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Question: 1

Which of the following is NOT an acceptable method for destroying confidential medical records?

A.Placing them in a medical waste container
B.Shredding, pulverizing, incinerating, and pulping
C.Digital sanitation
D.Transferring them to a disposal vendor

Answer: A

Explanation:
The proper disposal of confidential medical records involves the complete destruction of personally identifiable data. For paper records, this includes shredding, pulverization, incineration pulping, or transferring records to a destruction or disposal vendor. For electronic records, this includes the physical destruction of the computer hard drive or other practices that overwrite protected health information (PHI), such as digital sanitation or degaussing. When disposing of confidential medical records, a log should be kept containing minimal demographic information, along with the date, method of destruction, and any witnesses present at the time of disposal. When using a destruction or disposal vendor, a certificate of destruction should be issued.

Question: 2

A patient is seen first by the medical assistant, who documents a body mass index (BMI) of 36, a history of nicotine dependence, and a blood pressure reading of 140/85. The physician later documents a diagnosis of hypertension. What code(s) should be reported for this encounter?

A.110
B.110, Z87.891
C.110, E66.9, Z68.36, Z87.891
D.110, Z68.36, Z87.891

Answer: A

Explanation:
Because medical decision making is the driving force for determining the level of service, ancillary staff may contribute to the documentation of a medical record. However, ICD-IO-CM guidelines state that "the assignment of a diagnosis code is based only on the provider's diagnostic statement." There are some exceptions, including BMI, depth or stage of an ulcer, Glasgow Coma Scale, National Institutes of Health Stroke Scale, social determinants of health (SDOH), laterality, blood alcohol level, and an underimmunzation status. To report these secondary diagnoses, the provider would need to document

the associated condition. In this scenario, to report the patient's BMI, the provider would have had to indicate that the patient was overweight or obese.

Question: 3

Which of the following actions is a violation of the AHIMA Standards of Ethical Coding?

A.A query was sent to a physician to confirm a diagnosis of suspected Escherichia coli urinary tract infection.
B.A patient was seen for birth control and pelvic pain. Birth control is not covered under the patient's insurance; therefore, only pelvic pain is reported on the claim.
C.An online search engine was used to locate a diagnosis code for thickened endometrium.
D.Unsolicited advice was provided to educate physicians on correct documentation.

Answer: B

Explanation:
According to the AHIMA Standards of Ethical Coding, diagnosis and procedure codes must be reported in a way that most accurately represents the care rendered. In this scenario, by excluding birth control from the claim, a coding professional is intentionally omitting information in order to receive reimbursement from the insurance carrier. Although sending a query to a physician to confirm a suspected condition, using a search engine to locate a diagnosis code, and providing unsolicited advice to a physician are not advantageous actions, they are not considered violations of the AHIMA Standards of Ethical Coding.

Question: 4

Which diagnosis requires that additional data be abstracted from the health record?

A.Chronic kidney disease
B.Postprocedural hypothyroidism
C.Acute schizophrenia
D.Tinea corporis

Answer: A

Explanation:
When abstracting data from a health record, obtaining an accurate and specific diagnosis is essential, because it affects reimbursement rates and resource utilization. In this scenario, postprocedural hypothyroidism (E89.0), acute schizophrenia (F20.9), and tineas corporis (B35.4) are the most specific descriptors for their category of diseases. On the other hand, chronic kidney disease (CKD) is an illness that presents itself in six stages. By reporting CKD unspecified, as opposed to its specific stage, a facility cuts their reimbursement rate by almost 50%.

Question: 5

A primary care physician may request records from a patient's endocrinologist without obtaining a patient's authorization under which of the following laws?

A.Online Privacy Protection Act
B.HIPAA Privacy Rule
C.Privacy Act of 1974
D.Gramm-Leach-Bliley Act

Answer: B

Explanation:
The HIPAA Privacy Rule is a federal law established in 1996 to protect a patient's health information from being disclosed without their consent. However, the HIPAA Privacy Rule does allow a covered entity, including health plans, clearinghouses, and healthcare providers, to release health information for purposes of obtaining and releasing eligibility, authorizations, payment, and continuing care. In this scenario, the HIPAA Privacy Rule allows one physician to request records from another physician without obtaining an authorization from the patient because it involves continuity of care.

Question: 6

The following data are taken from a CMS spreadsheet regarding the 2021 coding updates for COVID-19:

CURRENT	EFFECTIVE	PREVIOUS
J12.82	1/1/2021	J12.89
M35.81	1/1/2021	M35.8
M35.89	1/1/2021	M35.8
Z11.52	1/1/2021	Z11.59
Z20.822	1/1/2021	Z20.828
Z86.16	1/1/2021	Z86.19

If it is now March 2021, which of these code sequences would be appropriate for an immunocompromised patient who presents for a COVID-19 screening due to having already contracted the virus in the past, resulting in pneumonia? (Note: this encounter is purely precautionary due to the patient's weakened immune status since birth.)

A.ZII.52, J12.82, D84.9
B.ZII.52, Z20.822, M35.81
C.ZII.52, Z86.16, 112.82
D.ZII.52, Z86.16, D84.9

Answer: D

Explanation:
Codes ZII.52, Z86.16, and D84.9 are the most appropriate codes, and they are also sequenced correctly. Even when armed with only an ICD-IO codebook that doesn't yet contain the new codes, one could still determine that these are the best codes through the application of basic logic. This is accomplished primarily through a coder's own familiarity with code categories (organized by letter) and by consulting the old codes given within their subclassifications (which also correspond to the new codes). To start, because the patient is presenting for a screening, an experienced coder knows that it will be a Z code. There are three given in the new code set. If one begins with the old code ZII.59, we see that it is listed under "ZII - Encounter for screening for infectious and parasitic diseases," and then it is subcategorized further under "ZII.5 — Encounter for screening for other viral diseases." Therefore, code Zl 1.52 applies; however, the reasons for the encounter make the remaining code selections more difficult to navigate. Because Z20.822 would be listed similarly to the old code Z20.828, in which both would be categorized under "Z20.8 - Contact with and (suspected) exposure to other communicable diseases," it can be eliminated as a potential code because it is known that the patient has a congenital immunosuppressive condition, D84.9, a fact that should also be present in the code report submitted due to the possibility that it will affect the test administration. Then, when further comparing J12.82 to Z86.16, the final answer becomes most evident: J is clearly an illness code ("J12 - Viral pneumonia, not elsewhere classified") versus Z86.16, which is a history code ("Z86.1 - Personal history of infectious and parasitic diseases"). Because it is known that the patient contracted COVID-19 in the past (pneumonic or not), it is the most logical choice here to justify the medical necessity of the encounter alongside code D84.9.

Question: 7

The following is taken from a PDF accessible online at cdc.gov with coding information that took effect in 2019:
For patients documented with electronic cigarette (e-cigarette), or vaping, product use-associated lung injury, assign the code for the specific condition, such as
•J68.0, Bronchitis and pneumonitis due to chemicals, gases, fumes, and vapors; includes chemical pneumonitis
•J69.1, Pneumonitis due to inhalation of oils and essences; includes lipoid pneumonia
•J80, Acute respiratory distress syndrome
•J82, Pulmonary eosinophilia, not elsewhere classified
•J84.114, Acute interstitial pneumonitis
•J84.89, Other specified interstitial pulmonary disease.
A physician admits a patient with severe dyspnea and chest pain to the hospital. He suspects pulmonary eosinophilia. Later, he submits his initial report to the coder with a diagnosis of "pulmonary infiltrate NOS." Choose the best code(s) for the patient.

A.R07.9, R06.00
B.J82, R07.9, R06.00
C.R91.8
D.J82

Answer: C

Explanation:
R91.8 is correct because it is indicated that the physician suspect's pulmonary eosinophilia, but that doesn't mean he knows for sure that this is the case. He is likely running several tests before a more specific diagnosis is certain. He therefore documents the condition for the time being as "pulmonary infiltrate NOS." Additionally, if one consults the tabular list for "pulmonary eosinophilia," the coder is led to J82—one of the conditions listed by the CDC as related to, or resulting from, vaping activity. That said, if J82 is examined more closely, there is a note at the very bottom of EXCLUDES 1 that reads: "pulmonary infiltrate NOS (R91.8)." This means that the patient may very well have the condition suspected, but because it is not known yet, this is the closest diagnosis code to what is already known for sure. Finally, R07.9 and R06.00 are the symptoms that the patient presented with; however, when a diagnosis (however vague) is documented, symptoms are not. These R codes would have been appropriate codes had the patient presented with these symptoms and the admitting physician had not yet determined a diagnosis.

Question: 8

The 2020 conversion factor (CF) for State X was $34.7701. For 2021, it has been adjusted to $35.0785. Calculate the 2021 facility pricing amount (FPA), Medicare payment (MP), State X, for CPT E/M code 99213, using the following information:
E/M code 99213
Work RVU: 0.95; FAC PE RVU: 0.39; MP RVU: 0.06
Practice cost index: State X
Work GPCI 1.000; PE GPCI 0.992; MP GPCI 1.088
FPA= [(Work RVU) x (Work GPCI) + (FAC PE RVU) x (PE GPCI) + (MP RVU) x (MP GCPI)] x CF

A.$69.79
B.$49.19
C.$48.23
D.$50.85

Answer: B

Explanation:
$49.19 is the correct answer.
FPA = [(0.95 x 1.000) + (0.39 x 0.992) + (0.06 x 1.088)] x $35.0785
= [(0.95) + (0.38688) + (0.06528)] x $35.0785
= [1.40216] x $35.0785
= $49.19
$69.79 is incorrect—this results when 0.6 is factored into the formula instead of the given 0.06.
$48.23 is incorrect—this results when 0.922 is factored into the formula instead of the given 0.992.
$50.85 is incorrect—this results when 1.88 is factored into the formula instead of the given 1.088.

Question: 9

The 2020 conversion factor (CF) for State Y was $32.0551. For 2021, it has been adjusted to $32.1618. Calculate the 2021 non-facility pricing amount (NFPA), Medicare payment, State Y, for CPT E/M code 99214, using the following information:
E/M Code 99214
Work RVU: 0.92; NON-FAC PE RVU: 1.85;
MP RVU: 0.07
Practice Cost Index: State Y
Work GPCI 1.500; PE GPCI 1.029;
MP GPCI 0.791
NFPA = [(Work RVU) x (Work GPCI) + (NON-FAC PE RVU) x (PE GPCI) + (MP RVU) x (MP GCPI)] x CF

A.$107.39
B.$123.42
C.$118.10
D.$107.79

Answer: A

Explanation:
$107.39 is the correct answer.
NFPA = [0.92 x 1.5 + 1.85 x 1.029 + 0.07 x 0.0791] x $32.1618
= [1.38 + 1.90365 + 0.05537] x $32.1618
= 3.33902 x $32.1618
= $107.39
$123.42 is incorrect—this results when 0.7 is factored into the formula instead of the given 0.07.
$118.10 is incorrect—this results when 1.209 is factored into the formula instead of the given 1.029.
$107.79 is incorrect—this results when 0.971 is factored into the formula instead of the given 0.791.

Question: 10

A young doctor who was recently board certified has just joined a practice. The in-house biller/coder is immediately tasked with helping her understand the discrepancies between the HIPAA 1995 and 1997 documentation guidelines for compliant E/M coding. Select the recommendation that correctly applies the basic principles of these guidelines.

A."Use medical necessity as a tool to select the guidelines that best characterize your individual patient encounters."
B."The 1995 guidelines are not open to interpretation; the 1997 guidelines have more gray areas. How you interpret those gray areas is your call."
C."The 1997 guidelines are not helpful with regard to note taking during an encounter; the 1995 guidelines are better suited for this purpose when first starting out."
D."We've found that carriers are relatively lenient with regard to what constitutes 'limited,' 'extended," and 'complete' exams—just use your best judgment."

Answer: A

Explanation:
As a general rule when assigning E/M codes, physicians are always encouraged to select the HIPAA guidelines that: 1) offer the best framework for justifying medical necessity and any associated note taking, 2) best characterize the nature of the encounter, and 3) best remunerate the doctor within the confines of the first two criteria. That said, anything that well documents the medical necessity of an encounter alone tends to be the best way to justify code selection. The second statement about "gray areas" is false because it is, in fact, on the contrary: it is well known that the very reason for the 1997 guideline release was because the 1995 guidelines were criticized as being too vague. The third statement is also switched: because the 1997 guidelines offer much more specific parameters for documenting an exam, they are actually much better suited to note taking—especially because it encourages the use of bulleted data (an organizational feature that the 1995 guidelines do not contain). Documentation—its structure, organization, and content—is often what makes or breaks coverage approval; so much so that different carriers may require data that fit within the construct of their own definitions. This makes the last statement totally false— carriers tend NOT to agree on what constitutes 'flimited," "extended," or "complete" exams. It is therefore imperative that the guidelines of each patient's carrier are taken into consideration before E/M codes and their corresponding documentation are submitted.

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