Medical Technology

AHIMA-RHIT

American Health Information Management Association Registered Health Information Technician Exam

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Question: 1

Based on the General Equivalence Mapping below, what conclusion can be drawn about mapping the ICD-9-CM codes E850.0 and E851 to ICD-10-CM codes?

ICD-9-CM	Description	ICD-10-CM	Description	Approx.	No map
E850.0	Accidental poisoning by heroin			0	1
E851	Accidental poisoning by barbiturates			0	1

A. These codes can each be approximately matched to one ICD-IO-CM code.
B. These codes cannot be mapped to ICD-IO-CM codes.
C. Each code can be directly matched to one ICD-IO-CM code.
D. Data are insufficient to make conclusions about mapping of the codes.

Answer: B

Explanation:

ICD-9-CM	Description	ICD-10-CM	Description	Approx.	No map
E850.0	Accidental poisoning by heroin			0	1
E851	Accidental poisoning by barbiturates			0	1

Based on the General Equivalence Mapping above, the ICD-9-CM codes E850.0 (accidental poisoning by heroin) and E851 (accidental poisoning by barbiturates) cannot be mapped to ICD-10-CM codes, as there is no direct or approximate equivalent.

Question: 2

The following information was collected from a recent HIM work sample for the month of May. There were 2,040 total claims and 1,746 clean claims submitted.

	Clean Claims				Total
Coder	Week 1	Week 2	Week 3	Week 4	Claims
1	124	182	101	181	823
2	170	133	174	104	611
3	200	115	163	99	606

Based on this information, which medical coder had the highest clean claim rate for the month?

A. Coder 1

B. Coder 2
C. Coder 3
D. Insufficient information to calculate the clean claim rate

Answer: C

Explanation:
Refer to the following calculations to determine the clean claim rate for each coder:

Coder	Clean Claims	Clean Claim Rate
1	124 + 182 + 101 + 181 = 588	588 ÷ 823 × 100 = 71.45%
2	170 + 133 + 174 + 104 = 581	581 ÷ 611 × 100 = 95.09%
3	200 + 115 + 163 + 99 = 577	577 ÷ 606 × 100 = 95.21%

Question: 3

Which one of the following is used to maintain an organization's master patient index (MPI)?

A. Data visualization tool
B. Remote monitoring device
C. Referral trackers
D. Data quality manager

Answer: D

Explanation:
A data quality manager tool is used to stringently monitor the master patient index (MPI) by allowing users to look at patient demographic data. This tool enables users to see how the MPI identifies potential and definite matches between patient records. The data quality manager tool can make corrections and help resolve duplicates, overlays, or overlaps.

Question: 4

An HIM professional is responsible for the destruction of medical records stored within the EHR system. Which one of the following terms best represents the activity that the worker will take to destroy these records?

A. Expunging
B. Deleting
C. Erasing
D. Degaussing

Answer: D

Explanation:
The best way to destroy health records in electronic form is degaussing, or demagnetizing, the

medium on which the documents reside. This HIPAA-compliant method is a fast easy, and cost-effective way to erase large volumes of data. The degausser device uses a strong magnetic field that renders any stored data unreadable. Removing data from hard drives by software deletion methods can take hours and is not reliable because some data may still remain. The degaussing process only takes a few seconds and ensures that all of the data (even encrypted data) are destroyed.

Question: 5

Which one of the following billing issues is common with telehealth services?

A. Incorrect modifiers
B. Lack of medical necessity
C. Missing authentication
D. Duplicate medical records

Answer: A

Explanation:
With the increased use of telehealth, many organizations have found that these services can complicate their billing processes. Reporting incorrect modifiers for these services often results in claim denials or delays in payment Modifiers 93 (synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system) and 95 (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system) are applied to telehealth services. Other telehealth modifiers include FQ, GQ, and GT.

Question: 6

According to HIPAA, how long should medical records be retained?

A. 3 years
B. 6 years
C. 10 years
D. 20 years

Answer: B

Explanation:
HIPAA guidelines require covered entities to retain medical records for six years from the date when they last were in effect or from the date of their creation (whichever is later). Each state determines how long medical records must be retained. Some states go by the HIPAA retention period, whereas others are more stringent, requiring retention of these records for 10 years.

Question: 7

A document is undergoing its fifth revision. Which one of the following is the most appropriate way of listing the revision number on the updated document?

A. 1*5
B. 1.5
C. 1-5
D. 5th

Answer: B

Explanation:
When a document changes, each revision must be listed on the document. The draft versions should increase by 0.1. For example, the document in the question underwent five revisions: therefore, the most appropriate revision number would be 1.5. Once the revisions are complete, the document that is deemed final shall increase by 1.0. Therefore, draft 1.5 would become a final document of 2.0 when finished.

Question: 8

As a clinical documentation specialist reviews a medical record, she notices an inconsistency. The provider mentions mesenteric ischemia twice in the medical record documentation. However, the final diagnosis is listed as ischemic colitis in the patient's discharge report. How should the CDI specialist resolve this issue?

A. Select the diagnosis that appears more often in the documentation.
B. Query the physician and resolve the discrepancy by having the physician confirm one diagnosis.
C. Ask the nurse who took care of the patient which one is correct.
D. Closely read the documentation to determine which code is most accurately reflected in the record.

Answer: B

Explanation:
Two similar-sounding diagnoses may end up in clinical documentation, which can cause adverse outcomes in patient care. These occurrences can be due to diseases that affect the same part of the body or diagnoses that look alike or share identical words. However, these conditions may have different implications, etiologies, prognoses, and treatments. In this scenario, the CDI specialist should query the physician to ensure that the correct diagnosis is selected. This clarification is crucial because mesenteric ischemia almost always requires surgery, whereas ischemic colitis can be treated through improved hemodynamics.

Question: 9

Tom has a doctor's appointment today and was asked to bring in copies of his recent medical records for this visit. He forgot to request his records, but he has a friend who works in the HIM department. Tom calls and asks his friend to print these documents so he can bring them to today's appointment. What should the HIM worker do?

A. If the worker has access to Tom's medical records, they are permitted to print these documents for him.
B. The worker does not have the right to print these records but can ask their manager to print them.
C. The worker must have Tom first sign an ROI authorization form.
D. Because the HIM worker received verbal consent from Tom, the worker can fax these records to Tom's doctors office.

Answer: C

Explanation:
Even though Tom gave his friend verbal consent to access and print his medical records, his friend the HIM worker must still have Tom sign an ROI authorization form. Unless the worker has a legitimate reason (i.e„ job-related) to access these records, releasing them without obtaining an ROI authorization form would be considered a HIPAA violation.

Question: 10

Travis is a 57-year-old Medicaid recipient who requires a level of care typically provided at a nursing facility. Which health plan would he likely be eligible to enroll in given these circumstances?

A. IHS
B. CHIP
C. CHAMPVA
D. PACE

Answer: D

Explanation:
The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare and Medicaid program that provides an alternative to institutional care for individuals aged 55 or older who can have their health needs met in the community instead of going to a nursing facility. This program is only available in some states, and most participants are dually eligible for Medicare and Medicaid. To be eligible for PACE, you must be at least 55 years old, live in the service area ofa PACE organization, be able to safely live in the community with help from PACE, and require nursing home-level care (certified at the state level).

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