Medical Technology

CCS
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Question: 1

Which of the following was adopted by the federal government as the standard for inpatient healthcare data?

A. POA
B. OPPS
C. UHDDS
D. RBRVS

Answer: C

Explanation:
The Uniform Hospital Discharge Data Set (UHDDS) was adopted by the federal government as the standard for collecting healthcare data. By providing a list of data elements that are required when submitting a claim, the quality and efficiency of healthcare services being rendered can more easily be evaluated and the costs for which those services should be paid can be standardized. Present on admission (POA) is a type of guideline used to differentiate illnesses and/or injuries that a patient presented with upon their admission from those that developed later during their inpatient stay. The resource-based relative value scale (RBRVS) is a payment system calculated by factoring the cost of the physician's work, practice expense, professional liability insurance, and geographical location. The outpatient prospective payment system (OPPS) is a payment system designed to promote the predictability of payment, promote consistency, and encourage the quality of care given to Medicare patients receiving outpatient services in a hospital setting.

Question: 2

How is data for the UHDDS collected?

A. By submitting statistical data through CMS.gov
B. By reviewing inpatient claim submissions
C. Through annual audits
D. By submitting statistical data to the Department of Health and Human Services

Answer: B

Explanation:
All of the data required by UHDDS that should be documented in an individual's medical record is reviewed and reported by the coding staff and matched with the appropriate ICD-IO-CM and CPT codes. Each CPT code should have a cost associated with it, thus creating a total charge for the services provided. All of this information is then entered on an insurance claim form and is submitted to the healthcare payer for evaluation and review. This information is next collected by UHDDS to evaluate the

quality and efficiency of healthcare services being rendered and to standardize the cost for which those services should be charged and paid.

Question: 3

A patient with a history of type 1 diabetes is admitted to the hospital and later develops hyperglycemia. What ICD-IO-CM code(s) should the physician report if the POA indicator is

A. ElO.69, R73.9
B. ElO.9, R73.9
C. ElO.65
D. R73.9

Answer: C

Explanation:
When an illness or disease is POA, but a manifestation or complication of the disease presents itself during an inpatient stay, the combination ICD-IO-CM code should always be reported. POA guidelines stipulate that if both conditions in the combination code are POA, the POA indicator should be Y. On the other hand, if the patient only presents with the one disease, in this case the type 1 diabetes mellitus, and later develops an associated complication, the POA indicator should be N.

Question: 4

Which of the following is NOT a violation of HIPAA?

A. An encrypted laptop is stolen from a physician's vehicle.
B. A hospital with a multilayered cybersecurity defense experiences a data breach by a cybercriminal.
C. An office fails to perform a risk assessment of electronic health information.
D. An employee drops off patient records on a physician's porch.

Answer: B

Explanation:
HIPAA is in place to reduce the associated risk of a potential violation or breach. Although a breach has occurred in this scenario, HIPAA was not violated because the hospital took appropriate preventative measures. High-risk behaviors, such as leaving a laptop in an unattended vehicle or leaving medical records outside, allow opportunities for an unauthorized individual to access protected health information. Finally, a medical practice is required by HIPAA to perform a risk analysis of electronic health information and rectify any issues immediately.

Question: 5

Which service would NOT be covered under Medicare Part A?

A. Inpatient hospital care
B. Home health service
C. Observation hospital care
D. Hospice care

Answer: C

Explanation:
Observation hospital care is provided to patients who are not sick enough to be admitted. Therefore, this type of care is considered outpatient and is covered under Medicare Part B.

Question: 6

Assign the appropriate CPT code(s) for the following ultrasound report: Fetal Biometry

BPD	92.9 mm
OFD	116.5 mm
HC	331.7 mm
AC	319.5 mm
Femur	67.3 mm
EFW	2,810 g
AFI	25.2 cm

Biophysical Profile (BPP): 8/8

2	Fetal breathing movements
2	Gross body movements
2	Fetal tone
2	Amniotic fluid volume

Nonstress test (NST) 11:12 am-11:47 am
The BPP and NST are reassuring, as described above. The biometry is consistent with 33 weeks 5 days of gestation. Follow up for weekly testing and serial growth ultrasounds every 3 to 4 weeks.

A. 76815, 76816, 76819, 59025
B. 76815, 76816, 76818
C. 76816, 76819, 59025
D. 76818, 76816

Answer: D

Explanation:
The documentation supports CPT code 76816 (Ultrasound, pregnant uterus, real time with image documentation, follow up) and CPT code 76818 (Fetal biophysical profile; with non-stress testing). Although CPT code 76815 meets the documentation requirements (requiring only one of the following elements: fetal heartbeat, placental location, fetal position, and qualitative amniotic fluid volume), it is considered inclusive to CPT code 76816 and should not be billed as an additional procedure. Additionally, although CPT codes 59025 (Fetal nonstress test) and 76819 (Fetal biophysical profile) were performed, reporting them separately is considered unbundling. Finally, to ensure proper payment, sequence CPT codes in order of highest relative value units to lowest. In this scenario, CPT code 76818 has a higher reimbursement value than 76816 and should be listed first.

Question: 7

Many payers reduce reimbursement by up to 50% for procedures with which of the following modifiers?

A. 51
B. 59
C. 53
D. 58

Answer: A

Explanation:
Modifier 51 is used when multiple procedures (excluding E/M and rehabilitation services) are performed during the same session by the same provider. Keywords like "a different procedure" or "separate from" are indicators of when modifier 51 should be appended to the secondary procedure code. Coders should be aware that when reporting secondary and tertiary procedures with modifier 51, a multiple procedure payment reduction may be applied. This means that the primary procedure will be reimbursed at 100% of the fee schedule, whereas all other procedures will be reimbursed at 25%-50% of the fee schedule.

Question: 8

In which scenario should POA indicator W be reported?

A. A patient with a history of chronic obstructive pulmonary disease develops a flare-up after she is admitted.
B. A breast abscess is discovered when an obstetric patient attempts to breastfeed after the delivery of her child.

C. A patient is admitted with suspected autoimmune thyroiditis.
D. A laceration occurs during the delivery of a fetus.

Answer: B

Explanation:
POA indicator W is used to report an illness or condition that clinically cannot be determined whether it was POA. An incidental finding during an inpatient stay, such as a breast abscess, should be reported with POA indicator W because it would be difficult to determine when the condition was established. An exacerbation of a chronic condition or injury sustained during a hospital stay would be reported with POA indicator N because these were not present at the time of admission. Finally, any suspected, possible, or probable diagnoses documented on admission are considered present and are reported with POA indicator Y.

Question: 9

A gastroenterologist submits an out-of-network claim for a member of the following plan, in which the patient has met his deductible. The allowable amount of the claim is $170. What is the member responsible for paying?
Healthy Humans Plus Plan

Primary Care	Covered at 100%
Specialist Care	Subject to Deductible
Hospital Care	Subject to Deductible
Copay	$0
In-Network Deductible	$1,600, Covered at 75%
Out-of-Network Deductible	$2,375, Covered at 55%

A. $127.50
B. $76.50
C. $93.50
D. $42.50

Answer: B

Explanation:
The out-of-network deductible for the member is $2,375. Because this amount has been met, the insurance plan will pay 55% of the allowable amount and places the remaining 45% on the member as their responsibility. Therefore, the member is responsible for 45% of $170, or $76.50.

Question: 10

Beginning January 1, 2021, which of the following is no longer a required component to level an E/M?

A. Examination
B. MDM
C. Face-to-face time
D. Non-face-to-face time

Answer: A

Explanation:
The American Medical Association (AMA) has outlined new office and other outpatient E/M coding guidelines that are effective January 1, 2021. Up to this point, the three components required to level a new and established office and other outpatient E/M code were history, examination, and MDM. However, these new guidelines stipulate that although a medically appropriate history and examination should be obtained, these are no longer the driving force to level an E/M. On the other hand, code selection will now be based on the total time spent by the provider, including face-to-face and non-face-to-face time, as well as the severity of the MDM.

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