Medical Technology

CCA-Examination

Certified Coding Associate Examination

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Question: 1

The AHIMA Standards of Ethical Coding encourage which of the following actions?

A. Altering information within a health record to match the reported CPT code
B. Assigning diagnosis codes reported on a previous encounter for a current encounter
C. Taking measures to expose the negligent conduct of coworkers
D. Using a different encounter within a patient's health record to generate a physician query

Answer: C

Explanation:
The AHIMA Standards of Ethical Coding is a set of guidelines and expectations set forth to ensure that moral decision-making, conduct, and activities are performed within the healthcare setting. This includes taking immediate action to discourage, prevent, expose, and correct unethical conduct if observed in the workplace. These guidelines apply not only to coding professionals, but also to auditors, educators, students, managers, and clinical documentation improvement professionals. All employees must work together to create a workplace environment that fosters honesty and adherence to local laws and government regulations.

Question: 2

If a patient is admitted to the hospital with two conditions that both meet the criteria of principal diagnosis, which condition should be reported first on the claim?

A. The condition that has the greater chance of mortality
B. The condition that the patient complains about the most
C. The condition with the higher reimbursement rate
D. Either condition

Answer: D

Explanation:
The Uniform Hospital Discharge Data Set (UHDDS) defines a principal diagnosis as the condition or illness that is most responsible for the reason of admission into the hospital for care. When a patient is admitted to the hospital with two conditions that equally meet the criteria of principal diagnosis, either condition may be sequenced first, unless the ICD-IO guidelines state otherwise for the specific conditions being reported.

Question: 3

Which element is missing in the following documented history of present illness?
Patient is seen in the ER complaining of sharp abdominal pains that began last night after eating at a new restaurant.

A. Timing
B. Duration
C. Context
D. Quality

Answer: A

Explanation:
The elements included in a history of present illness are location (i.e., where the problem occurs), timing (i.e., how often it occurs), modifying factors (i.e., what has been done to help the problem), severity (being rated on a scale of 1-10), duration (i.e., when the problem began), associated signs and/or symptoms (i.e., anything else that is unusual for the patient), quality (i.e., the adjectives used to describe the problem), and context (i.e., what activity was being done when the problem began). In this scenario, how often the abdominal pain is occurring (e.g., constant or it comes and goes) is not documented. Although outpatient services no longer consider the history of present illness when determining the level of service, it is still a required component during level selection for inpatient services.

Question: 4

A 59-year-old male is admitted with second- and third-degree burns to the face and third-degree burns to the chest after catching on fire while grilling. He also has extensive scarring on his right forearm due to a second-degree burn from several years ago. How should this be coded?

A. T20.30XA, T21.31XA, X03.OXXA, L90.5, T22.219S, Y93.G2
B. T20.30XA, T21.31XA, X03.OXXA, Z87.828, Y93.G2
C. T20.30XA, T20.20XA, T21.31XA, X03.OXXA, Z87.828, Y93.G2
D. T20.30XA, T20.20XA, T21.31XA, X03.OXXA, L90.5, T22.219S, Y93.G2

Answer: A

Explanation:
Burn codes are sequenced in order of most severe (third-degree burns) to least severe (first- degree burns). Additionally, when multiple burns are being treated on the same anatomical location and the same side of the body, only the burn that reflects the highest degree of severity should be reported. In this scenario, only the third-degree burns to the face (T 20.30XA) and the third-degree burns to the chest (T 21.31XA) are coded, followed by the agent (X03.0XXA), and the activity the patient was involved in when the injury occurred (Y93.G2). Because the physician documented the existence of a sequela of a previous burn, it should be coded as such (L90.5, T 22.219S), rather than a history of healed trauma.

Question: 5

Which of the following is a commonly used encoder?

A. Allscripts
B. Cerner
C. Epic
D. 3M

Answer: D

Explanation:
During the 1990s, encoding software was released that allowed medical coders to shift from searching through manuals to accessing just one portal to locate any HCPCS Level II, ICD-IO, and CPT code. Encoding software not only serves as a tool for coding and classification, but it also provides guidance on reimbursement methodologies, clinical documentation integrity, and quality. Some of the most commonly used encoders include Encoder Pro, 3M, and AHIMA VLab.

Question: 6

Which of the following would be flagged in a qualitative analysis of a medical record?

A. Missing attestation
B. Unsigned documentation
C. Copying and pasting
D. Incomplete family history

Answer: C

Explanation:
Duplication or repetition in documentation, otherwise known as cloning or copying and pasting, would be flagged in a qualitative analysis of a medical record. Although some demographic information may be brought forward from an existing note, the actual history, evaluation, and plan of treatment for the patient should be originated on the date the patient was actually seen. When these aspects of the note are copied and pasted from previous dates of service, the actual author of the note and their thoughts on the patient's condition become ambiguous, which may adversely affect patient care.

Question: 7

A patient is seen in the emergency room complaining of chest pain. The physician performs a 12-lead ECG. How should this be coded?

A. 99282-59, 93005
B. 99282, 93005-59
C. 99282-25, 93005
D. 99282, 93005-25

Answer: C

Explanation:
Modifier 25 is reported to indicate that an E/M service is separately identifiable to a procedure or other service done by the same physician on the same date and may be appended only to office or outpatient services (99201-99215), emergency department services (99281-99285), critical care services (99291), and office or other outpatient consultations (99241-99245). In this scenario, an E/M is performed (99282), in addition to a 12-lead ECG (93005). Modifier 59 is used to indicate that two independent, non-E/M services are being performed on the same day.

Question: 8

Which of the following is NOT considered a valid exception to information blocking?

A. Content
B. Fees
C. Security
D. Time

Answer: D

Explanation:
There are eight exceptions to information blocking, which may prevent or delay a healthcare entity from fulfilling a request to exchange, use, or access PHI:
• Preventing harm
• Privacy
• Security
• Infeasibility
• Health information technology performance
• Content and manner
• Fees
• Licensing

Question: 9

Which of the following terms represents all of the HCCs submitted for a member in an entire calendar year?

A. Risk adjustment performance
B. Financial risk management
C. Risk adjustment factor score
D. Inherent risk measurement

Answer: C

Explanation:

All of the HCCs submitted for a member in an entire calendar year cumulate to a risk adjustment factor (RAF) score. For a new member enrolled in a Medicare Advantage plan for fewer than 12 months, the RAF score is calculated based on their age, sex, and current disabilities. An RAF score for a healthy, adult patient is 1.0, and the score increases when the patient sustains a severe injury and/or chronic illness. Therefore, accurate coding for patients with Medicare Advantage plans is imperative because overcoding or falsely inflating diagnoses will result in higher government funding, whereas under- or incomplete coding may result in not enough funding.

Question: 10

Why is it important for physicians to adhere to the same coding rules and conventions found in the CPT, HCPCS, and ICD-IO manuals?

A. In order to receive optimal reimbursement rates
B. So an insurance company can receive, process, and issue payment within a IS-day time frame
C. To obtain consistent data that will assist in tracking public health and to measure quality and safety practices
D. To ensure that patients receive the same high standard of care despite the location it is rendered in

Answer: C

Explanation:
It is important for physicians to adhere to the same coding rules and conventions when assigning CP T, HCPCS, and ICD-IO codes for the purpose of tracking public health data and for the federal government to measure quality and safety practices. These data are collected for present and future use. However, in order for them to be reliable and accurate, the data must be consistent: The same coding rules and conventions need to be followed by everyone. Additionally, when physicians and coding professionals allow reimbursement to inappropriately influence code assignment, they put themselves and their facilities at risk for audits, fines, and healthcare exclusions.

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