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CCA Prep

6 CCA Domains

- Domain I – Clinical Classification Systems (32%)
- Domain II – Reimbursement Methodologies (23%)
- Domain III – Health Record and Data Content (15%)
- Domain IV – Compliance (14%)
- Domain V – Information Technologies (8%)
- Domain VI – Confidentiality & Privacy (8%)

HIMage CONSULTING

Which of the following is the correct ICD-10-CM code for type 2 diabetes mellitus with diabetic nephropathy?

a) E10.21
b) E11.21
c) N18.9
d) E13.21

(b) E11.21 – Type 2 diabetes with nephropathy is coded with **E11.21**. Type 1 diabetes would use **E10.21**.

- Which of the following is the correct ICD-10-CM code for type 2 diabetes mellitus with diabetic nephropathy?

a) E10.21
b) E11.21
c) N18.9
d) E13.21

- A patient is admitted for pneumonia due to COVID-19. What is the correct sequencing of ICD-10-CM codes?

a) J18.9, B97.29
b) B97.29, J18.9
c) U07.1, J12.89
d) J12.89, U07.1

(c) U07.1, J12.89 – The correct sequence is **U07.1** (COVID-19) **first**, followed by **J12.89** (pneumonia due to COVID-19).

- A patient is admitted for pneumonia due to COVID-19. What is the correct sequencing of ICD-10-CM codes?

a) J18.9, B97.29
b) B97.29, J18.9
c) U07.1, J12.89
d) J12.89, U07.1

Which of the following is a valid ICD-10-PCS root operation for a laparoscopic cholecystectomy?

a) Excision
b) Resection
c) Extraction
d) Bypass

(b) Resection – The **ICD-10-PCS root operation "Resection"** refers to the complete removal of a body part (e.g., gallbladder).

- Which of the following is a valid ICD-10-PCS root operation for a laparoscopic cholecystectomy?

a) Excision
b) Resection
c) Extraction
d) Bypass

- A patient underwent an open reduction with internal fixation (ORIF) of the right femur fracture. What is the correct ICD-10-PCS root operation?

a) Reposition
b) Repair
c) Replacement
d) Fusion

(a) Reposition – ORIF is the surgical correction of a **displaced fracture**, so the **root operation is "Reposition"** in ICD-10-PCS.

A patient underwent an open reduction with internal fixation (ORIF) of the right femur fracture. What is the correct ICD-10-PCS root operation?

a) Reposition
b) Repair
c) Replacement
d) Fusion

What is the purpose of a modifier in CPT coding?

a) To add additional reimbursement

b) To indicate a service was altered in some way

c) To replace an existing code

d) To provide medical necessity

(b) To indicate a service was altered in some way – Modifiers clarify changes in a procedure without changing the code itself.

What is the purpose of a modifier in CPT coding?

a) To add additional reimbursement

b) To indicate a service was altered in some way

c) To replace an existing code

d) To provide medical necessity

What ICD-10-CM code would be used for a patient with a history of myocardial infarction?

a) I21.9
b) I25.2
c) I50.9
d) Z86.74

(b) I25.2 – I25.2 is used for a **past myocardial infarction (history of heart attack)**.

What ICD-10-CM code would be used for a patient with a history of myocardial infarction?

a) I21.9
b) I25.2
c) I50.9
d) Z86.74

What is the purpose of an encoder in medical coding?

a) To verify insurance claims
b) To assist coders in assigning correct codes
c) To create documentation for billing
d) To calculate reimbursement amounts

(b) To assist coders in assigning correct codes – Encoders help automate and ensure accuracy in medical coding.

What is the purpose of an encoder in medical coding?

a) To verify insurance claims

b) To assist coders in assigning correct codes

c) To create documentation for billing

d) To calculate reimbursement amounts

Which term describes a coding system that classifies diseases and procedures for statistical purposes?

a) Clinical Terminology
b) Nomenclature
c) Classification System
d) Data Mapping

(c) Classification System – ICD-10-CM is an **example of a classification system**, used for grouping diseases.

Which term describes a coding system that classifies diseases and procedures for statistical purposes?

a) Clinical Terminology
b) Nomenclature
c) Classification System
d) Data Mapping

What is the term for an error in coding where an incorrect diagnosis code is assigned?

a) Upcoding
b) Under-coding
c) Mis-coding
d) Unbundling

(c) Mis-coding – Assigning the **wrong diagnosis or procedure code** is **mis-coding**, which can lead to claim denials.

What is the term for an error in coding where an incorrect diagnosis code is assigned?

a) Upcoding
b) Under-coding
c) Mis-coding
d) Unbundling

- The process of converting diagnoses and procedures into numerical codes is called:
  a) Data abstraction
  b) Clinical documentation improvement
  c) Medical coding
  d) Revenue cycle management

(c) Medical coding – The **translation of medical services into numerical codes** is called medical coding.

- The process of converting diagnoses and procedures into numerical codes is called:
  a) Data abstraction
  b) Clinical documentation improvement
  c) Medical coding
  d) Revenue cycle management

The Uniform Hospital Discharge Data Set (UHDDS) is used for what type of healthcare facility?

a) Physician offices
b) Long-term care
c) Outpatient clinics
d) Acute care hospitals

(d) Acute care hospitals – UHDDS applies to **inpatient (acute care) settings** to standardize data collection.

The Uniform Hospital Discharge Data Set (UHDDS) is used for what type of healthcare facility?

a) Physician offices
b) Long-term care
c) Outpatient clinics
d) Acute care hospitals

What is the primary purpose of the MS-DRG system?
a) To standardize medical terminology
b) To classify inpatient hospital cases for reimbursement
c) To track outpatient visits
d) To identify medical necessity

(b) To classify inpatient hospital cases for reimbursement – MS-DRG groups inpatient cases for Medicare reimbursement.

What is the primary purpose of the MS-DRG system?
a) To standardize medical terminology
b) To classify inpatient hospital cases for reimbursement
c) To track outpatient visits
d) To identify medical necessity

The Outpatient Prospective Payment System (OPPS) is primarily used by:

a) Skilled nursing facilities

b) Physician offices

c) Outpatient hospitals

d) Home health agencies

(c) Outpatient hospitals – OPPS is used to **calculate Medicare payments for outpatient services.**

The Outpatient Prospective Payment System (OPPS) is primarily used by:

a) Skilled nursing facilities

b) Physician offices

c) Outpatient hospitals

d) Home health agencies

- Which type of insurance plan typically requires a referral from a primary care physician before seeing a specialist?
  a) PPO
  b) HMO
  c) Medicare Part D
  d) Medicaid

16. **(b) HMO** – HMOs **require referrals from a primary care physician** before seeing specialists.

- Which type of insurance plan typically requires a referral from a primary care physician before seeing a specialist?
  a) PPO
  b) HMO
  c) Medicare Part D
  d) Medicaid

- What form is used to bill Medicare Part B services?
  a) UB-04
  b) CMS-1500
  c) CMS-1450
  d) HCFA-1400

16. **(b) CMS-1500** – The **CMS-1500 form** is used for **billing outpatient physician services**.

- What form is used to bill Medicare Part B services?
  a) UB-04
  b) CMS-1500
  c) CMS-1450
  d) HCFA-1400

- In the Revenue Cycle Management (RCM) process, what is the first step?
  a) Claim submission
  b) Pre-registration
  c) Coding
  d) Payment posting

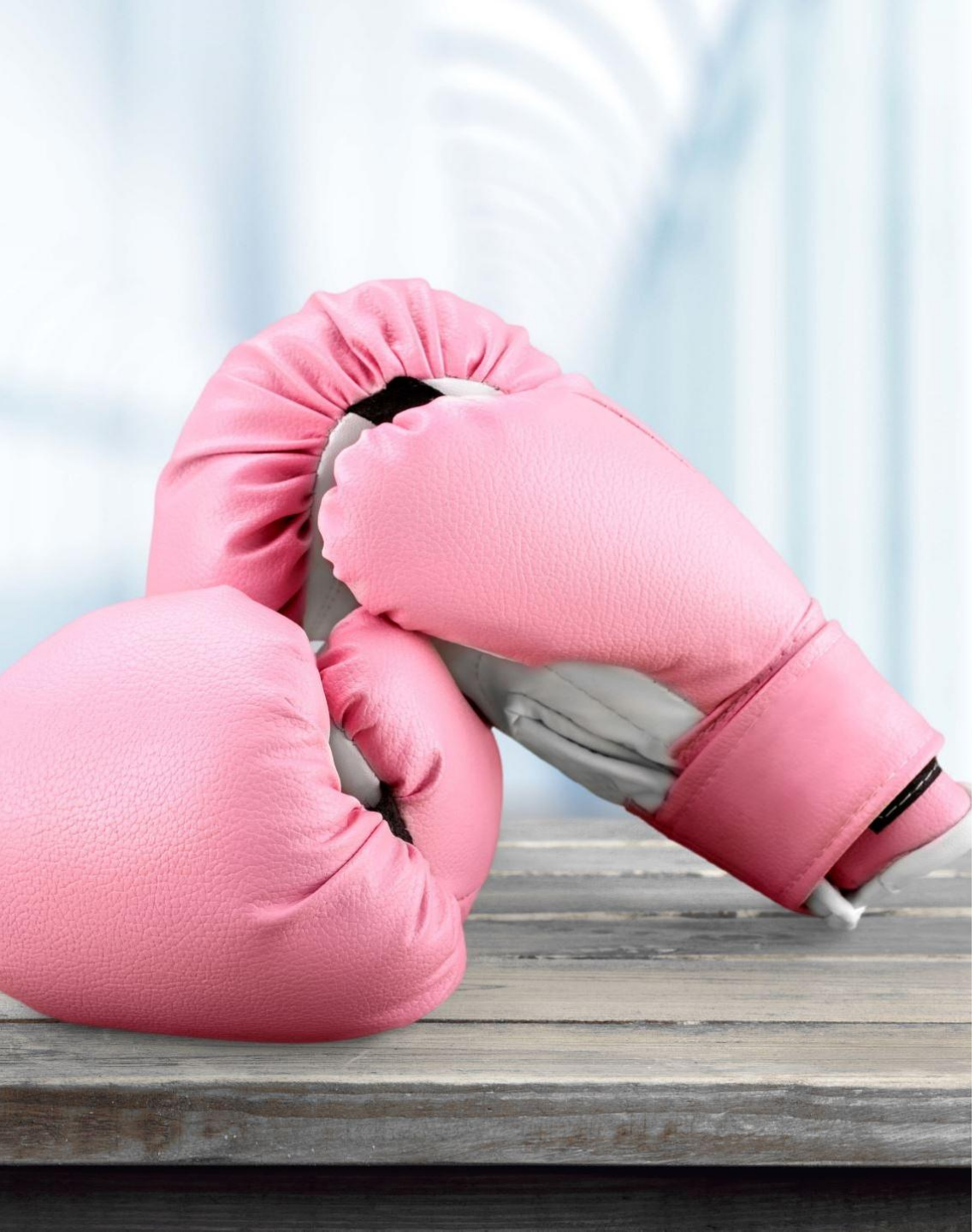
16. **(b) Pre-registration** – The **first step in revenue cycle management** is **pre-registration** to gather insurance details.

- In the Revenue Cycle Management (RCM) process, what is the first step?
  a) Claim submission
  b) Pre-registration
  c) Coding
  d) Payment posting

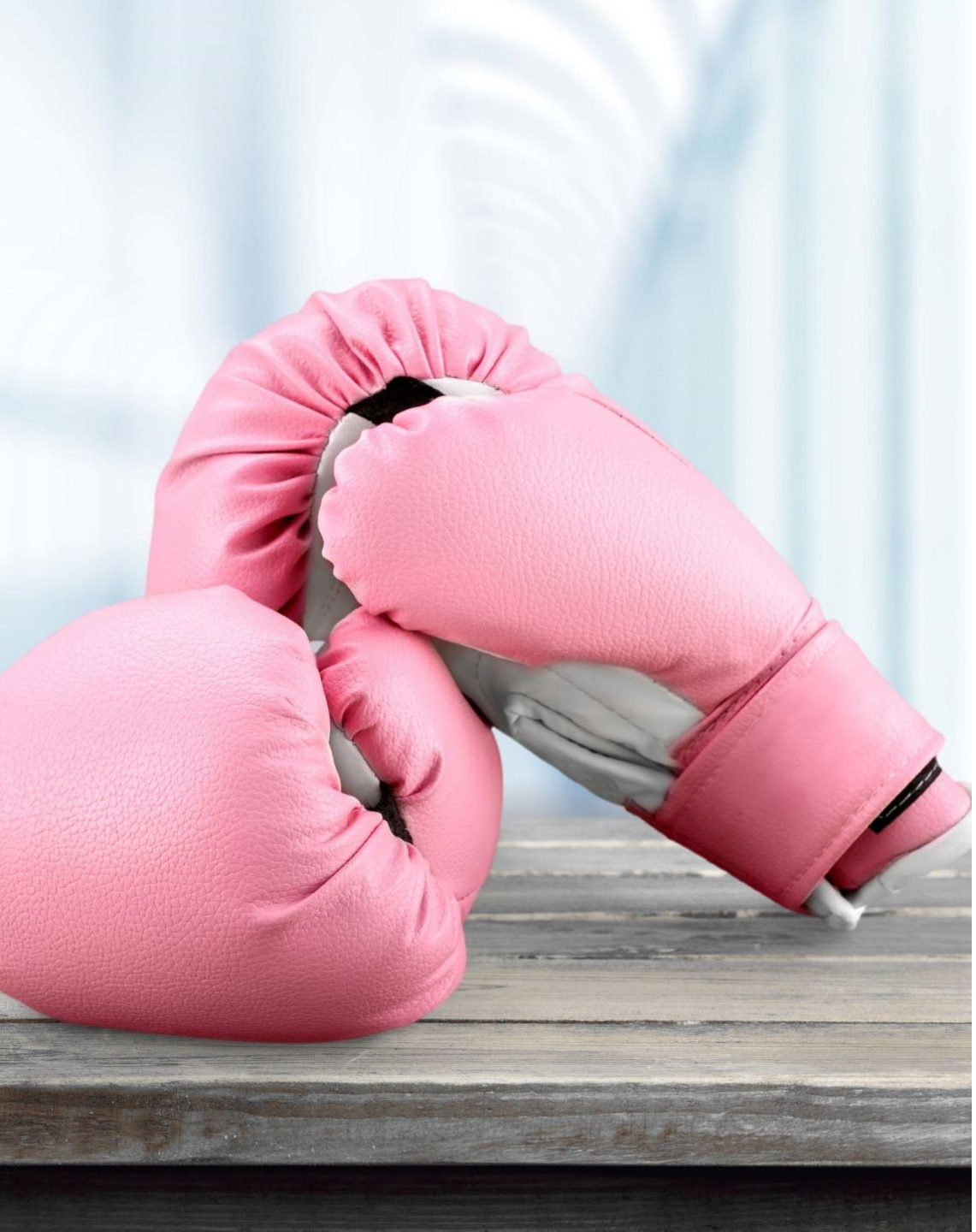
- What federal law mandates the protection of patient health information (PHI)?
  a) HIPAA
  b) EMTALA
  c) HITECH
  d) Stark Law

21. **(a) HIPAA** – HIPAA ensures **patient data privacy** and **security of protected health information (PHI)**.

- What federal law mandates the protection of patient health information (PHI)?
  a) HIPAA
  b) EMTALA
  c) HITECH
  d) Stark Law



- Upcoding is considered a violation of which law?
  a) Anti-Kickback Statute
  b) False Claims Act
  c) Stark Law
  d) HIPAA



21. **(b) False Claims Act – Upcoding** (coding for a more expensive service than provided) **violates the False Claims Act**.

- Upcoding is considered a violation of which law?
  a) Anti-Kickback Statute
  b) False Claims Act
  c) Stark Law
  d) HIPAA

- The Office of Inspector General (OIG) publishes:
  a) National Correct Coding Initiative (NCCI) edits
  b) Coding Guidelines
  c) Work Plan for fraud and abuse investigations
  d) CPT updates

21. **(c) Work Plan for fraud and abuse investigations** – The **OIG Work Plan** outlines **fraud investigations and compliance efforts**.

- The Office of Inspector General (OIG) publishes:
  a) National Correct Coding Initiative (NCCI) edits
  b) Coding Guidelines
  c) Work Plan for fraud and abuse investigations
  d) CPT updates

- What does a Compliance Plan help a healthcare organization achieve?
  a) Increased reimbursement
  b) Avoidance of audits
  c) Adherence to regulations and reduce fraud risks
  d) Elimination of billing errors

21. **(c) Adherence to regulations and reduce fraud risks** – A **Compliance Plan** ensures adherence to healthcare regulations.

- What does a Compliance Plan help a healthcare organization achieve?
  a) Increased reimbursement
  b) Avoidance of audits
  c) Adherence to regulations and reduce fraud risks
  d) Elimination of billing errors

- The Stark Law prohibits:
  a) Coding errors
  b) Self-referrals by physicians
  c) Reimbursement denials
  d) Overpayment recovery

21. **(b) Self-referrals by physicians – The Stark Law** prohibits **physician self-referrals for services they financially benefit from**.

- The Stark Law prohibits:
  a) Coding errors
  b) Self-referrals by physicians
  c) Reimbursement denials
  d) Overpayment recovery

- What does EHR stand for?
  a) Electronic Health Review
  b) Emergency Healthcare Record
  c) Electronic Health Record
  d) Encrypted Health Registry

26. **(c) Electronic Health Record** – **EHRs** store **digital patient medical records** for easy access and interoperability.

- What does EHR stand for?
  a) Electronic Health Review
  b) Emergency Healthcare Record
  c) Electronic Health Record
  d) Encrypted Health Registry

- A software that helps coders find the most accurate codes is called:
  a) Encoder
  b) Data dictionary
  c) Clinical decision support
  d) Chargemaster

26. **(a) Encoder** – **Encoders** help coders assign codes accurately and efficiently.

- A software that helps coders find the most accurate codes is called:
  a) Encoder
  b) Data dictionary
  c) Clinical decision support
  d) Chargemaster

- Which organization is responsible for the development of CPT codes?
  a) AHIMA
  b) CMS
  c) AMA
  d) WHO

26. (c) AMA – The **American Medical Association (AMA)** develops **CPT codes**.

- Which organization is responsible for the development of CPT codes?
  a) AHIMA
  b) CMS
  c) AMA
  d) WHO

- Which government agency oversees Medicare and Medicaid?
  a) HHS
  b) OIG
  c) CMS
  d) FDA

26. (c) CMS – Centers for Medicare & Medicaid Services (CMS) oversee Medicare and Medicaid programs.

- Which government agency oversees Medicare and Medicaid?
  a) HHS
  b) OIG
  c) CMS
  d) FDA

- What does SNOMED CT stand for?
  a) Standardized Nomenclature of Medicine – Clinical Terms
  b) Systemized National Operational Medical Data
  c) Statistical Network of Medical Education Database
  d) Structured National Order of Medical Electronic Data

26. (a) Standardized Nomenclature of Medicine – Clinical Terms – SNOMED CT is a **detailed medical terminology system**.

- What does SNOMED CT stand for?
  a) Standardized Nomenclature of Medicine – Clinical Terms
  b) Systemized National Operational Medical Data
  c) Statistical Network of Medical Education Database
  d) Structured National Order of Medical Electronic Data

- Which document in a patient's medical record contains the attending physician's assessment, diagnosis, and treatment plan upon admission?
  a) Discharge Summary
  b) History and Physical (H&P)
  c) Operative Report
  d) Progress Notes

31. **(b) History and Physical (H&P)** – The **H&P report** provides a patient's **assessment, diagnosis, and treatment plan** at admission.

- Which document in a patient's medical record contains the attending physician's assessment, diagnosis, and treatment plan upon admission?
  a) Discharge Summary
  b) History and Physical (H&P)
  c) Operative Report
  d) Progress Notes

- What is the **minimum necessary standard** under HIPAA?
  a) Healthcare providers can access any patient information they want
  b) PHI should be disclosed only to the extent necessary to accomplish the intended purpose
  c) All healthcare employees should have full access to PHI
  d) Patients cannot request their own medical records

(b) PHI should be disclosed only to the extent necessary – The **"minimum necessary" rule** limits access to PHI.

What is the **minimum necessary standard** under HIPAA?
a) Healthcare providers can access any patient information they want
b) PHI should be disclosed only to the extent necessary to accomplish the intended purpose
c) All healthcare employees should have full access to PHI
d) Patients cannot request their own medical records

What does **querying a physician** mean in medical coding?

a) Changing a diagnosis without physician approval

b) Asking a provider for clarification or additional information

c) Rejecting a provider’s documentation

d) Submitting a claim without proper documentation

(b) Asking a provider for clarification –
Querying a physician is a best practice when **documentation is unclear**.

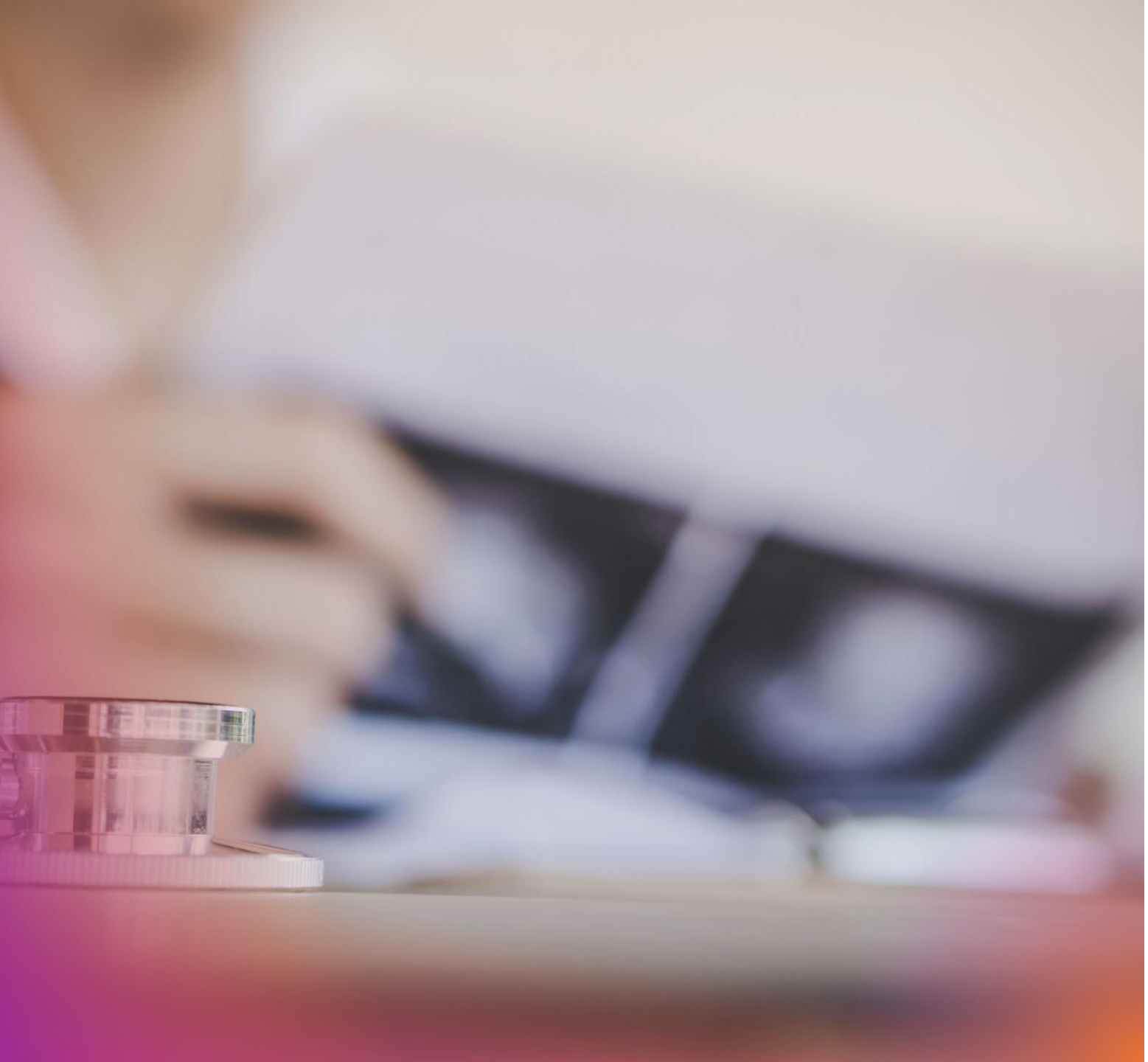
What does **querying a physician** mean in medical coding?
a) Changing a diagnosis without physician approval
b) Asking a provider for clarification or additional information
c) Rejecting a provider’s documentation
d) Submitting a claim without proper documentation

- When should a **discharge summary** be completed?
  a) Within 10 days of discharge
  b) Within 30 days of discharge
  c) Within 24-48 hours of discharge
  d) Only when requested by the patient

(c) Within 24-48 hours of discharge – Discharge summaries should be completed within 24-48 hours per best practice.

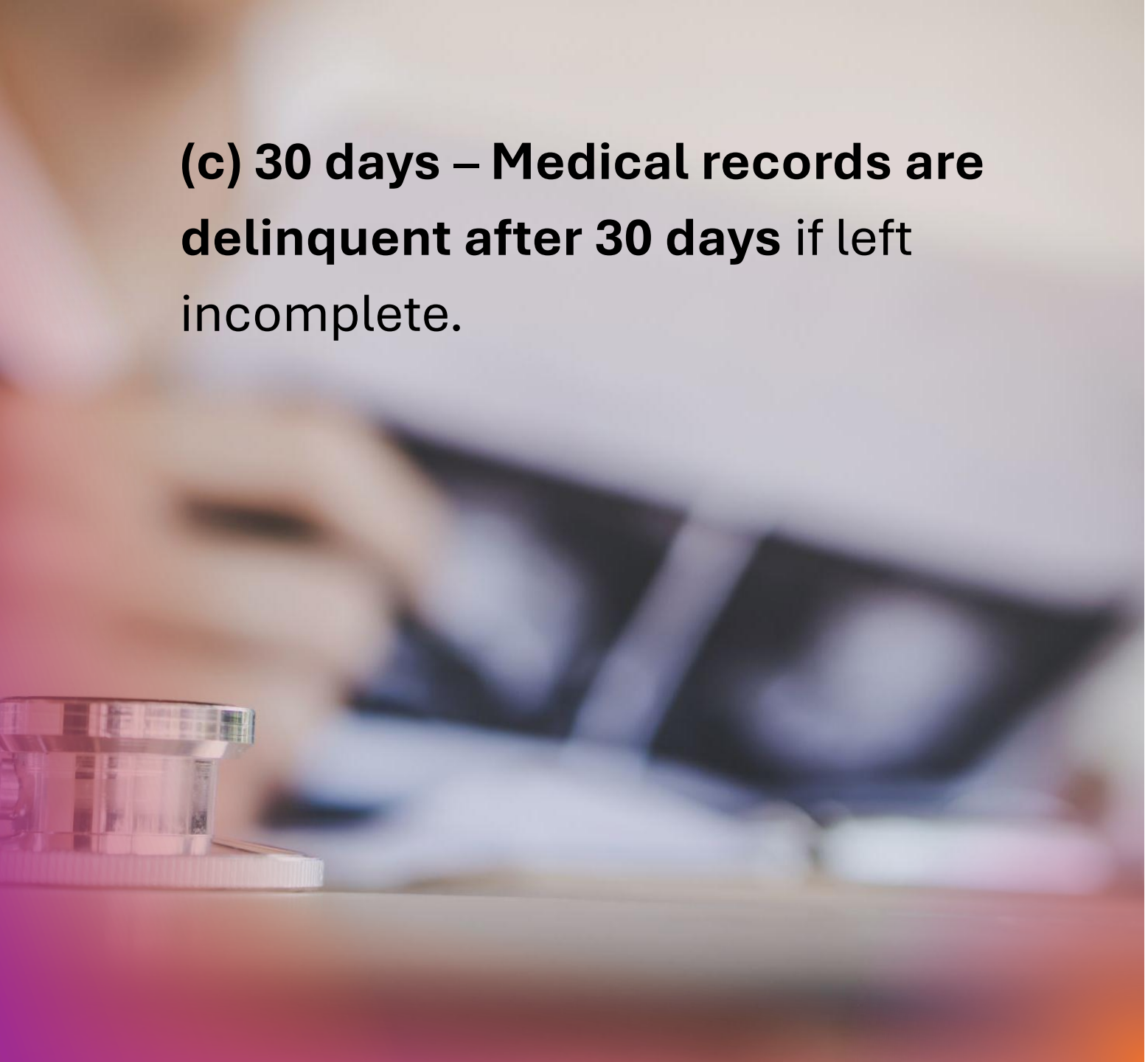
When should a **discharge summary** be completed?

a) Within 10 days of discharge
b) Within 30 days of discharge
c) Within 24-48 hours of discharge
d) Only when requested by the patient



A **delinquent medical record** is one that is incomplete for how many days?

a) 15 days
b) 20 days
c) 30 days
d) 60 days



(c) 30 days – Medical records are delinquent after 30 days if left incomplete.

A **delinquent medical record** is one that is incomplete for how many days?

a) 15 days
b) 20 days
c) 30 days
d) 60 days

- Which of the following organizations publishes the **ICD-10-CM Official Guidelines for Coding and Reporting**?
  a) WHO
  b) AMA
  c) CMS and NCHS
  d) AHIMA

(c) CMS and NCHS – The **ICD-10-CM Official Guidelines** are published by **CMS & the National Center for Health Statistics (NCHS)**.

Which of the following organizations publishes the **ICD-10-CM Official Guidelines for Coding and Reporting**?

a) WHO
b) AMA
c) CMS and NCHS
d) AHIMA

What is the primary purpose of the **National Correct Coding Initiative (NCCI)** edits?

a) Prevent upcoding
b) Prevent unbundling of procedures
c) Prevent fraudulent billing
d) Assign DRGs

(b) Prevent unbundling of procedures – NCCI edits prevent improper billing of procedures that should be bundled together.

What is the primary purpose of the **National Correct Coding Initiative (NCCI)** edits?

a) Prevent upcoding

b) Prevent unbundling of procedures

c) Prevent fraudulent billing

d) Assign DRGs

- When coding **sequela (late effects)** in ICD-10-CM, what is the correct guideline?
  a) Code only the residual condition
  b) Code the residual condition first, followed by the sequela code
  c) Code the sequela code first, then the residual condition
  d) Do not report sequela codes

(b) Code the residual condition first, followed by the sequela code – Sequela coding **requires the residual condition to be coded first**.

When coding **sequela (late effects)** in ICD-10-CM, what is the correct guideline?

a) Code only the residual condition

b) Code the residual condition first, followed by the sequela code

c) Code the sequela code first, then the residual condition

d) Do not report sequela codes

What should a coder do if medical documentation is incomplete?

a) Guess the correct code based on patient history
b) Assign a non-specific code
c) Query the physician for clarification
d) Leave the diagnosis field blank

(c) Query the physician – If documentation is **incomplete**, **querying the physician** is necessary for coding accuracy.

What should a coder do if medical documentation is incomplete?
a) Guess the correct code based on patient history
b) Assign a non-specific code
c) Query the physician for clarification
d) Leave the diagnosis field blank

A patient is diagnosed with **acute bronchitis due to influenza A**. What is the correct **ICD-10-CM** coding?

a) J20.9, J10.1
b) J10.1, J20.9
c) J09.X2
d) J10.1

(d) J10.1 – Influenza A with acute bronchitis
is coded with **J10.1** in ICD-10-CM.

A patient is diagnosed with **acute bronchitis due to influenza A**. What is the correct **ICD-10-CM** coding?
a) J20.9, J10.1
b) J10.1, J20.9
c) J09.X2
d) J10.1

A patient has **bilateral carpal tunnel release surgery**. What **modifier** should be used?

a) -LT
b) -RT
c) -50
d) -51

(c) -50 – Modifier -50 is used for **bilateral procedures**.

A patient has **bilateral carpal tunnel release surgery**. What **modifier** should be used?

a) -LT
b) -RT
c) -50
d) -51

If a patient is admitted with **sepsis due to pneumonia**, what is the correct **ICD-10-CM code sequencing**?

a) A41.9, J18.9
b) J18.9, A41.9
c) A41.9 only
d) J18.9 only

(a) **A41.9, J18.9 – Sepsis (A41.9) is coded first, followed by pneumonia (J18.9).**

If a patient is admitted with **sepsis due to pneumonia**, what is the correct **ICD-10-CM code sequencing**?

a) A41.9, J18.9
b) J18.9, A41.9
c) A41.9 only
d) J18.9 only

A coder is reviewing **outpatient** records. What **coding system** should be used for procedures?

a) ICD-10-PCS
b) CPT
c) DRG
d) LOINC

(b) CPT – CPT codes are used for outpatient procedures, whereas **ICD-10-PCS is for inpatient procedures**.

- A coder is reviewing **outpatient** records. What **coding system** should be used for procedures?

a) ICD-10-PCS
b) CPT
c) DRG
d) LOINC

What is the purpose of a **Clinical Documentation Improvement (CDI) program**?

a) Increase hospital revenue

b) Improve patient outcomes through accurate documentation

c) Assign CPT codes

d) Reduce medical errors

(b) Improve patient outcomes through accurate documentation – CDI ensures **complete and precise documentation**.

What is the purpose of a **Clinical Documentation Improvement (CDI) program**?

a) Increase hospital revenue

b) Improve patient outcomes through accurate documentation

c) Assign CPT codes

d) Reduce medical errors

In the **Medicare Inpatient Prospective Payment System (IPPS)**, payment is primarily based on:

a) Length of stay

b) Physician charges

c) DRG assignment

d) Service location

(c) DRG assignment – Under **IPPS, hospital reimbursement is based on MS-DRG classification**

- In the **Medicare Inpatient Prospective Payment System (IPPS)**, payment is primarily based on:
  a) Length of stay
  b) Physician charges
  c) DRG assignment
  d) Service location

What government agency investigates **healthcare fraud**?

a) CDC
b) OIG
c) FDA
d) CMS

(b) OIG – The **Office of Inspector General (OIG)** investigates **healthcare fraud and abuse**.

What government agency investigates **healthcare fraud**?

a) CDC

b) OIG

c) FDA

d) CMS

Medical necessity is determined based on:

a) Payer contracts

b) Clinical documentation supporting the service provided

c) Patient preference

d) Insurance company policies only

(b) Clinical documentation supporting the service provided – Medical necessity is based on **documentation that justifies services**.

- **Medical necessity** is determined based on:
  a) Payer contracts
  b) Clinical documentation supporting the service provided
  c) Patient preference
  d) Insurance company policies only

- What is the **purpose of the UB-04 form**?
  a) Physician office billing
  b) Hospital inpatient billing
  c) Dental billing
  d) Outpatient prescriptions

(b) Hospital inpatient billing – UB-04 is the **billing form for hospital inpatient claims**.

What is the **purpose of the UB-04 form**?

a) Physician office billing

b) Hospital inpatient billing

c) Dental billing

d) Outpatient prescriptions