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# Healthcare NCICS

**NCCT National Insurance and Coding Specialist (NCICS)**

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## Question: 1

How many characters are CPT codes?

- A. 3.
- B. 5.
- C. 7.
- D. 9.

**Answer: B**

Explanation:

CPT, which stands for Current Procedural Terminology, is a comprehensive and standardized coding system used by healthcare professionals to document and report medical, surgical, and diagnostic services. The primary purpose of CPT codes is to facilitate uniform communication among providers, patients, and payers about the procedures performed during medical care.

The CPT code system is divided into three distinct categories: 1. **Category I**: These are the most frequently used codes and represent procedures and services that are consistent with contemporary medical practice and are widely performed. These codes are evidence-based and are generally accepted in the medical community. 2. **Category II**: These codes are optional and are used to track performance management and additional data for the purposes of enhancing the quality of care. Category II codes are not used for billing or reimbursement. 3. **Category III**: These codes are for emerging and experimental medical procedures and services. They allow for more detailed data collection about new and developing technologies and services.

All CPT codes consist of five alphanumeric characters. The first character is always a number, while the subsequent four characters can be either numbers or letters. The use of alphanumeric characters helps in providing a granular description of the services rendered. For example, the use of a letter in the code can indicate that the procedure was an alteration of a standard procedure.

Understanding the structure and use of CPT codes is crucial for healthcare billing and can significantly impact the reimbursement process. Accurate coding helps in ensuring that providers are properly compensated for the services they provide and helps in the analysis and management of healthcare data for policy development and resource allocation.

## Question: 2

What does SAN stand for?

- A. Saved Area Networks.
- B. Storage Adjusted Networks.
- C. Storage Area Networks.
- D. Storage Attention News.

**Answer: C**

Explanation:

The correct answer to the question "What does SAN stand for?" is "Storage Area Networks." SANs are high-speed, dedicated networks that provide access to consolidated block-level storage, making them an integral part of the data storage infrastructure, especially in enterprise environments.

In the context of electronic medical records, SANs are categorized under online storage options. Online storage is designed to allow immediate and simultaneous access to data by multiple users within a network. This is particularly beneficial in healthcare settings where quick access to patient records can be critical. SANs ensure that this data is not only readily accessible but also stored securely and efficiently.

The technology behind SANs involves pooling storage from multiple network storage devices so that it appears to be a single storage device to the server. This configuration enhances both the storage utilization and the data redundancy, which is crucial for disaster recovery scenarios. SANs typically use fiber channel or Ethernet protocols to provide high-speed connectivity.

Other examples of online storage technologies mentioned include Just A Bunch Of Disks (JBOD), which is a straightforward accumulation of hard disks without complex configurations, and Redundant Array of Inexpensive Disks (RAID), which is a method of storing the same data in different places on multiple hard disks to protect data in the case of a drive failure.

Understanding these storage options is essential for managing electronic medical records effectively, ensuring that they are not only secure but also accessible when needed. SANs, with their robust and scalable design, are particularly suited for handling large volumes of data such as those involved in medical records management.

### Question: 3

The NCCI coding manual is updated on what basis?

- A. A monthly basis.
- B. Annual basis.
- C. Every 2 years.
- D. Every 5 years.

**Answer: B**

Explanation:

\*The NCCI, or National Correct Coding Initiative, plays a crucial role in the healthcare industry, specifically in ensuring accurate and efficient processing of medical claims. This initiative is primarily focused on preventing improper coding practices that could lead to incorrect billing or fraudulent claims

submissions. By promoting standardized coding methodologies, the NCCI helps maintain the integrity and consistency of billing practices across the healthcare sector. \*

\*The coding guidelines and methodologies endorsed by the NCCI are compiled and disseminated through the NCCI coding manual. This manual is a critical resource for healthcare providers, billing professionals, and auditors who ensure that claims are compliant with accepted medical coding practices. \*

\*It is important to note that the NCCI coding manual is not static; it undergoes regular updates. The reason for these updates is to accommodate new medical procedures, changes in healthcare practices, and revisions in billing rules and regulations. To keep all stakeholders informed and compliant with the latest standards, the NCCI coding manual is updated on an annual basis. This yearly update cycle allows for the inclusion of new data, the adjustment of coding rules as necessary, and the clarification of existing codes and guidelines. \*

\*The annual updates ensure that the manual remains relevant and continues to be an authoritative resource for correct coding. These updates are typically aligned with changes in the fiscal year or calendar year, making it easier for organizations to implement new guidelines simultaneously with other annual updates in operational and financial processes. \*

\*In summary, the NCCI coding manual is an essential tool in the medical billing process, designed to ensure accuracy and prevent fraud. Its annual updates are critical in keeping it effective and relevant, aligning with the evolving landscape of healthcare services and regulations.

## Question: 4

Regarding OPPS, what status indicator denotes partial hospitalization?

- A. P.
- B. H.
- C. G/J.
- D. K.

**Answer: A**

Explanation:

In the context of the Outpatient Prospective Payment System (OPPS) used by Medicare, different services and items provided to patients are categorized using status indicators. These indicators are essential for determining the reimbursement method for each service or item. Each status indicator represents a specific category of payment, handling, or coverage rules.

The status indicator "P" specifically denotes partial hospitalization. Partial hospitalization is an outpatient service designed for patients who require intensive psychiatric care but do not need 24-hour supervision. This type of program provides therapeutic services during the day, which can include individual and group therapy, counseling, and sometimes medical services, allowing patients to return home at night.

Other status indicators, such as "H", "G/J", and "K", refer to different categories of services and items. For instance, "H" is assigned to pass-through devices which are typically new, innovative medical devices that are temporarily allowed additional payment to facilitate their introduction into the market. "G/J" covers certain drugs and biologicals, where "G" could be assigned to high-cost drugs and "J" to lower-cost drugs or biologicals. Lastly, "K" denotes non pass-through drugs and non-implantable biologicals,

including therapeutic radiopharmaceuticals, which are used for treatment in outpatient settings but do not benefit from the pass-through status.

Understanding these status indicators is crucial for healthcare providers as they navigate billing and reimbursement processes within the Medicare framework. It ensures that services are billed correctly and that facilities receive appropriate payment for the services they provide to Medicare beneficiaries.

### Question: 5

How are magnetic tapes with medical information on them properly destroyed?

- A. Computerized data.
- B. Laser discs.
- C. DVDs.
- D. Demagnetizing.

**Answer: D**

Explanation:

Magnetic tapes used in medical facilities to store sensitive information must be disposed of with particular care to ensure that the data is completely irretrievable. To achieve this, the recommended method of destruction is demagnetizing, also known as degaussing. Degaussing is a process that removes or disrupts the magnetic field on the tape, thereby erasing the data stored on it. This process is essential because merely physically destroying the tape (e.g., cutting or shredding) might not completely erase the data, potentially allowing it to be reconstructed or retrieved.

Demagnetizing involves using a specialized device called a degausser. This device generates a powerful magnetic field that disrupts the magnetic alignment of the particles on the tape, effectively erasing its contents. It is crucial that the degausser used is powerful enough to match the coercivity (resistance to demagnetization) of the magnetic media being erased. If the degausser is not sufficiently powerful, some data might remain on the tape, posing a security risk.

When demagnetizing magnetic tapes with medical information, it is important to follow a strict protocol. This protocol includes ensuring that the degaussing device is well-maintained and operating at full efficiency. Additionally, staff responsible for the destruction of these tapes must be trained to handle the equipment properly and understand the importance of confirming that all data has been securely erased. After degaussing, it is advisable to physically destroy the tapes as well, to prevent any chance of the tapes being reused or mishandled.

Compliance with federal, state, and local regulations is also a critical aspect of the destruction process. These regulations often stipulate how and when medical records should be destroyed, including specific requirements for magnetic tape destruction. These legal requirements are designed to protect patient privacy and ensure that all medical data handling practices comply with standards such as the Health Insurance Portability and Accountability Act (HIPAA) in the United States.

Moreover, it is essential that a record of the destruction process is maintained. This documentation should include details such as the date of destruction, the method used, and the personnel involved. This record helps in providing an audit trail and is necessary for compliance should there be any legal inquiries or investigations concerning the handling and disposal of medical information.

In summary, the proper destruction of magnetic tapes containing medical data through demagnetizing is a critical process that requires careful implementation of technical procedures, adherence to legal

standards, and thorough documentation. This ensures not only the protection of sensitive medical information but also compliance with legal and ethical standards.

### Question: 6

Medicare's NCD guidelines are designed to specify Medicare coverage on what level?

- A. On a local level.
- B. On hospital level only.
- C. On a national level.
- D. By patient determination.

**Answer: C**

Explanation:

Medicare's National Coverage Determinations (NCDs) are designed to specify Medicare coverage on a national level. This means that the coverage decisions made under NCDs apply uniformly across the entire United States, ensuring that all beneficiaries are subject to the same coverage rules regardless of where they live.

In contrast, Local Coverage Determinations (LCDs) are used to address coverage for items and services on a regional level. These determinations are made by Medicare Administrative Contractors (MACs) who oversee the administration of Medicare claims in specific geographic areas. LCDs take into account local medical practices and the availability of services in the region.

The main purpose of NCDs is to provide a clear and consistent framework for coverage across the national Medicare system, thereby promoting fairness and uniformity in the services available to all Medicare beneficiaries. This national level policy helps to prevent discrepancies in Medicare coverage that could otherwise occur due to regional differences in medical practices and opinions.

In summary, while LCDs allow for some regional discretion based on local healthcare environments, NCDs ensure that essential medical services and products are uniformly covered across the country under Medicare. This system of national determinations supports equitable health care access for all Medicare beneficiaries, regardless of their geographic location.

### Question: 7

What is the correct ICD-10-CM code for other bacterial foodborne intoxications, not elsewhere classified?

- A. A04.
- B. A05.
- C. A06.
- D. A07.

**Answer: B**

Explanation:

The correct ICD-10-CM code for other bacterial foodborne intoxications, not elsewhere classified, is A05.

ICD-10-CM stands for the International Classification of Diseases, Tenth Revision, Clinical Modification. This system is used in healthcare settings for the coding and classification of diagnoses and is a critical element for data management, billing, and record-keeping. Each code is alphanumerically structured to represent a specific medical diagnosis.

The codes within the range of A00 to A09 are designated for intestinal infectious diseases. Each of these codes specifies a particular type of infection primarily affecting the gastrointestinal tract. Here's a brief overview of the codes listed in your Cholera, caused by specific strains of the bacterium *Vibrio cholerae*.

- A01: Typhoid and paratyphoid fevers, systemic illnesses caused by the bacteria *Salmonella typhi* and *Salmonella paratyphi*. - A02: Other salmonella infections, which can cause conditions ranging from localized enteritis to systemic diseases. - A03: Shigellosis, an infection caused by *Shigella* bacteria, leading to diarrhea and other severe gastrointestinal symptoms. - A04: Other bacterial intestinal infections, which cover infections excluding those specifically classified under other headings. - A05: Other bacterial foodborne intoxications, not elsewhere classified, which includes bacterial infections resulting from consuming contaminated food, not covered by more specific categories. - A06:

Amebiasis an intestinal illness caused by the protozoan *Entamoeba histolytica*

a. - A07: Other protozoal intestinal diseases, which include various protozoan infections affecting the intestines except amebiasis. - A08: Viral and other specified intestinal infections, a category for viral illnesses and other specified agents not classified elsewhere. - A09: Infectious gastroenteritis and colitis, unspecified, typically used when the specific agent or type of gastroenteritis or colitis is not specified.

Therefore, for any case of bacterial foodborne intoxication that doesn't fall under more specific categories previously defined by A00-A04, the appropriate code to use is A05. This ensures accurate documentation and appropriate medical billing for the services provided.

## Question: 8

Refusing to participate in unethical coding is what Standard in AHIMA's Code of Ethics?

- A. 2.
- B. 4.
- C. 10.
- D. 11.

**Answer: B**

Explanation:

HIM professionals are obligated to show actions that reflect ethical principles, ethical guidelines, and ethical values. The American Health Management Association (AHIMA) created a Code of Ethics to be used by AHIMA members and CCHIIM credentialed HIM professionals. The code has 11 different standards. They are: apply accurate, consistent, and complete coding practices for high quality medical data, report all healthcare elements (diagnosis codes, procedure codes, present on admission indicator, discharge status) that are required for reporting purposes, assign and report only codes that are clear and supported by the medical record documentation, query provider for clarification, refuse to participate in coding practices meant to increase payments, skew data, or qualify for insurance policy coverage, facilitate interdisciplinary collaboration in situation that support proper coding practices, advance coding knowledge with education, refuse to participate in unethical coding, procedures, or abstraction practices, protect the confidentiality of medical records at all times, and demonstrate behavior that shows integrity.

## Question: 9

The CAC software has finished scanning a patient's chart and wants to code for pneumonia

a. Upon a manual check, which of the following should also be included in the chart to confirm the diagnosis?

- A. Simple blood tests.
- B. Symptoms such as cough or sneezing
- C. A chest x-ray ordered to detect for pneumonia.
- D. A report of the patient starting an antibiotic.

**Answer: C**

Explanation:

The question is centered around validating the diagnosis of pneumonia in a patient's chart, particularly after a Computer Assisted Coding (CAC) software has scanned the chart. The key to confirming the diagnosis lies not only in the presence of clinical symptoms but also in specific diagnostic tests ordered by the physician. Here's an expanded explanation of the question and its context:

Computer Assisted Coding (CAC) systems are increasingly utilized in the healthcare industry to streamline the coding process. These systems scan patient records and use algorithms to suggest diagnostic and procedural codes based on the documentation present in the chart. While this technology can enhance efficiency and accuracy, it is not infallible. Therefore, manual verification by a coder or healthcare professional remains a critical step to ensure accuracy in coding, which is vital for appropriate billing and patient care management.

For the diagnosis of pneumonia, which is a respiratory condition characterized by the inflammation of the lungs typically caused by an infection, specific clinical documentation is crucial. Pneumonia can manifest with a variety of symptoms such as cough, fever, chills, and difficulty breathing. These symptoms should be clearly documented in the patient's medical records. However, symptoms alone may not be sufficient for a definitive diagnosis of pneumonia.

The question specifically points to the necessity of including certain types of diagnostic tests in the chart to confirm the diagnosis. Among the most definitive tests for pneumonia is a chest x-ray. This imaging test allows physicians to visualize the lungs and check for the presence of any abnormal opacities or infiltrates that indicate an infection, which are characteristic of pneumonia. A chest x-ray not only supports the diagnosis but is often used to assess the severity and exact location of the lung infection.

Other diagnostic tests that might be mentioned in patient charts and are critical in diagnosing pneumonia include blood cultures, which can help identify the organism causing the infection, and complete blood counts (CBCs), which can show an elevated white blood cell count indicative of infection. However, the question highlights the importance of a chest x-ray as a primary piece of evidence needed to confirm pneumonia following the CAC's coding suggestion.

In summary, while CAC software plays a significant role in the preliminary identification of potential diagnoses like pneumonia, the inclusion of a chest x-ray result in the patient's medical record is essential for validating this diagnosis. This ensures that coding is accurate, which subsequently impacts clinical decision-making, billing, and the overall management of the patient. Manual checks by coders are indispensable in this process as they bridge the gap between technology-generated data and real-world clinical assessment.



## Question: 10

If a covered entity receives a notification of violation of HIPAA standards, the covered entity has how many days to respond to reduce the penalty?

- A. 15.
- B. 30.
- C. 60.
- D. 120.

**Answer: B**

Explanation:

The correct response to the question regarding the timeframe for a covered entity to respond to a notification of a HIPAA violation in order to potentially reduce the penalty is **\*\*30 days\*\***. This is outlined in the explanation of civil money penalties for HIPAA non-compliance, which hinge on several factors including the entity's awareness of the compliance failure, the timing of the violation, and if the non-compliance was due to willful neglect.

Under HIPAA regulations, penalties can vary significantly, but certain situations allow for the mitigation or even avoidance of these penalties. Notably, if the Department of Justice (DOJ) has already imposed a criminal penalty for the failure to comply, or if the non-compliance, which was not a result of willful neglect, is corrected within a 30-day period from the date of notification, penalties may not be enforced. This corrective window is critical as it provides an opportunity for the entity to address and rectify the compliance issues without incurring further penalties.

Moreover, once a covered entity receives a notification of a penalty, it has a 30-day period to submit evidence or arguments to reduce the proposed penalty. This period is essential for the covered entity to gather necessary documentation, conduct internal audits, or take corrective actions that demonstrate compliance or mitigating circumstances which could influence the reduction of the penalty.

In summary, the 30-day response period is a crucial timeframe for covered entities to react to notifications of HIPAA violations. This allows entities to potentially reduce penalties by demonstrating either corrected compliance measures or presenting mitigating factors to regulatory bodies.



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