
D) CPT, HCPCS, and DSM IV

39) The time allowed for completing the CPC exam is:

A) 5 hours 40 minutes
B) 6 hours
C) 5 hours
D) 5 hours 30 minutes

40) The CPC exam tests the coder's ability and understanding of all of the following except:

A) ICD-10-CM
B) Hemic and lymphatic
C) Laboratory
D) ICD-10-PCS

41) The adjudication period begins upon:

A) Receipt of a clean claim
B) Submission of a claim to the payer
C) Receipt of a claim
D) Providing services

42) Provider language includes terms such as:

A) medical terminology, procedures, and services
B) accounts receivable, procedures, and services
C) noncovered services, medical terminology, and procedures
D) false claim, modifiers, and denials

43) Coding and billing language is used to assist the following except:

A) patients
B) collectors
C) hospitals
D) physician offices

44) Physicians need to be aware of what is necessary in their documentation in all of the following medical documents except:

A) superbill
B) CMS 1500 form
C) handwritten notes in charts
D) dictated reports

45) The CPC exam tests the coder's ability and understanding of which content areas?

A) ICD-10-PCS, practice management, and medical terminology
B) Evaluation and management, ICD-10-PCS, and practice management
C) Medical terminology, ICD-10-PCS, and evaluation and management
D) Medical terminology, practice management, and evaluation and management

A) Consistently billing the same, low level E/M service code

B) Consistently billing the same, high level E/M service code

C) Billing an even distribution of low and high level E/M service codes

D) Consistently billing the same, low level E/M service code and consistently billing the same, high level E/M service code

47) When taking the CPC exam, it is best to do all of the following except:

A) Leave questions you are unsure of blank

B) Follow all instructions the proctor gives

C) Complete questions about which you are more confident first

D) Make your best attempt to answer a question then move on

48) The acronym AAPC stands for:

A) American Academy of Professional Coders

B) American Academy of Physician Coders

C) Academy of American Physician Coders

D) Academy of Auditors and Physician Coders

49) CPT stands for:

A) Current Procedural Terminology

B) Coding Physician Terminology

C) Current Physician Terminology

D) Coding Process Tabular

50) An individual who has demonstrated his or her knowledge of medical coding by successfully completing the CPC exam is known as:

A) Certified

Coding Specialist
B) Certified Professional Coder
C) Certified Coding Professional
D) Certified Coding Association

51) HCPCS stands for

A) Healthcare Common Procedure Coding System
B) Healthcare Procedures Common System
C) Health Provider Coding Systems
D) Healthcare Procedures Coding Systems

52) All of the following are benefits of becoming a certified coder except:

A) certified coders are more likely to pursue continuing education
B) certified coders may make medical necessity determinations
C) certified coders earn more salary on average than noncertified coders
D) certified coders are typically eligible for various career opportunities

53) Compliance language includes:

A) Services, procedures, and medical terminology
B) Unbundling, fraud, and abuse
C) Noncovered services, medical necessity, and unbundling
D) Denials, modifiers, and advanced beneficiary notices

54) The AAPC supports its members by providing all of the following except:

A) offering networking opportunities
B) identifying job opportunities
C) resume writing assistance
D) coding education

55) A CMS 1500 claim that is complete and accurate from the demographic portion to the diagnosis and procedure is a:

A) advanced beneficiary notice
B) modifier
C) false claim
D) clean claim

56) The _____ form becomes the source of the statistical medical data for the practice, payer, and governing bodies.

A) Billing language
B) Advanced Beneficiary Notice (ABN)
C) UB-04
D) CMS 1500

57) Which of the following are areas being audited by payers:

A) all of these
B) medical necessity
C) duplicate claims
D) incorrect use of modifiers

58) The CPC exam tests the coder's ability and understanding of which content areas?

A) Anatomy and physiology, pharmacology, and Eye and Ocular Adnexa
B) Pharmacology, anatomy and physiology, and Male/Female Genital
C) Anatomy and physiology, Eye and Ocular Adnexa, and Male/Female Genital
D) Eye and Ocular Adnexa, Male/Female Genital, and pharmacology

A) consistent use of the same level of evaluation and management codes
B) use of invalid codes
C) consistent use of the same procedural codes
D) unbundling

60) One of the more common reasons for a coder performing poorly on the exam when he/she knows the material well is:

A) The coder studied for weeks leading up to the exam date
B) The coder ran out of time to take the exam
C) The coder got lost on the way to the test site
D) The coder forgot to bring food to the test site

61) Billing language includes terms such as:

A) unbundling, abuse, and fraud
B) noncovered services, compliance language, and unbundling
C) medical terminology and anatomy and physiology
D) accounts receivable, denials, and modifiers

62) ICD-10 codes are reported in field _____ of the CMS form.

A) 22
B) 25
C) 21
D) 18

63) The code set(s) used to translate the specific services, procedures, and supplies performed on a date of service is/are:

A) ICD, HCPCS
B) ICD, CPT
C) HCPCS Level II, CPT
D) CPT

64) Revenue that is due to the practice or provider for services or procedures rendered to the patient is:

A) accounts payable
B) remittance advice
C) accounts receivable
D) adjudication

65) Errors in the medical records may be corrected by doing which of the following?

A) Creating an addendum to the record that is dated and legibly signed
B) Drawing a strike-through line through the error, writing the correction beside it, and initialing or creating an addendum to the record that is dated and legibly signed
C) Drawing a strike-through line through the error, writing the correction beside it, and initialing
D) Erasing the error, writing the correction in its place, and initialing

66) The most effective way to increase revenue at a physician practice is to:

A) Increase patient workload
B) Remain aware of billing and coding guidelines
C) Hire more office staff
D) Hire more physicians

67) _____ validate the knowledge and expertise of the individual who holds them.

A) Speaking opportunities
B) Credentials
C) Licensure
D) Continuing education credits

68) Recommended strategies for improving test-taking skills include all of the

A) Use available resources to practice specific areas of weakness

B) Perform a cramming session the night before the exam

C) Take a mock/practice test a few months before the actual test

D) Form a study group among your peers

69) The CPC exam tests the coder's ability and understanding of which of the following areas:

A) HCPCS Level II
B) All of these
C) Anesthesia
D) Radiology

70) Payer language includes terms such as:

A) compliance language, unbundling, and medical necessity
B) medical necessity, clean claims, and denials
C) accounts receivable, medical necessity, and unbundling
D) advanced beneficiary notices, fraud, and abuse

71) Coding guidelines and regulations can change:

A) Monthly
B) Quarterly
C) Weekly
D) Annually

72) The diagnostic portion of the CMS 1500 form:

A) Includes information such as the patient's name and date of birth
B) Includes information such as the patient's medical condition
C) Is found at the bottom of the form
D) Is found at the top of the form

73) Medical necessity is:

A) Documented in the patient's chart and is not a translated piece of provider information
B) Any diagnosis, condition, procedure, or service documented in the patient record as having been treated or medically managed

C) Represented by a HCPCS code on the CMS 1500 claim form

D) Determined by the Certified Professional Coder

74) The CPC exam tests on the following code sets:

A) ICD, CPT, HCPCS Level II
B) ICD, CPT
C) ICD, HCPCS Level II
D) ICD

Answer Key 2018

Test name: Medical Coding,Stewart 2th ch1

1) B

2) D

3) B

4) D

5) A

6) C

7) A

8) A

9) D

10) C

11) B

12) C

13) A

14) A

15) D

16) A

17) B

18) D

19) A

20) D

21) A

22) B

23) B

24) B

25) A

26) B

27) B

28) B

29) C

30) C

31) C

32) D

33) B

34) B

35) B

36) A

37) A

38) C

39) A

40) D

41) A

42) A

43) B

44) B

45) D

46) D

47) A

48) A

49) A

50) B

51) A

52) B

53) B

54) C

55) D

56) D

57) A

58) C

59) C

60) B

61) D

62) C

63) C

64) C

65) B

66) B

67) B

68) B

69) B

70) A

71) D

72) B

73) B

74) A