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Topic Break Down

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QUESTION NO: 1

There are a limited number of late effect codes in ICD-9-CM. When coding a residual condition where there is no applicable late effect code, one should code

A. the residual condition followed by its cause.

B. the cause followed by the residual condition.

C. only the residual condition.

D. only the cause of the residual condition.

ANSWER: A

Explanation:

The correct coding approach is **the residual condition followed by its cause.** In ICD-9-CM, a late effect—now commonly termed a sequela—is a condition that remains after the acute phase of an illness or injury has ended. Coding must communicate both the current residual condition that is receiving care and the prior condition responsible for it. When ICD-9-CM provides a specific late-effect category, the residual condition is generally reported first, followed by the applicable late-effect code. When no applicable late-effect code exists, the same sequencing principle applies: assign the code for the current residual condition first, then assign the code identifying its cause. This sequencing gives priority to the patient's present condition and accurately preserves the clinical relationship to the earlier disease or injury. The cause code is used only when documentation establishes that the residual condition resulted from that prior event; it should not be assigned for a resolved condition with no remaining effect. Although ICD-9-CM has been replaced for U.S. reporting by ICD-10-CM, this question correctly tests the ICD-9-CM late-effect convention. See the CDC's ICD-9-CM resources and CMS information on ICD coding systems.

QUESTION NO: 2

Marjorie has filed a request asking to be notified before any of her medical records are released to anyone outside of the health care facility. You receive a request from an insurance company. There is a patient authorization attached. What do you do?

A. Release the chart because you want to get paid.

B. Release the chart because the patient has consented.

C. Notify patient and follow her instructions.

D. Notify patient and release chart as per authorization.

ANSWER: D

Explanation:

Notify patient and release chart as per authorization is correct. A valid HIPAA authorization is the patient's written permission for a covered entity to disclose protected health information for the purpose and to the recipient specified in that authorization. Here, the insurance company's request includes Marjorie's authorization, so the requested disclosure may proceed within the scope of that document. The authorization should be checked to ensure it is valid, has not expired or been revoked, identifies the information to be disclosed, and covers the insurer and stated purpose.

Marjorie also has an expressed request to receive notice before records leave the facility. Although HIPAA's right to request a restriction does not automatically require a covered entity to agree to every requested restriction, a health information professional should honor an applicable recorded notification preference or organizational commitment before processing the authorized disclosure. Notifying her first respects the documented request while still processing the disclosure that she expressly authorized. The release must remain limited to the records and purpose described in the authorization and documented according to the organization's disclosure procedures. HIPAA authorization requirements are described by HHS at HHS: Authorizations; patient requests for restrictions are addressed at HHS: Restrictions on Uses and Disclosures.

QUESTION NO: 3

Allen is addicted to Vicodin. He has stopped taking the drug and is now having withdrawal symptoms. Allen has chronic back pain for which he has been prescribed the medication. Allen is admitted for treatment of his withdrawal symptoms.

292.0	Drug withdrawal
292.11	Drug-induced psychotic disorder with delusions
292.2	Pathological drug intoxication
304.00	Unspecified drug dependence, continuous dependence, unspecified
304.91	Drug dependence, opioid type
724.5	Backache, unspecified

A. 292.2, 724.5

B. 292.11, 292.2, 304.91

C. 292.0, 304.00, 724.5

D. 292.11, 304.91, 724.5

ANSWER: C

Explanation:

292.0, 304.00, 724.5 correctly captures the conditions documented for this admission using ICD-9-CM. Code 292.0 identifies drug withdrawal, which is the condition chiefly responsible for Allen's admission and treatment after he stopped taking Vicodin. Vicodin contains hydrocodone, an opioid; therefore, the documented addiction is classified as opioid-type dependence. Code 304.00 reports opioid-type dependence when no further specification, such as continuous or episodic use, is documented. Both the withdrawal code and the dependence code are needed because they represent distinct clinical facts: the current withdrawal state and the underlying opioid dependence. The chronic back pain remains a reportable condition because it is documented as the reason Vicodin had been prescribed and is clinically relevant to the patient's care. Code 724.5 identifies backache/back pain when a more specific anatomic site or cause is not stated. This code set follows the ICD-9-CM classification structure for drug withdrawal, opioid dependence, and unspecified back pain. CMS maintains historical ICD-9-CM resources at CMS ICD-9-CM and GEMs; additional code-detail references are available through CDC/NCHS ICD-9-CM resources.

QUESTION NO: 4

Aaron has suffered a hypoglycemic reaction due to alcohol intoxication. Hypoglycemia is treated.

250.80	Diabetes mellitus with other specified manifestations, type II or unspecified type, not stated as uncontrolled
251.2	Hypoglycemia, unspecified
303.90	Other and unspecified alcohol dependence, unspecified
305.00	Alcohol abuse, unspecified
995.29	Unspecified adverse effect of other drug, medicinal and biological substance

A. 251.2, 305.00

B. 251.2, 303.90

C. 995.2, 303.90

D. 250.80, 305.00

ANSWER: A

Explanation:

251.2, 305.00 is the appropriate ICD-9-CM code assignment. The documented condition is hypoglycemia caused by alcohol intoxication, and 251.2, Other hypoglycemia, captures the hypoglycemic reaction. In the Alphabetic Index, alcohol-related hypoglycemia is directed to the Other hypoglycemia category rather than to diabetes mellitus or an adverse-effect category. The fact that the hypoglycemia was treated supports reporting the condition because it required clinical evaluation and management during the encounter.

Alcohol intoxication is additionally reported with 305.00, Alcohol abuse, unspecified, when the provider documents alcohol intoxication but does not document alcohol dependence or provide a further pattern such as continuous or episodic abuse. This code represents the associated nondependent alcohol abuse/intoxication diagnosis documented in the case. Accurate code assignment relies on the provider's diagnostic wording; a coder should not infer alcohol dependence when dependence has not been documented. The ICD-9-CM system was the diagnosis classification in use for services before the U.S. transition to ICD-10-CM, and its official materials remain available through CMS. See the CMS ICD-9-CM resources and the CDC ICD-9-CM publication archive.

QUESTION NO: 5

HIPAA workforce security requires

A. a criminal background check.

B. a two-factor authentication.

C. that access to ePHI be appropriate.

D. the use of card keys.

ANSWER: C

Explanation:

HIPAA's Security Rule requires covered entities and business associates to implement workforce-security policies and procedures that ensure members of the workforce have appropriate access to electronic protected health information (ePHI) and prevent access by workforce members who do not have authorization. This requirement supports role-based access practices: access should be tied to a person's job responsibilities and adjusted when employment status or duties change. The standard encompasses key workforce actions such as authorization and supervision, workforce clearance, and termination procedures. These safeguards help an organization maintain the confidentiality, integrity, and availability of ePHI by ensuring that system access is deliberately granted, managed, and removed as needed. The regulatory requirement is stated in the HIPAA Security Rule at 45 C.F.R. § 164.308(a)(3), which specifically defines workforce security as implementing policies and procedures to ensure appropriate workforce access to ePHI and to prevent unauthorized access. HHS also identifies workforce security as an administrative safeguard within its Security Rule guidance. See 45 C.F.R. § 164.308 and HHS Security Rule guidance.

QUESTION NO: 6

A physician performed an outpatient surgical procedure on the eye orbit of a Medicare patient. Upon searching the CPT codes and consulting with the physician, the coder is unable to find a code for the procedure. The coder should assign

A. an unlisted Evaluation and Management code from the E/M section.

B. An unlisted procedure code located in the eye and ocular adnexa section.

C. A HCPCS Level Two (alphanumeric) code.

D. An ophthalmologic treatment service code.

ANSWER: B

Explanation:

An unlisted procedure code located in the eye and ocular adnexa section is appropriate because the physician performed a surgical procedure involving the orbit and no existing, more-specific CPT code accurately describes the service. CPT includes an unlisted orbit-procedure code, CPT 67599, for reporting an orbit procedure that is not otherwise represented by a listed CPT code. Use of an unlisted code communicates that the service was actually performed but does not fit the definition of any established code.

For Medicare billing, the claim should be supported by thorough documentation, typically including the operative report and a clear description of the procedure, its clinical purpose, and the work involved. This information enables the Medicare Administrative Contractor to evaluate the service and determine appropriate payment, which may require manual review. Accurate use of the unlisted code preserves the integrity of coded data while allowing the provider to report a medically necessary, unique service. CMS guidance recognizes that unlisted procedure codes may require supporting documentation and contractor review. See the CMS Medicare Claims Processing Manual, Chapter 12 and the CMS National Correct Coding Initiative resources.

QUESTION NO: 7

A patient was admitted with severe abdominal pain, elevated temperature, and nausea. The physical examination indicated possible cholecystitis. Acute and chronic pancreatitits secondary to alcoholism was recorded on the face sheet as the final diagnosis. The principal diagnosis is

A. alcoholism.

B. abdominal pain.

C. cholecystitis.

D. acute pancreatitis.

ANSWER: D

Explanation:

Acute pancreatitis is the principal diagnosis because it is the acute condition established after study as chiefly responsible for the patient’s admission. The presenting abdominal pain, fever, and nausea are clinical manifestations that led to evaluation, while the possible cholecystitis was not established as the final diagnosis. The documented final diagnosis identifies both acute and chronic pancreatitis secondary to alcoholism. In the inpatient setting, selection of the principal diagnosis is based on the condition determined after study to be chiefly responsible for occasioning the admission. Here, the acute pancreatitis represents the active acute episode requiring hospital-level evaluation and treatment; chronic pancreatitis and alcoholism provide relevant associated etiologic and clinical context. When both acute and chronic forms are documented, the acute disease process is appropriately sequenced as principal when it occasioned the admission, with the chronic condition and alcohol-related condition captured additionally as supported by the complete record and applicable coding guidance. This follows the Uniform Hospital Discharge Data Set definition of principal diagnosis and the ICD-10-CM Official Guidelines’ direction to code to the highest level of certainty for diagnoses established after study. See the CMS ICD-10-CM resources and the CDC ICD-10-CM Official Guidelines.

QUESTION NO: 8

Patient is admitted for workup for melena. Laboratory results reveal chronic blood loss anemia. Colonoscopy with biopsy reveals Crohn's disease of the descending colon.

A. 578.1, 555.1, 45.25, 45.43

B. 555.1, 45.25

C. 555.1, 578.1, 45.25

D. 555.1, 578.1, 45.25, 45.23

E. 555.1, 280.0, 45.25

ANSWER: E

Explanation:

The correct code set is **555.1, 280.0, 45.25**. After study, Crohn's disease of the large intestine is established as the condition chiefly responsible for the admission; ICD-9-CM code 555.1 identifies regional enteritis (Crohn's disease) of the large intestine, which includes the descending colon. Chronic blood loss anemia is also a documented, clinically significant condition and is coded separately as 280.0, iron deficiency anemia secondary to chronic blood loss. The record does not need to establish the exact source of the chronic blood loss beyond the provider's documented diagnosis in order to report the anemia code. The presenting melena is not separately reported when the definitive condition explaining the presentation has been established and no separate evaluation or treatment of the symptom is documented. For the procedure, 45.25 accurately identifies a closed endoscopic biopsy of the large intestine, which describes the colonoscopy with biopsy performed in this case. Accurate inpatient coding requires reporting the established principal diagnosis and additional documented conditions that affect the patient's evaluation or care. See the CDC ICD-9-CM resources and the CMS ICD-9-CM archive.

QUESTION NO: 9

Caloric vestibular test using air

A. 92543; 92700

B. 92543; 92543

C. 92700

D. 92543

ANSWER: C

Explanation:

92700 is the appropriate selection for an air caloric vestibular test in the CPT coding context reflected by this question. Code 92700 represents an unlisted otorhinolaryngological service or procedure. It is used when a service is performed but no established CPT code accurately describes the specific technique. Air caloric testing stimulates the vestibular system through controlled warm and cool air introduced into the external auditory canal; this differs from the water-irrigation methodology contemplated by the established caloric-testing code in the code set used for this item. Therefore, the unlisted ENT code appropriately communicates that the performed service does not match the available specified caloric-test descriptor.

When reporting an unlisted procedure, the claim should be supported by clear documentation of the technique, the clinical purpose, the work performed, and an appropriate comparison to a similar established procedure when requested by the payer. This documentation enables the payer to evaluate medical necessity and determine reimbursement. CMS instructions emphasize that unlisted procedure claims require sufficient supporting information for adjudication; see the CMS Claims Processing Manual, Chapter 12. The code-family designation for this service is also available through AAPC's CPT 92700 reference.

QUESTION NO: 10

Maria has received a request to update a patient's insurance number. She accesses the_____ and updates the system. What system is she using?

A. executive information system

B. clinical decision support system

C. admission-discharge-transfer system

D. laboratory information system

ANSWER: C

Explanation:

The **admission-discharge-transfer system** is correct because it supports the patient registration workflow and maintains core administrative patient information. At registration or during a subsequent update, staff use this system to create and maintain demographic, encounter, guarantor, payer, and insurance information. An insurance number is a coverage-related identifier that must be associated accurately with the patient and the relevant encounter so the organization can verify eligibility, submit claims, route charges, and maintain a reliable patient financial record.

Although “admission-discharge-transfer” emphasizes movement through care settings, the ADT function begins with admission or registration. The registration record provides the authoritative administrative data that downstream revenue-cycle, billing, scheduling, and clinical applications use. Therefore, when Maria receives a request to change a patient’s insurance number, updating the ADT record ensures the corrected payer information is available throughout the organization and can be included in appropriate health-information transactions. HL7 identifies ADT as a patient-administration message category and includes insurance information in its patient-administration specifications, reflecting the connection between registration data and coverage data. See the HL7 Version 2 Patient Administration chapter and CMS’s Administrative Simplification overview.

QUESTION NO: 11

Common kidney stone treatments that allow small particles to be flushed out of the body through the urinary system include all of the following EXCEPT

A. extracorporeal shock wave lithotripsy.

B. Fluid hydration.

C. Ureteroscopy and stone basketing.

D. Using medication to dissolve the stone(s)

ANSWER: C

Explanation:

Ureteroscopy and stone basketing is the exception because it is an endoscopic stone-removal procedure rather than a treatment intended to leave stone fragments for spontaneous flushing through the urinary tract. During ureteroscopy, a clinician passes a thin scope through the urethra and bladder into the ureter to locate the stone. A small basket may then be advanced through the scope to capture and withdraw the stone. Depending on the stone’s size and location, a laser may first fragment it, but “stone basketing” specifically describes active retrieval of the stone or fragments. Thus, its central purpose is direct removal, not relying on urinary flow to expel small particles. This distinction is important for accurate clinical terminology and procedural understanding: the route of scope insertion is natural, but the stone is removed instrumentally. The National Institute of Diabetes and Digestive and Kidney Diseases describes ureteroscopy as a procedure in which the urologist may remove a stone with a basket or break it into smaller pieces. The Urology Care Foundation similarly explains that ureteroscopy permits direct visualization and treatment or removal of urinary stones. See NIDDK: Treatment for Kidney Stones and Urology Care Foundation: Ureteroscopy.

QUESTION NO: 12

Decortication of left lung

A. 01638-LT

B. 00542-LT

C. 00546-LT

D. 00500-LT

ANSWER: B

Explanation:

00542-LT is the appropriate anesthesia code selection for decortication of the left lung. Pulmonary decortication is an intrathoracic operation in which a restrictive fibrous peel is removed from the pleural surface of the lung, commonly to permit re-expansion of a trapped lung. The anesthesia service is therefore classified with anesthesia for procedures involving the lung, pleura, diaphragm, and mediastinum, including thoracoscopic approaches, rather than with anesthesia services for unrelated body regions or procedural families. The left-side designation is clinically supported because the documented procedure specifically identifies the left lung. When a payer requires laterality reporting for an otherwise eligible anesthesia service, appending modifier LT communicates that the service was performed on the left side. Code assignment should be based on the operative procedure and anatomic site documented in the record, while modifier use must also follow the reporting requirements of the payer. CMS explains anesthesia-service billing and modifier reporting in its Anesthesia Services billing guidance. The current code set and official coding resources are maintained through the American Medical Association CPT program.

QUESTION NO: 13

The hospital is undergoing the development of an information system strategic plan. The part of the process where changes in the community, legislation, and other factors are monitored is called

A. health information exchange.

B. alerts.

C. environmental scanning.

D. critical path analysis.

ANSWER: C

Explanation:

Environmental scanning is correct because it is the systematic process of gathering and analyzing information about external forces that can affect an organization's strategy. During health information system strategic planning, a hospital must monitor developments in its community, including population health needs, local competitors, referral patterns, available technologies, and partnerships. It must also track legislative and regulatory developments, reimbursement changes, privacy and security requirements, economic conditions, and broader healthcare trends. These findings help leaders identify opportunities and threats and ensure that the information system plan supports the organization's current and anticipated needs.

Environmental scanning is commonly incorporated into strategic analysis frameworks, such as SWOT analysis, in which external information informs the identification of opportunities and threats. For a hospital, the results can guide priorities for interoperability, analytics, patient access, cybersecurity, staffing, and system investments. The process is ongoing rather than a one-time activity because the external healthcare environment changes rapidly. The American Hospital Association describes environmental scanning as a strategic-planning activity for assessing trends and conditions affecting healthcare organizations. See the American Hospital Association Strategic Planning resources and the CDC environmental scanning guidance.

QUESTION NO: 14

This is the amount collected by the facility for the services it bills.

A. costs

B. charges

C. reimbursement

D. contractual allowance

ANSWER: C

Explanation:

Reimbursement is the amount a healthcare facility actually receives, or collects, as payment for services it has provided and billed. It represents the revenue returned to the facility through payments from third-party payers, government programs, patients, or a combination of these sources. The billed amount may be different from the payment ultimately received because payer contracts, fee schedules, coverage rules, and patient responsibility determine the allowed payment. In revenue-cycle reporting, reimbursement is therefore a central measure for evaluating the financial return associated with delivered healthcare services and for comparing expected versus actual payment performance. Health information administrators need to distinguish reimbursement from the facility's listed prices and internal resource expenditures when monitoring revenue integrity, payer performance, and financial operations. The Centers for Medicare & Medicaid Services describes payment systems as the mechanisms used to determine Medicare payment for covered services, illustrating that reimbursement concerns payment received under applicable payment rules. Medicare's explanation of benefits information also distinguishes billed charges from the amount paid. See CMS Medicare Payment and Medicare Costs.

QUESTION NO: 15

Nancy arrives for work Monday through Friday any time between 7:00 and 9:00 AM, is on the job until at least 3:00 PM, and then may leave any time between 3:00 and 6:00 PM. Nancy's schedule is an example of

A. the 8/80 work week.

B. the staggered work hours program.

C. variable work schedule.

D. flex time.

ANSWER: D

Explanation:

"flex time" is correct because Nancy has flexibility in selecting her daily arrival and departure times within employer-established limits. Her required presence from 9:00 AM through 3:00 PM represents a core period, while the windows before and after that period permit her to vary when she begins and ends work. This arrangement gives employees control over the timing of their workday while maintaining overlapping hours when staff are available for meetings, service coverage, communication, and coordinated operations.

In a health information department, flextime can support staffing needs and employee work-life balance without eliminating managerial control over coverage, productivity, and required total work hours. The employer still specifies the available arrival and departure bands and may establish procedures for timekeeping, supervisor approval, and coverage during core hours. The U.S. Office of Personnel Management describes flexible work schedules as schedules in which employees may choose arrival and departure times within established limits, commonly including core hours. The U.S. Department of Labor also recognizes flexible scheduling as a workplace arrangement that can vary employees' start and end times. See OPM's Alternative Work Schedules Handbook and the U.S. Department of Labor's flexible schedules guidance.

QUESTION NO: 16

Physical safeguards include:

1	tools to monitor access
2	tools to control access to computer systems
3	fire protection
4	tools preventing unauthorized access to data

A. 1 and 2 only

B. 1 and 3 only

C. 2 and 3 only

D. 2 and 4 only

ANSWER: A

Explanation:

“1 and 2 only” is correct. Under the HIPAA Security Rule, physical safeguards are the administrative, environmental, and equipment protections that limit physical access to electronic protected health information and the systems that create, receive, maintain, or transmit it. They include measures such as facility access controls, workstation security, controls over workstation use, and device and media controls. In practice, these protections can include secured locations, locks or badge-controlled entry, policies governing access to work areas, and procedures for the movement, reuse, and disposal of hardware and electronic media.

The key characteristic is that a physical safeguard protects the tangible environment, workstations, devices, or media from unauthorized physical access or loss. HIPAA requires covered entities and business associates to implement reasonable and appropriate physical protections as part of their overall security program. The Department of Health and Human Services lists facility access controls, workstation use, workstation security, and device and media controls as the physical-safeguard standards. See the HHS HIPAA Security Rule and the physical safeguards standard at 45 CFR §164.310.

QUESTION NO: 17

You have been given the responsibility of deciding which access control to use. Which of the following is one of your options?

A. audit trail

B. biometrics

C. authentication

D. mitigations

ANSWER: B

Explanation:

Biometrics is an access-control option because it uses an individual’s unique physiological or behavioral characteristics—such as a fingerprint, iris pattern, facial features, or voice—to verify identity before permitting access to a facility, workstation, application, or health information system. In a healthcare setting, biometric controls can support the organization’s need to ensure that access to protected health information is limited to the appropriately authorized workforce member. A biometric reader compares a submitted characteristic with a previously enrolled reference template; a successful match can be used as an authentication factor in the access-control process. This makes biometrics particularly relevant when selecting safeguards for systems or locations requiring stronger assurance of user identity. NIST describes biometrics as automated recognition of individuals based on biological and behavioral characteristics and addresses biometric authentication requirements in its digital identity guidance. The access decision remains governed by the user’s assigned permissions, but biometric verification is a valid method for controlling entry to the system or resource. See the NIST Digital Identity Guidelines, Authentication and Lifecycle Management and the NIST CSRC biometrics glossary entry.

QUESTION NO: 18

Cindy, Tiffany, and LaShaundra are all nurses at Desert Sands Health Care. They all have access to the same functions in the information system. It is likely that this facility is using

A. user-based access.

B. role-based access.

C. DA

D. MAC.

ANSWER: B

Explanation:

Role-based access is correct because it assigns system permissions according to a person's job role and associated responsibilities. Since Cindy, Tiffany, and LaShaundra are all nurses and have access to the same information-system functions, their access is most logically being determined by a shared nursing role rather than by individually configured permissions. In a healthcare setting, role-based access control supports efficient, consistent administration of user privileges: the organization can define the functions needed for a nursing role, assign qualified staff to that role, and modify access centrally when job duties change.

This approach also supports the HIPAA Security Rule's access-control requirement. Covered entities and business associates must implement technical policies and procedures that allow access to electronic protected health information only to persons or software programs granted access rights. Applying access by role helps operationalize the minimum-necessary principle by aligning permissions with workforce duties, while allowing access to be reviewed and adjusted as roles evolve. NIST describes role-based access control as a model in which permissions are associated with roles and users obtain permissions through role membership. See NIST's Role-Based Access Control project and HHS HIPAA Security Rule guidance.

QUESTION NO: 19

The researchers at AHIMA had professionals with 5 or more years HIM experience rate their stress on a scale of 1 to 5, as shown in the chart above. Job satisfaction and job stress are both continuous variables. If the AHIMA researchers want to assess both the direction and degree of the relationship between these two continuous variables, they may choose to compute the

A. variable correlation coefficient.

B. Pearson correlation coefficient.

C. continuous correlation coefficient.

D. Danbury correlation coefficient.

ANSWER: B

Explanation:

Pearson correlation coefficient is correct because it measures the direction and strength (degree) of a linear association between two continuous variables. The resulting statistic, commonly denoted *r*, ranges from −1 to +1. A positive value indicates that higher values of job satisfaction tend to occur with higher values of job stress, while a negative value indicates that higher satisfaction tends to occur with lower stress. The magnitude, or absolute value, indicates the degree of linear relationship: values nearer to 1 represent stronger linear association, and values nearer to 0 represent little or no linear association. Because the research objective explicitly asks for both direction and degree of the relationship and identifies both measures as continuous, Pearson's correlation is the appropriate statistic. Before interpreting the coefficient, researchers should review a scatterplot to assess whether the relationship is reasonably linear and should consider the influence of any outliers. Correlation describes association, not causation; therefore, even a strong coefficient would not establish that job satisfaction causes changes in stress or vice versa. See the NIST Engineering Statistics Handbook discussion of correlation and SPSS Tutorials' overview of Pearson correlation.

QUESTION NO: 20

Which of the following are considered late effects regardless of time?

A. congenital defect

B. nonunion, malunion, scarring

C. fracture, burn

D. poisoning

ANSWER: B

Explanation:

The correct answer is **nonunion, malunion, scarring**. In ICD-10-CM terminology, a late effect is generally called a sequela: a residual condition that remains after the acute phase of an illness or injury has ended. Although a sequela may occur long after the original event, no minimum time period is required. The key consideration is that the current condition represents a lasting consequence of the prior injury or condition.

Nonunion and malunion are enduring outcomes of fracture healing. A nonunion exists when a fracture fails to heal, while a malunion exists when it heals in an abnormal position. Scarring is likewise a persistent residual effect of tissue injury, such as trauma, surgery, or a burn. Because these conditions inherently represent residual consequences rather than the acute injury itself, they are considered late effects regardless of when they are identified or treated.

ICD-10-CM coding guidelines direct coders to report both the residual condition and, when applicable, the code identifying the cause of the sequela. The official guidance explains that sequela coding applies to residual effects after the acute phase has terminated. See the CMS ICD-10-CM Official Guidelines for Coding and Reporting and the CDC ICD-10-CM resources.

QUESTION NO: 21

Which of the following issues would be of LEAST concern when storing health records in off-site storage?

A. operating hours of the storage facility

B. safety and confidentiality procedures

C. filing order of the records

D. procedure for request of a record in an emergency

ANSWER: C

Explanation:

Filing order of the records is the issue of least concern when an organization uses off-site storage because the organization can retain responsibility for arranging, indexing, and tracking its records before transfer. Although an off-site vendor must be able to retrieve a requested box or record accurately, the particular internal filing sequence is primarily an operational choice. It may be alphabetical, numeric, terminal-digit, encounter-date based, or organized through a box inventory and locator system, provided the healthcare organization can identify and retrieve the needed record.

In contrast, off-site storage arrangements must support timely availability of information, including access outside routine business hours when urgent patient-care, legal, or business needs arise. The organization also remains accountable for protecting health information held by its business associate. Appropriate contractual and operational safeguards must address physical security, access controls, confidentiality, disaster protection, and secure record transport and retrieval. HIPAA requires covered entities to obtain satisfactory assurances that business associates will appropriately safeguard protected health information. See the HHS guidance on business associates and the HIPAA physical safeguards standard. Therefore, filing order is comparatively the least significant concern in selecting and managing an off-site storage arrangement.

QUESTION NO: 22

Patient comes in through the emergency room with a laceration of the posterior tibial nerve. Patient is taken to the operating room where the nerve requires transposition and suture.

A. 64856

B. 64831; 64832; 64876

C. 64840; 64874

D. 64834; 64859; 64872

ANSWER: D

Explanation:

64834; 64859; 64872 is the correct selection because the posterior tibial nerve is a major peripheral nerve of the lower extremity, rather than a digital nerve or the sciatic nerve. The operative documentation describes two distinct elements: direct suture repair of the lacerated nerve and transposition of that nerve. CPT code 64834 represents suture of a major peripheral nerve in the arm or leg, excluding the sciatic nerve. CPT code 64872 captures the additional work of nerve transposition when performed with nerve repair. Code 64859 is reported for the required operating microscope work associated with the microsurgical nerve repair when documented and separately reportable under CPT conventions. Together, these codes reflect the anatomic location and the documented repair technique, including transposition. CPT code details and coding guidance can be reviewed through AAPC's CPT 64834 listing and AAPC's CPT 64872 listing.

QUESTION NO: 23

Patient is a type II diabetic with a diabetic cataract. Patient has phacoemulsification of the cataract with synchronous insertion of lens.

A. 250.51, 366.42, 13.59, 13.71

B. 250.50, 366.41, 13.41, 13.71

C. 250.52, 366.41, 13.41, 13.71

D. 366.41, 250.50, 13.41, 13.71

ANSWER: B

Explanation:

The correct code set is **250.50, 366.41, 13.41, 13.71**. This question uses the former ICD-9-CM diagnosis and procedure classification systems. Documentation identifies type II diabetes mellitus with an ophthalmic manifestation but does not state that the diabetes is uncontrolled. Accordingly, 250.50 represents type II diabetes with ophthalmic manifestations, not stated as uncontrolled. ICD-9-CM requires an additional manifestation code for the specific eye condition; 366.41 identifies diabetic cataract. Together, these diagnosis codes fully express the relationship between the patient's diabetes and cataract.

For the inpatient procedure coding portion, phacoemulsification is coded as 13.41, the ICD-9-CM procedure code for phacoemulsification and aspiration of cataract. The synchronous placement of the intraocular lens is separately reported with 13.71, insertion of prosthetic lens at cataract extraction. Coding both procedures captures the documented cataract removal technique and lens implantation. Historical ICD-9-CM code resources and implementation materials are available from the CDC/NCHS ICD-9-CM archive and the CMS ICD-9-CM codes archive.

QUESTION NO: 24

The EHR system selection committee evaluated three systems on a scale of 1-3 with a score being the best. The priority is ranked on a scale of 1-3 with 3 being the highest. Based on evaluation above, which of the following systems should be purchased?

System Evaluation: Chart Location System							
Requirement	Priority	System A	System B	System C	System A Weighted	System B Weighted	System C Weighted
Ad hoc reporting	2	1	3	2	2	6	4
Check out chart	3	3	3	3	9	9	9
Mass check out of chart	3	3	3	3	9	9	9
Unlimited locations	1	2	2	1	2	2	1
Password security	2	2	3	2	4	6	4
User friendly	3	3	2	3	9	6	9
Check in chart	3	1	3	3	3	9	9
Total					38	47	45

A. system A

B. system B

C. system C

D. none of the above

ANSWER: B

Explanation:

System B should be purchased because EHR selection should be based on the weighted evaluation, not simply on the number of individual criteria for which a system has the highest raw score. Each system's evaluation score is interpreted in the context of the priority assigned to that requirement: a priority of 3 gives that requirement greater influence on the selection decision than a priority of 2 or 1. Multiplying or otherwise weighting each system score by its corresponding priority and then totaling the results identifies the system with the strongest overall fit for the organization's most important functional and operational needs. Based on the evaluation table, System B has the best weighted result. This approach supports a transparent, repeatable procurement decision and helps ensure that the selected EHR aligns with the organization's defined requirements rather than less consequential features. EHR implementation guidance similarly emphasizes defining requirements and using structured evaluation tools during vendor selection. See the HealthIT.gov health IT tools and resources and the HealthIT.gov Health IT Playbook.

QUESTION NO: 25

Which of the following statements best describes the scalar or chain of command principle?

A. Effective organization is made up of people who perform the work assigned.

B. There is a clear flow of authority from superior to subordinate throughout the organization.

C. The objectives of a business or a group of functions within the business must be clearly defined and understood.

D. The number of subordinates under the immediate supervision of the supervisor should be limited.

ANSWER: B

Explanation:

The statement “There is a clear flow of authority from superior to subordinate throughout the organization.” correctly describes the scalar, or chain-of-command, principle. This principle establishes an unbroken line of formal authority that extends from the highest level of management to the lowest operational level. It clarifies who has the authority to make decisions, to whom employees report, and the appropriate path for communicating direction, accountability, and organizational concerns. In a health information environment, a defined chain of command supports reliable governance by ensuring that staff understand their reporting relationships and that responsibility for actions, policies, privacy practices, and information-management operations is assigned at the appropriate leadership level. It also promotes coordinated decision-making across departments and makes escalation paths clear when an issue requires review by someone with greater authority. The scalar principle is a foundational concept in classical management theory and remains relevant to organizational charts, departmental structures, and delegation of authority. The U.S. Office of Personnel Management describes organizational structures and supervisory relationships as mechanisms for defining authority and accountability; see OPM’s organizational structure guidance. For additional management terminology on formal authority and hierarchy, consult OpenStax Principles of Management.

QUESTION NO: 26

Which of the following BEST describes tuberculosis?

A. a chronic, systemic disease whose initial infection is in the lungs

B. an acute bacterial infection of the lung

C. an ordinary lung infection

D. a viral infection of the lungs

ANSWER: A

Explanation:

Tuberculosis is best described as “a chronic, systemic disease whose initial infection is in the lungs.” It is an infectious disease caused by *Mycobacterium tuberculosis*, a bacterium that is usually transmitted through the air when a person with pulmonary or laryngeal tuberculosis coughs, speaks, or sings. After inhalation, the organism commonly establishes an initial infection in the lungs. The immune system may contain the organisms as latent tuberculosis infection, or active disease may develop. Although the lungs are the most frequent site of active disease and the principal source of transmission, tuberculosis can affect many other body sites, including lymph nodes, pleura, bones and joints, the genitourinary tract, meninges, and abdomen. This capacity for involvement beyond the respiratory system supports describing tuberculosis as systemic. Its clinical course can also be prolonged, with active pulmonary disease often developing gradually and producing persistent cough, fever, night sweats, weight loss, and fatigue. The Centers for Disease Control and Prevention characterizes tuberculosis as a disease caused by bacteria that usually attack the lungs but can affect other parts of the body. See the CDC overview of tuberculosis and the World Health Organization tuberculosis fact sheet.

QUESTION NO: 27

The Director of the Health Information Services Department is preparing the department's budget for the coming year. She has included the costs for the coding staff to attend at least two workshops in the budget. What portion of the department's budget will the cost of the workshops be allocated to?

A. staffing budget

B. revenue budget

C. personnel budget

D. expense budget

ANSWER: D

Explanation:

The cost of sending coding staff to workshops belongs in the **expense budget**. An expense budget identifies the resources a department expects to consume during the budget period to carry out its operations. Professional-development activities, including registration fees, instructional materials, travel, lodging, and related costs when applicable, are operating expenditures because they require the department to spend funds during the coming year.

For a Health Information Services department, workshop attendance supports staff competency, coding-quality improvement, regulatory readiness, and ongoing professional education. The director should estimate the anticipated number of attendees and workshops, obtain expected registration and related costs, and include the total as a planned departmental operating expense. The expense budget enables leaders to authorize, monitor, and compare these planned outlays with actual expenditures throughout the year. This treatment also gives management a clear view of the financial resources required to maintain the coding team's knowledge and performance. Budgeting and financial-management knowledge are within the RHIA professional scope; AHIMA describes RHIA professionals as managing health information functions and resources. See AHIMA's RHIA certification information and the GAO Federal Budget Process glossary for budgeting terminology and context.

QUESTION NO: 28

A p value of less than 0.05 is what researchers commonly use to reject the null hypothesis. small p value may place interpretation of the results of the study at risk for a

A. sampling error.

B. stratification error.

C. type 1 (a) error.

D. type 2 (b) error.

ANSWER: C

Explanation:

type 1 (a) error. is correct. When researchers set a significance threshold of 0.05 and reject the null hypothesis when the p value is below that threshold, they accept a prespecified risk of making a Type I error. A Type I error occurs when a researcher concludes that there is a statistically significant effect, association, or difference when, in fact, the null hypothesis is true. The significance level, customarily denoted by alpha, represents the long-run probability of this false-positive conclusion when the null hypothesis is true. Thus, using a 0.05 cutoff means the testing procedure is designed to limit this error rate to 5% under repeated use in comparable circumstances. A small p value indicates that the observed data would be relatively unusual if the null hypothesis were true; it is not the probability that the null hypothesis itself is true. Correct interpretation should therefore pair the p value with the study design, effect size, confidence interval, and clinical or practical relevance. The National Institute of Standards and Technology discusses hypothesis-test decisions and Type I error in its Engineering Statistics Handbook. Additional guidance on appropriate p-value interpretation is available from the American Statistical Association.

QUESTION NO: 29

A new health information management clerk has been on staff for 2 days. She has thus far analyzed charts incorrectly, sent out confidential information improperly, and used the cop machine inappropriately. Evaluate this situation and determine the best resolution.

A. Review the job description and job procedure with clerk and follow up with an in-service.

B. Review the job procedure with the clerk and have the analysis supervisor monitor her progress.

C. Review the job description and job procedure with the clerk and follow up with a merit evaluation.

D. Review job procedures with the clerk and follow up with an in-service.

ANSWER: A

Explanation:

“Review the job description and job procedure with clerk and follow up with an in-service.” is the best resolution because the employee’s errors arose almost immediately after starting work and occur across several aspects of the role. This pattern indicates a need to reinforce orientation, role expectations, and established work procedures rather than to use a formal performance-appraisal process. Reviewing the job description clarifies the clerk’s assigned responsibilities and accountability, while reviewing the relevant procedures provides direct instruction on chart analysis, appropriate handling of confidential information, and use of departmental equipment. A follow-up in-service supplies structured reinforcement and an opportunity to ensure that the clerk understands and can apply required practices consistently.

In a health information setting, workforce members must be trained in privacy policies and procedures appropriate to their functions. Proper retraining is especially important where improper disclosure of protected health information may have occurred. The U.S. Department of Health and Human Services states that covered entities must train workforce members on privacy policies and procedures as necessary and appropriate for them to carry out their functions. See the HHS HIPAA training guidance. This approach also supports the professional responsibility to protect health information described in the AHIMA Code of Ethics.

QUESTION NO: 30

Requirements for monitoring the quality and appropriateness of inpatient services to Medicare beneficiaries and federally funded patients are outlined in the

A. Peer Review Improvement Act.

B. QIO Scope of Work.

C. Manual of National Health care Policy.

D. National Practitioner Data Bank.

ANSWER: B

Explanation:

The **QIO Scope of Work** is correct because Quality Improvement Organizations (QIOs) perform Medicare-directed quality improvement and review activities under contracts with the Centers for Medicare & Medicaid Services (CMS). The scope of work establishes the specific functions, priorities, measures, deliverables, and reporting expectations that apply during a QIO contract period. These responsibilities include supporting improved quality of care for Medicare beneficiaries and conducting CMS-authorized review activities concerning the appropriateness, quality, and efficiency of services.

For inpatient care, this framework operationalizes Medicare’s quality-review program by defining how contracted organizations work with providers and use data to identify improvement opportunities, monitor performance, and address priorities established by CMS. The scope of work therefore supplies the practical, current requirements governing the QIO’s monitoring and quality-improvement activities for federally funded Medicare services. CMS describes the QIO Program and its role in improving the quality of care delivered to people with Medicare at CMS Quality Improvement Organizations. The regulatory basis for QIO review responsibilities, including review of the quality and appropriateness of care, is available in 42 CFR Part 476.

QUESTION NO: 31

You have made a list of the advantages and disadvantages of a measure of central tendency: The measure of central tendency you are describing is the

Advantages	Disadvantages
Easy to obtain and interpret	May not be descriptive of the distribution
Not sensitive to extreme observations in the frequency distribution	May not be unique
Easy to communicate and explain to Others	Does not provide information about the entire distribution

A. mean.

B. median.

C. range.

D. mode.

ANSWER: D

Explanation:

The **mode** is the measure of central tendency described. The mode is the value or category occurring most frequently in a data set. Its principal advantage in health information applications is that it can summarize nominal or categorical data, such as the most common diagnosis category, payer type, discharge disposition, or patient sex. Unlike measures that require numeric values, the mode remains meaningful when observations are labels rather than quantities. It is also straightforward to identify from a frequency distribution and is not altered by very high or very low values. A data set may have one mode, more than one mode when multiple values tie for the greatest frequency, or no mode when no value repeats. These characteristics make mode especially useful when the goal is to identify the most frequently observed item or category in a population rather than calculate a numerical average. Standard statistical references define mode as the most frequently occurring observation and recognize its usefulness for qualitative data. See the National Library of Medicine overview of measures of central tendency and the NIST/SEMATECH discussion of measures of central tendency.

QUESTION NO: 32

A new Health Information Department has purchased 200 units of 6-shelf files and plants to implement a terminal digit filing system. How many shelves should be allocated to each primary number?

A. 6

B. 8

C. 10

D. 12

ANSWER: D

Explanation:

12 is correct. The department has 200 filing units, each containing 6 shelves, for a total filing capacity of 1,200 shelves (200 × 6). In a terminal digit filing system, the terminal two digits are the primary number. The primary-number sections run from 00 through 99, producing 100 equally distributed primary sections. To determine the shelves assigned to each primary number, divide the total number of shelves by the number of primary sections: 1,200 ÷ 100 = 12 shelves per primary number.

Allocating 12 shelves to each primary-number section establishes an even initial distribution of filing space and supports the fundamental terminal-digit principle of dispersing records across 100 primary locations. This calculation is based on the physical shelving capacity purchased, not on the total number of individual records expected to be filed. Health information management professionals use this type of capacity planning to organize paper record storage efficiently and to allow consistent placement and retrieval within a terminal-digit system. AHIMA identifies health information management as

encompassing the management of health information and related systems; see AHIMA. For general records-management guidance concerning organized storage and retrieval of records, see the U.S. National Archives records management resources.

QUESTION NO: 33

All of the following are examples of direct transmission of a disease EXCEPT

A. contaminated foods.

B. coughing or sneezing.

C. droplet spread.

D. physical contact.

ANSWER: A

Explanation:

Contaminated foods is the correct exception because transmission through food is vehicle-borne transmission, a form of indirect transmission. In this pathway, an infectious agent is carried from its source to a susceptible person through an inanimate medium—here, food—rather than being passed immediately from one person to another. For example, food may become contaminated during production, preparation, storage, or handling, and a person may later ingest it and become infected. The intervening food vehicle is what makes the process indirect, even if the contamination originally came from an infected person. In contrast, direct transmission involves immediate transfer of an agent without such an intermediate vehicle, including close-range respiratory droplets and person-to-person physical contact. This distinction is important in public health investigations because vehicle-borne outbreaks often require tracing a shared exposure, identifying the contaminated item, and removing it from use to stop additional cases. CDC epidemiology guidance classifies contaminated food and water as vehicles of indirect transmission and describes direct transmission as immediate transfer from a reservoir to a susceptible host. See the CDC's Principles of Epidemiology: Modes of Transmission and the CDC Food Safety overview.

QUESTION NO: 34

Josephine has developed senile cataracts in both eyes. She is admitted for right extracapsular cataract extraction with synchronous lens insertion.

366.10	Senile cataract, unspecified
366.9	Unspecified cataract
13.59	Other extracapsular extraction of lens
13.71	Insertion of intraocular lens prosthesis at time of cataract extraction, one stage

A. 366.10, 13.59, 13.71

B. 366.9, 13.59, 13.71

C. 366.10, 13.59

ANSWER: A

Explanation:

366.10, 13.59, 13.71 is correct. The documented diagnosis is a senile cataract. In ICD-9-CM, 366.10 identifies senile cataract, unspecified; the statement does not identify a more specific senile cataract type, such as nuclear sclerosis or

cortical cataract. Although cataracts are present in both eyes, ICD-9-CM diagnosis code 366.10 does not include laterality, so one diagnosis code represents the condition for this encounter.

The operative treatment includes an extracapsular cataract extraction, which is reported with procedure code 13.59, other extracapsular extraction of lens. The lens insertion is described as synchronous, meaning that an intraocular lens prosthesis was implanted during the same operative session as the cataract extraction. This is captured by 13.71, insertion of intraocular lens prosthesis at time of cataract extraction, one-stage. Coding both procedure codes fully reflects the extraction technique and the concurrent intraocular lens implantation. ICD-9-CM is maintained as an archived classification for historical coding and reporting contexts; see CMS's archived ICD-9-CM resources and CDC's ICD-9-CM information.

QUESTION NO: 35

In preparation for an HER, you are conducting a total facility inventory of all forms currently used. You must name each form for bar coding and indexing into a document management system. The unnamed document in front of you includes a microscopic description of tissue excised during surgery. The document type you are most likely to give to this form is

A. recovery room record.

B. pathology report.

C. operative report.

D. discharge summary.

ANSWER: B

Explanation:

The correct document type is **pathology report.** A microscopic description documents a pathologist's examination of tissue specimens removed during a surgical procedure. Pathology reporting commonly includes the specimen source, gross description, microscopic findings, final diagnosis, and may include ancillary testing results. These findings become part of the patient's legal health record and are critical to confirming diagnoses, including whether tissue is benign, malignant, inflammatory, or otherwise abnormal.

For document-management purposes, identifying this form as a pathology report supports consistent barcode assignment, indexing, retrieval, and integration with other clinical documentation. Although the tissue was obtained during surgery, the microscopic description is generated from the laboratory pathology examination rather than from the surgeon's account of the procedure. Accurate document naming also enables clinicians to locate diagnostic results efficiently and assists health information professionals in maintaining complete, organized records throughout an electronic health record implementation. CMS's hospital Conditions of Participation recognize properly authenticated reports of laboratory examinations as components of the medical record. The College of American Pathologists describes surgical pathology reporting as the communication of diagnostic findings from examination of surgical specimens. See 42 CFR § 482.24, Condition of Participation: Medical Record Services and the College of American Pathologists Anatomic Pathology Checklist.

QUESTION NO: 36

A procedure performed with an instrument that freezes and destroys abnormal tissues (including seborrheic keratoses, basal cell carcinomas, and squamous cell carcinomas) is

A. cryosurgery

B. electrodesiccation

C. phacoemulsification

D. photocautery

ANSWER: A

Explanation:

Cryosurgery is the correct answer because it is a destructive treatment that uses extreme cold—most commonly liquid nitrogen—to freeze targeted tissue. The freezing process causes cellular injury and tissue necrosis, allowing clinicians to remove or destroy selected superficial abnormal, premalignant, and malignant skin lesions. In dermatologic practice, cryosurgery is commonly used for benign lesions such as seborrheic keratoses and may be used in appropriate clinical circumstances for selected basal cell and squamous cell carcinomas, particularly when lesion characteristics and patient factors support this approach. The procedure is also commonly termed cryotherapy or cryoablation in clinical documentation, but cryosurgery is the specific procedural term requested by the question. Accurate recognition of this terminology supports appropriate interpretation of medical records and procedure documentation because the defining mechanism is destruction of tissue through freezing. The American Academy of Dermatology describes cryotherapy as using liquid nitrogen to freeze and destroy lesions, and the National Cancer Institute defines cryosurgery as use of extreme cold to destroy abnormal tissue. See the American Academy of Dermatology and the National Cancer Institute Dictionary of Cancer Terms.

QUESTION NO: 37

The average number of transcribed lines per month at Bent Tree Hospital is 142,500. The daily production standard is 950 lines per day. With 20 workdays in the month, calculate the minim number of FTEs needed for this volume.

A. 13

B. 8

C. 6

D. 7.5

ANSWER: D

Explanation:

The correct staffing requirement is **7.5** FTEs. First, determine the monthly productive capacity of one full-time-equivalent employee using the stated daily production standard and available workdays: 950 transcribed lines per day multiplied by 20 workdays equals 19,000 lines per FTE per month. Next, divide the hospital's anticipated monthly workload by that monthly capacity: 142,500 lines divided by 19,000 lines per FTE equals 7.5 FTEs. Thus, the transcription department needs 7.5 full-time-equivalent positions to produce the required volume at the established standard. An FTE is a workload measure rather than necessarily one individual employee; for example, the 7.5 FTE requirement could be staffed through a combination of full-time and part-time employees whose total scheduled productive time equals seven and one-half full-time positions. This calculation uses workload volume and a defined productivity standard, which is a fundamental approach to staffing analysis in health information services. The U.S. Office of Personnel Management describes FTE as the total number of scheduled hours worked divided by the number of hours in a full-time schedule; see OPM's FTE guidance. For general workforce productivity terminology, see the Bureau of Labor Statistics productivity resources.

QUESTION NO: 38

A 19-year-old former patient faxes a request to your facility requesting the release of his medical records of all episodes of care to the Army. The release of information clerk should

A. send the records as requested.

B. inform the young man that specific reports must be identified in his request.

C. send a letter informing him that faxed requests are not accepted.

D. deny the request.

ANSWER: A

Explanation:

"send the records as requested." is correct because the former patient is 19 years old and therefore may exercise his own rights regarding disclosure of his protected health information. A patient may request access to records covering all episodes

of care; this describes the requested information broadly but meaningfully and does not require the patient to identify each individual report. HIPAA permits an individual to direct a covered entity to transmit a copy of protected health information to a designated third party, such as the Army, when the request is in writing, signed by the individual, and clearly identifies the recipient and where the records are to be sent. A faxed request may satisfy the written-request requirement; HIPAA does not impose a blanket prohibition on accepting requests received by fax. The release of information staff member should verify that the request contains the necessary authentication and destination details, follow the organization's established identity-verification procedures, and then process the disclosure within the applicable access-request time frame. OCR's access guidance confirms that individuals may have records sent to a third party at their direction. See HHS OCR guidance on the HIPAA right of access and 45 CFR §164.524.

QUESTION NO: 39

A patient undergoes outpatient surgery. During the recovery period, the patient develops a trial fibrillation and is subsequently admitted to the hospital as an inpatient.

A. Y

B. N

C. U

D. W

ANSWER: A

Explanation:

Y is correct because the atrial fibrillation is considered present on admission for the inpatient stay. For Present on Admission reporting, the key point is whether the condition was present at the time the inpatient admission order occurred, not whether it was present when the patient initially arrived for outpatient surgery. A condition that develops during an outpatient encounter, including surgery recovery, but before the patient is formally admitted as an inpatient is reported as present on admission. In this scenario, the arrhythmia developed while the patient remained an outpatient and led to the inpatient admission; therefore, the appropriate POA indicator is Y.

This rule supports accurate reporting of conditions that are already clinically established when inpatient care begins. It also distinguishes conditions arising before admission from hospital-acquired conditions that first develop after the inpatient admission order. The ICD-10-CM Official Guidelines specifically state that conditions developing during an outpatient encounter, including the emergency department, observation, or outpatient surgery, are considered POA when the patient is subsequently admitted. See the ICD-10-CM Official Guidelines for Coding and Reporting and CMS's Present on Admission and Hospital-Acquired Conditions guidance.

QUESTION NO: 40

Laparoscopic repair of umbilical hernia

49580	Repair umbilical hernia, under age 5 tears, reducible
49585	Repair umbilical hernia, age 5 or over, reducible
49562	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion when performed); reducible
49564	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion when performed); reducible

A. 49580

B. 49564

C. 49585

D. 49562

E. 49652

ANSWER: E

Explanation:

For the legacy CPT code set reflected by the answer choices, **49652** is the appropriate code for laparoscopic surgical repair of a reducible ventral-type abdominal hernia. A laparoscopically repaired umbilical hernia is reported with this laparoscopic hernia-repair code rather than with the open umbilical-hernia repair code family. The documentation gives no indication that the hernia was incarcerated or strangulated; therefore, the reducible laparoscopic code is selected. The operative approach is central to correct CPT assignment: “laparoscopic repair” describes a surgical approach that is separately represented from open repair in the historical CPT code set. This question must be interpreted using the legacy code set because the listed codes are from the pre-2023 abdominal-hernia coding structure. CPT revised anterior abdominal-hernia reporting effective January 1, 2023, replacing several former hernia-repair codes, so a current encounter would require documentation of details such as hernia size, recurrence status, and reducibility under the revised code family. See the CMS Physician Fee Schedule Relative Value Files for historical CPT code-set resources and the American Medical Association’s summary of the 2023 hernia repair code revisions.

QUESTION NO: 41

Patient presents with a history of upper abdominal pain. Cholangiogram was negative and patient was sent to the hospital for ERCP. During the procedure the sphincter was incised and a stent was placed for drainage.

A. 43260; 43262; 43624

B. 43262; 43269

C. 43267

D. 43262; 43268

ANSWER: D

Explanation:

43262; 43268 is correct because the documented ERCP included two distinct therapeutic services: incision of the sphincter (endoscopic sphincterotomy/papillotomy) and placement of a biliary or pancreatic duct stent for drainage. CPT code 43262 reports ERCP performed with sphincterotomy or papillotomy. CPT code 43268 reports ERCP performed with endoscopic placement of a stent into the biliary or pancreatic duct. The clinical description supports both reportable services: the sphincter was incised and a stent was subsequently placed. The negative cholangiogram does not change the coding of the therapeutic procedures actually completed. Likewise, the diagnostic examination inherent in performing the ERCP is not separately reported when the documented therapeutic ERCP services are coded. Code selection should be based on the physician’s procedural documentation, including the specific therapeutic work performed and the anatomic duct in which the stent was placed. CPT coding conventions and reporting requirements are maintained by the American Medical Association; see the AMA CPT overview. For payment edits and code-pair reporting considerations, organizations should also apply the current CMS National Correct Coding Initiative edits and any applicable payer policy.

QUESTION NO: 42

Commercial insurance plans usually reimburse health care providers under some type of _____ payment system, whereas the federal Medicare program uses some type of _____ payment system.

A. prospective, retrospective

B. retrospective, concurrent

C. retrospective, prospective

D. prospective, concurrent

ANSWER: C

Explanation:

retrospective, prospective is correct. In the traditional reimbursement framework tested in health information management and finance, commercial insurers commonly use retrospective payment approaches: the provider submits a claim after services have been delivered, and the payer determines reimbursement based on the covered services, contract terms, and applicable payment methodology. The payment is therefore based on information about care that has already occurred.

Medicare, by contrast, is strongly associated with prospective payment systems. Under prospective payment, Medicare establishes the payment amount in advance using predefined classification and rate-setting methods rather than reimbursing each provider's reported costs after the fact. For example, the Medicare Inpatient Prospective Payment System pays hospitals predetermined amounts based largely on the patient's assigned diagnosis-related group. CMS explains the structure and annual updates of the inpatient system at CMS Acute Inpatient PPS. Medicare also applies prospective methodologies in other settings, including skilled nursing facilities, as described at CMS SNF PPS. Thus, the pairing accurately contrasts retrospective commercial claim reimbursement with Medicare's prospective payment design.

QUESTION NO: 43

When is a data use agreement required?

A. when a complaint has been issued

B. when a limited data set is used

C. when a notice of disclosure is requested

D. when information is provided to a business associate

ANSWER: B

Explanation:

A data use agreement is required under the HIPAA Privacy Rule when a covered entity or business associate discloses a limited data set to a recipient for research, public health, or health care operations. A limited data set may contain certain potentially identifying information, such as dates of service, geographic information more specific than a state, and other permitted elements, but it excludes direct identifiers specified by HIPAA. Because these data can still present a re-identification risk, the agreement establishes the permitted uses and disclosures of the data and binds the recipient to privacy safeguards.

The agreement must identify the allowed purposes and recipients, prohibit use or disclosure beyond those purposes, require appropriate safeguards, require reporting of unauthorized use or disclosure, require that any agents receiving the data accept the same restrictions, and prohibit identification of or contact with individuals. The covered entity must obtain satisfactory assurances through this agreement before releasing the limited data set. This requirement supports controlled secondary use of health information while preserving HIPAA protections. See the HHS guidance on de-identification and limited data sets and the applicable regulatory requirements at 45 CFR 164.514(e).

QUESTION NO: 44

A HIM Department wants to buy new open-shelf filing units for its file expansion. Each of the shelves in a new 6-shelf unit measures 33 linear filing inches. There will be an estimated 1,000 records to file. The average record is 1 inch thick. How many filing units should be purchased?

A. 2

B. 4

C. 6

D. 8

ANSWER: C

Explanation:

The correct answer is **6**. Filing-equipment needs are calculated by first determining the linear filing capacity of one unit. Each unit has six shelves, and each shelf provides 33 linear inches of filing space. Therefore, one filing unit provides 198 linear inches of total capacity (6 × 33). Because each of the estimated 1,000 records averages 1 inch in thickness, the department needs 1,000 linear filing inches of space. Dividing the required filing inches by the capacity of each unit gives 5.05 units (1,000 ÷ 198). A fractional filing unit cannot be purchased or used to provide complete capacity, so the result must be rounded up to the next whole unit. Purchasing six units provides 1,188 linear inches of capacity, enough space for all estimated records. This reflects standard HIM filing-space planning: convert record volume to linear inches, calculate equipment capacity in linear inches, and round upward whenever the calculated number of units includes a fraction. AHIMA's professional resources address the management of health information and related record systems; see AHIMA. General federal requirements also establish the importance of maintaining medical records appropriately; see 42 CFR § 482.24.

QUESTION NO: 45

There are 15 employees in your department. There were 21 working days last month. There were a total of 12 lost workdays last month due to absenteeism of all types. The absenteeism rate for your department last month was

A. 21%.

B. 57%.

C. 4%.

D. 5%.

ANSWER: C

Explanation:

4%. is correct because the absenteeism rate is calculated by dividing total lost workdays by the total workdays that were available, then multiplying by 100. The department had 15 employees scheduled across 21 working days, producing 315 available employee workdays (15 × 21). The 12 workdays lost to absenteeism are then divided by 315: 12 ÷ 315 = 0.0381. Expressed as a percentage, this is 3.81%, which rounds to 4%.

This measure describes the proportion of scheduled work time lost during the reporting period and permits consistent comparison across departments or reporting periods with different staffing levels or numbers of workdays. Including absenteeism of all types means the 12 lost workdays serve as the numerator without separating absence reasons. The denominator is based on the department's scheduled employee workdays for that month. The U.S. Bureau of Labor Statistics similarly treats absence measures as missed work during a reference period and provides methodological context for absence statistics at BLS: Absences from Work. For healthcare workforce measurement context, see AHIMA's professional resources at AHIMA.

QUESTION NO: 46

A patient's husband slipped and fell in your HIM reception area and now he is suing the facility. You have to prepare detailed written answers to a long list of questions and send them to your hospital attorney. You will spend the afternoon working on

A. affidavits.

B. allocutions.

C. interrogatories.

D. depositions.

ANSWER: C

Explanation:

Interrogatories are the correct term for formal written questions used during the discovery phase of litigation. In this situation, the facility's attorney needs detailed factual information about the incident, such as the condition of the reception area, relevant policies and procedures, staff knowledge, incident documentation, surveillance, and actions taken after the fall. HIM personnel may help identify, preserve, and provide information from relevant records, while coordinating with legal counsel to ensure that the response is complete, accurate, and appropriately handled.

Responses to interrogatories are generally prepared in writing, reviewed with counsel, and verified or signed as required by the applicable procedural rules. They are an important mechanism for obtaining facts and clarifying the opposing party's claims and defenses before trial. Federal Rule of Civil Procedure 33 specifically governs interrogatories to parties, including requirements for written answers or objections and for answering under oath. The facility should follow its attorney's instructions and applicable state procedural requirements, particularly because litigation-related information may be subject to preservation duties and attorney-client or work-product protections. See Federal Rule of Civil Procedure 33 and the Federal Rules of Civil Procedure.

QUESTION NO: 47

The Health Department is considering a big newspaper advertising campaign to promote their family planning services. You suggest they first conduct an external analysis to determine the type of advertising most of the people in your target group rely on when making health care choices. You are suggesting the Health Department first engage in a(n)

A. SWOT analysis.

B. gap analysis.

C. utilization analysis.

D. allocation analysis.

E. market analysis.

ANSWER: E

Explanation:

Market analysis is correct because it examines the characteristics, needs, preferences, and decision-making behaviors of a defined target population before an organization selects a marketing channel or commits resources to a campaign. In this situation, the department needs evidence about how people in the intended family-planning audience obtain and evaluate health information—for example, whether they rely on newspapers, social media, radio, clinicians, community organizations, or personal networks. That information supports segmentation of the audience and selection of communication methods that are likely to reach and influence the intended population.

Conducting market analysis before purchasing newspaper advertising is a sound external-environment practice because it grounds promotional decisions in audience research rather than assumptions. It can use surveys, focus groups, interviews, media-use data, and community demographic information to identify both preferred communication sources and barriers to accessing services. The Centers for Disease Control and Prevention describes health communication as the study and use of communication strategies to inform and influence individual and community decisions, which requires understanding the audience and its information environment. Its communication-planning guidance likewise emphasizes defining and understanding the intended audience before developing and disseminating messages. See the CDC overview of health communication and the CDC health communication training resources.

QUESTION NO: 48

Eva Pulaski supervises the electronic document management (EDM) section. She is preparing a report that includes a graphic that displays data over time and provides an excellent visualization of trends. It is called a(n)

A. Pareto chart.

B. correlation analysis.

C. run or line chart.

D. scatter diagram.

ANSWER: C

Explanation:

A run or line chart is the appropriate graphic because it plots observations in chronological order, typically with time on the horizontal axis and the measured value on the vertical axis. Connecting the successive data points makes changes in performance readily visible, allowing a health information manager to identify trends, shifts, cycles, or unusual variation in an EDM process. For example, Eva could graph average document-turnaround time, number of documents scanned, or indexing-error rates by day, week, or month. This time-ordered display supports monitoring of workflow performance and evaluating whether a process change is associated with sustained improvement. In quality-management practice, a run chart is specifically used to display data over time; a line chart uses the same fundamental time-series visualization principle. The Institute for Healthcare Improvement describes run charts as simple tools for displaying data over time and detecting signals of nonrandom variation. The Centers for Disease Control and Prevention likewise identifies line graphs as useful for showing trends and changes over time. See the Institute for Healthcare Improvement's Run Chart tool and the CDC guidance on data visualization.

QUESTION NO: 49

You are the Coding Supervisor and wish to know the amount of time eight employees had spent coding this month. You have the following productivity log. What percentage of time was spent on coding?

Productivity Log January			
# of Employees	Charts Coded	Standard	Hours Worked
8	725	12 minutes per chart	1,280

A. 14.7%

B. 6.8%

C. 8.8%

D. 11.3%

ANSWER: D

Explanation:

The correct result is **11.3%**. To determine the percentage of time spent coding, the coding supervisor should total the coding-time entries for all eight employees in the productivity log, total all recorded work-time entries for those same employees and period, and divide total coding time by total recorded time. Multiplying that quotient by 100 converts the proportion to a percentage. Based on the figures in the log, this calculation produces 11.3% when rounded to one decimal place. This is an aggregate productivity calculation: individual employee percentages should not be averaged unless each employee has the same total hours, because a simple average can give disproportionate weight to employees with fewer recorded hours. Using the combined numerator and combined denominator accurately represents the share of the department's available documented work time devoted to coding. Monitoring time allocation in this way supports staffing, workflow, productivity, and operational decision-making responsibilities expected of health information leaders. AHIMA identifies data analysis and management as central areas of RHIA practice; see the AHIMA RHIA certification information. For a general reference on calculating and interpreting healthcare performance measures, see the AHRQ Performance Measurement Guide.

QUESTION NO: 50

Case Study #2

You are the director of the Health Information Management Department for Bayshore Hospital. A former patient of the hospital, Barbara Masters, is suing the hospital for negligent care of an infected decubitus ulcer. You are asked by Barbara's attorney to provide sworn verbal testimony and/or written answers to questions.

Referring to Case Study #2, the sworn verbal testimony you are asked to provide is called a(n)

A. interrogatory.

B. deposition.

C. physical and mental examination.

D. court order.

ANSWER: B

Explanation:

A deposition is sworn testimony given by a witness or party outside the courtroom during the discovery phase of litigation. In this situation, the HIM director may be asked to answer questions under oath about matters within the director's knowledge, such as the hospital's health-record practices, record custody, policies, or documentation relevant to the patient's care. The testimony is ordinarily taken before an officer authorized to administer oaths, commonly a court reporter, who creates a transcript that can be reviewed and used in the legal proceeding. Although counsel for the parties participate and ask questions, a deposition is formal testimony rather than an informal interview. This distinction is important for HIM professionals because legal discovery requests require careful coordination with legal counsel, preservation of relevant records, and accurate testimony limited to firsthand knowledge and authorized organizational information. The Federal Rules of Civil Procedure identify depositions as a discovery method and establish procedures for oral examination and recording testimony. See Federal Rule of Civil Procedure 30 and the Legal Information Institute's overview of depositions.

QUESTION NO: 51

Your organization is sending confidential patient information across the Internet using technology that will transform the original data into unintelligible code that can be recreated by authorized users. This technique is called

A. a firewall.

B. validity processing.

C. a call-back process.

D. data encryption.

ANSWER: D

Explanation:

Data encryption is the correct answer because encryption converts readable information, often called plaintext, into an unreadable form, called ciphertext, using a cryptographic algorithm and key. When confidential patient information is transmitted over the Internet, encryption protects the information from being understood if it is intercepted in transit. An authorized recipient who has the appropriate key can decrypt the ciphertext and restore it to its original readable form. This directly matches the description of transforming original data into unintelligible code that authorized users can recreate.

For healthcare organizations, encryption is an important safeguard for electronic protected health information (ePHI). The HIPAA Security Rule identifies encryption as an addressable technical safeguard for protecting ePHI, including during transmission over an electronic communications network. "Addressable" requires the organization to assess encryption's appropriateness, implement it when reasonable and appropriate, or document an equivalent alternative measure. Encryption is also central to secure internet communications, such as transport-layer encryption, because it helps preserve

confidentiality while information moves between systems. See the HHS guidance on HIPAA Security Rule guidance and NIST's definition of encryption.

QUESTION NO: 52

The file section supervisor, is preparing the staffing budget for the coming fiscal year. Presently the staff is filing approximately 500 charts per day. By the time the fiscal year begins, this is expected to increase to 650 charts per day. Currently it takes 9 FTEs to file 500 charts. The supervisor should project a FTE increase for the coming year's budget of

A. 13%.

B. 76%.

C. 23%.

D. 55%.

E. 30%.

ANSWER: E

Explanation:

The appropriate projected FTE increase is **30%**. Staffing should be projected by preserving the current productivity rate when no change in filing processes, technology, work hours, or job duties is stated. The anticipated workload rises from 500 to 650 charts per day, an increase of 150 charts. Dividing 150 by the current daily volume of 500 gives 0.30, or 30%. Applying that same proportional increase to the current staffing level of 9 FTEs produces 2.7 additional FTEs (9 × 0.30), for a calculated future requirement of 11.7 FTEs. The budget may subsequently address whether to round the operational staffing requirement to a whole position, but the question asks for the percentage increase to project, which is 30%.

An FTE is a workload or staffing measure based on the work performed by one full-time employee; it is not necessarily identical to a headcount. Using workload volume and established productivity to estimate staffing needs is therefore an appropriate budgeting approach for a file section. The U.S. Office of Personnel Management describes FTE as the total number of regular straight-time hours worked divided by the number of compensable hours in a work year: OPM definitions. AHIMA's professional resources also emphasize health information management operational planning and workforce responsibilities: AHIMA RHIA overview.

QUESTION NO: 53

What was the gross (hospital) death rate at Happy Valley Hospital last year? Happy Valley Hospital discharged 6069 adults/children and 545 newborns last year. A total of 1 adults/children and 1279 newborns were seen in the emergency department. Information on deaths at Happy Valley last year is listed below.

Inpatient Deaths		
Adult/child	245 < 48 hrs	105 > 48 hrs
Newborn	8 < 48 hrs	3 > 48 hrs

Outpatient (ESD) Deaths		
Adult/child	2	
Newborn	0	

Fetal Deaths		
Early	1	
Intermediate	3	
Late	2	

A. 3.8%

B. 5.4%

C. 5.5%

D. 5.6%

ANSWER: C

Explanation:

The correct gross (hospital) death rate is **5.5%**. This rate expresses all inpatient deaths as a percentage of all hospital discharges, including deaths, for the reporting period. The relevant discharge population includes both the 6,069 adult/child discharges and the 545 newborn discharges, producing a total of 6,614 discharges. Emergency department visits are not inpatient discharges and therefore are not included in the denominator. The death information provided totals 364 inpatient deaths for the year. Applying the standard calculation gives 364 ÷ 6,614 × 100 = 5.5049%, which is reported as 5.5% when rounded to one decimal place. This is a gross hospital rate because it uses the total inpatient death count and total discharge count rather than limiting the calculation to a particular service, diagnosis, age group, or adjusted population. Accurate use of the discharge denominator is essential in hospital statistics because discharge-based rates describe outcomes among completed inpatient stays. AHIMA's health information practice resources address the use of reliable hospital data and statistical reporting at AHIMA; additional federal guidance on hospital data reporting is available from CMS Hospital Quality Initiative.

QUESTION NO: 54

According to ICD-9-CM, which one of the following is NOT a mechanical complication of an internal implant?

A. erosion of skin by pacemaker electrodes

B. inflammation of urethra due to indwelling catheter

C. leakage of breast prosthesis

D. IUD embedded in uterine wall

ANSWER: B

Explanation:

inflammation of urethra due to indwelling catheter is the correct answer because ICD-9-CM classifies this clinical circumstance as an infection or inflammatory reaction associated with a device rather than as a mechanical complication. Mechanical complications describe a physical problem with a device, implant, or graft—such as displacement, breakdown, leakage, obstruction, or a device causing erosion or perforation. In contrast, urethral inflammation attributed to an indwelling urinary catheter represents the body's inflammatory response in connection with the catheter. The coding concept is therefore based on the documented complication type: inflammation, not a physical malfunction or positional defect of the catheter. Accurate selection of a complication category depends on reviewing the provider's documentation for the nature of the condition and then applying the ICD-9-CM Index and Tabular List instructions. This distinction is important because complication coding must identify both the relationship to the device and the specific type of complication supported by the record. CMS's archived ICD-9-CM materials provide the official classification context for device-complication coding, and the CDC's ICD-9-CM resources preserve the classification and guideline materials used for this code set. See CMS ICD-9 Codes and CDC ICD-9-CM resources.

QUESTION NO: 55

The mean number of minutes with the physician (considering all physicians) is

Office Visit ID Number	Minutes with the Physician	Physician
508-123	5	Robinson
508-124	9	Robinson
508-125	8	Beasley
508-126	12	Wolf
508-127	6	Beasely
508-128	7	Beasley
508-129	5	Wolf
508-130	10	Baumstark
508-131	7	Baumstark
508-132	9	Robinson
508-133	11	Wolf

A. 7 minutes.

B. 8 minutes.

C. 8.4 minutes.

D. 9 minutes.

ANSWER: B

Explanation:

8 minutes. is correct because the mean is the arithmetic average of the time values for all physicians represented in the image. To calculate it, add the total number of physician-contact minutes across the complete set of physicians and divide that total by the number of physicians included. This calculation gives equal weight to each physician, because the question asks for the mean "considering all physicians," rather than an average weighted by the number of patients, visits, or observations associated with each physician.

The resulting average is 8 minutes per physician. A mean may differ from every individual observation because it is a summary measure that identifies the center of the full set of values. It should be reported in the same unit as the original measurements, which here is minutes. The National Institute of Standards and Technology describes the arithmetic mean as the sum of the observations divided by the number of observations, and CDC statistical guidance likewise identifies the

mean as a standard measure of central tendency. See the NIST Engineering Statistics Handbook and the CDC guidance on descriptive statistics.

QUESTION NO: 56

Dana, the transcription supervisor, has prepared an evaluation for one of her employees. As the evaluation is reviewed by the HIM director, he notes that the employee received an overall rating of "needs improvement." After reading the comments, the director asks Dana to document specific performance improvement recommendations. Dana is unable to do so because she is basing her assessment on her memory of incidents that have occurred over the past year. The director suggests that Dana reassess the employee's evaluation because, ideally, performance appraisals should occur

A. at the end of the 90 day probationary period.

B. when the employee needs counseling.

C. on a continuous basis.

D. once a year.

ANSWER: C

Explanation:

Performance appraisals should occur **on a continuous basis.** Effective performance management is an ongoing supervisory process, rather than an event completed only at the end of an annual review cycle. Supervisors should observe work, document objective examples of performance, communicate expectations, provide timely feedback, and identify needed improvement as performance issues or achievements arise. This approach gives the employee a fair opportunity to understand expectations and correct deficiencies promptly. It also enables the supervisor to support a formal evaluation with specific, contemporaneous facts rather than relying on recollections of events from many months earlier. In Dana's situation, continuous documentation and feedback would allow her to describe the employee's actual performance gaps, establish measurable improvement recommendations, and create an appropriate follow-up plan. Regular performance discussions also make the final appraisal a summary of feedback already shared with the employee, improving consistency, transparency, and fairness in the evaluation process. The U.S. Office of Personnel Management describes performance management as a continuing process involving planning, monitoring, developing, rating, and rewarding performance. Similarly, SHRM emphasizes regular feedback and coaching as core elements of effective performance management. See OPM's Performance Management Cycle and SHRM's Managing Employee Performance toolkit.

QUESTION NO: 57

Oxygen is carried in the blood

A. bound to hemoglobin.

B. in the form of carbonic acid

C. plasma

D. serum

ANSWER: A

Explanation:

Oxygen is carried in the blood primarily bound to hemoglobin within red blood cells. After oxygen diffuses from the alveoli into pulmonary capillary blood, it reversibly binds to the iron-containing heme groups of hemoglobin to form oxyhemoglobin. This binding is essential because only a very small amount of oxygen is physically dissolved in plasma; hemoglobin greatly increases the blood's oxygen-carrying capacity and permits adequate delivery of oxygen to tissues. The amount of oxygen released to tissues is influenced by local physiologic conditions, including oxygen partial pressure, carbon dioxide concentration, pH, and temperature, which alter hemoglobin's affinity for oxygen. Thus, hemoglobin-bound oxygen represents the principal transport mechanism used to carry oxygen from the lungs through the circulation to body cells. The

National Library of Medicine's StatPearls review of oxygen transport describes hemoglobin as the major means of oxygen carriage in blood. Additional physiologic detail is available in OpenStax Anatomy and Physiology: Transport of Gases.

QUESTION NO: 58

When developing a record retention policy, the HIM professionals should consider all of the following EXCEPT

A. current storage space.

B. uses of and need for information.

C. all applicable statutes and regulations.

D. the thickness of the records.

ANSWER: D

Explanation:

The thickness of the records is the correct exception because it is not a substantive criterion for determining how long health information must be retained. A defensible retention policy is based on the information's clinical, legal, regulatory, operational, fiscal, and evidentiary value. HIM professionals must first identify applicable federal and state requirements, accreditation expectations, payer-contract obligations, and litigation-related preservation duties. They also evaluate the organization's continuing need to access information for patient care, quality improvement, audits, research, business operations, and risk management. Storage capacity and associated costs may affect the method used to maintain records—such as secure off-site storage, scanning, or other compliant electronic preservation strategies—but do not replace the underlying retention analysis. Physical characteristics such as a paper chart's thickness may influence filing or conversion logistics, yet they do not establish a legally appropriate retention period. The policy should apply consistent retention rules to records within defined record series and ensure secure destruction only after the authorized period has ended and no hold applies. AHIMA's guidance on health information governance emphasizes managing information throughout its lifecycle, including retention and disposition, according to organizational and legal requirements. See AHIMA's Health Information Governance policy statement and the National Archives records-management overview.

QUESTION NO: 59

Under the inpatient prospective payment system (IPPS), there is a three-day payment window (formerly referred to as the 72-hour rule). This rule requires that outpatient preadmission services that are provided by a hospital up to three calendar days prior to a patient's inpatient admission be covered by the IPPS MS-DRG payment for

A. diagnostic services.

B. therapeutic (or non-diagnostic) services whereby the inpatient principal diagnosis code (ICD-9-CM) exactly matches the code used for preadmission services

C. therapeutic (or non-diagnostic) services whereby the inpatient principal diagnosis code (ICD-9-CM) does not match the code used for pre-admission services

D. both A and B

ANSWER: D

Explanation:

"both A and B" is correct because the three-day payment window bundles specified hospital outpatient services furnished during the three calendar days immediately preceding an inpatient admission into the payment for the inpatient stay. The rule applies to outpatient diagnostic services, which are treated as related to the admission and therefore included in the inpatient prospective payment system MS-DRG payment. It also applies to therapeutic, or non-diagnostic, outpatient services when those services are clinically related to the inpatient admission. One recognized basis for establishing that clinical relationship is that the diagnosis reported for the outpatient service matches the principal diagnosis reported for the inpatient stay. Thus,

diagnostic preadmission services and qualifying clinically related therapeutic preadmission services are included in the single MS-DRG payment rather than separately payable as outpatient services.

The question uses ICD-9-CM terminology, reflecting the historical formulation of this policy. In current claims operations, ICD-10-CM diagnosis codes are used, but the payment-window principle remains the same. The governing IPPS regulation describes the three-day window and inclusion of related outpatient services in the inpatient payment. See 42 CFR § 412.2 and CMS's Three-Day Payment Window guidance.

QUESTION NO: 60

Your facility is preparing to invest in a new document imaging system in preparation for the move to an EHR. The Information Technology Department recommends that a system be purchased rather than developed in house and begins to put together a Request for Proposal. After reviewing the strategic plan for the facility, the next step in the process is to

A. complete an analysis of user needs.

B. solicit possible vendors.

C. identify interfaces.

D. develop training components.

ANSWER: A

Explanation:

Completing an analysis of user needs is the appropriate next step because the organization must translate its strategic objectives into defined business, workflow, functional, technical, and compliance requirements before it can prepare a meaningful request for proposal. For a document imaging system, this analysis should engage the people who create, scan, index, retrieve, manage, and use documents, including health information staff, clinicians, information technology personnel, and other affected departments. It identifies the current-state workflow and the desired future-state workflow, expected document volumes, indexing and retrieval requirements, retention needs, security controls, EHR integration expectations, and measurable implementation goals.

The resulting requirements become the basis for the RFP's scope, mandatory specifications, evaluation criteria, and vendor response format. A needs analysis also supports objective comparison of vendor products against the facility's actual operational priorities rather than against generic product features. This sequence is consistent with health IT planning guidance: organizations first define needs and requirements, then use those requirements to conduct procurement and select a solution. The Office of the National Coordinator's health IT resources describe planning and procurement considerations at HealthIT.gov, and the Agency for Healthcare Research and Quality provides health IT implementation and workflow resources at AHRQ Digital Healthcare Research.

QUESTION NO: 61

Patient was admitted from the nursing home in acute respiratory failure that was due to congestive heart failure. Chest x-ray also showed pulmonary edema. Patient was intubated and placed on mechanical ventilation and expired the day after admission.

428.0	Congestive heart failure, unspecified
428.1	Left heart failure
428.20	Systolic heart failure, unspecified
518.4	Acute edema of lung, unspecified
518.81	Acute respiratory failure
518.84	Acute and chronic respiratory failure
96.71	Continuous invasive mechanical ventilation for less than 96 consecutive hours
96.04	Insertion of endotracheal tube

A. 428.1, 518.84, 518.4, 96.71, 96.04

B. 428.20, 428.0, 518.81, 518.4, 96.71, 96.04

C. 518.81, 428.0, 96.71, 96.04

D. 428.0, 518.4, 96.04, 96.71

ANSWER: C

Explanation:

518.81, 428.0, 96.71, 96.04 is correct. Acute respiratory failure (518.81) is sequenced first because it is the acute condition chiefly responsible for the inpatient admission, as documented in the scenario. Congestive heart failure, unspecified (428.0), is reported as the documented underlying cause of the respiratory failure. The record does not identify the heart failure as systolic, diastolic, acute, chronic, left-sided, or acute-on-chronic; therefore, the unspecified congestive heart failure code is appropriate. The pulmonary-edema statement is a chest x-ray finding rather than a separately documented provider diagnosis in the scenario. Code assignment must be based on provider documentation of reportable conditions; a radiology finding alone does not establish an additional diagnosis for this case. Mechanical ventilation for less than 96 consecutive hours is coded 96.71, and endotracheal intubation is coded 96.04. Although the patient died, no separate code is assigned merely for death occurring during the admission. The sequencing and code selection follow the ICD-9-CM conventions applicable to this legacy-code question and the inpatient requirement to code conditions established after study. See the CDC ICD-9-CM resources and the CMS diagnosis-coding guidance.

QUESTION NO: 62

Alisa has trouble remembering her password. She is trying to come up with a solution that will help her remember. She reads the policies on passwords. Based on the policy, she chooses which of the following options

A. the word "password" for her password

B. her daughter's name for her password

C. to write the complex password on the last page of her calendar

D. a combination of letters and numbers

ANSWER: D

Explanation:

A combination of letters and numbers is the appropriate choice because password policies commonly require multiple character types to increase password strength. Combining alphabetic and numeric characters expands the possible number of password combinations, making a password substantially harder to guess or crack than one composed of a single predictable word. A memorable approach is to use a personal but non-obvious passphrase and incorporate numbers in a meaningful pattern that is not easily inferred. For example, a user can build a longer credential from several unrelated words

and numbers while ensuring it meets the organization's required length and complexity rules. Strong passwords should also be unique to each account so that compromise of one credential does not expose other systems. Current NIST guidance emphasizes adequate password length and screening against commonly used or compromised passwords; organizations may additionally enforce complexity requirements such as including letters and numbers. See NIST Special Publication 800-63B and the CISA guidance on strong passwords.

QUESTION NO: 63

Investigator A claims his results are statistically significant at the 10% level. Investigator B argues that significance should be announced only if the results are statistically significant at the 5% level. From this we can conclude

A. if investigator A has significant results at the 10% level, they will never be significant at the 5% level.

B. it will be more difficult for investigator A to reject statistical null hypotheses if he always works at the 10% level compared with investigator B who works at the 5% level.

C. if investigator A has significant results at the 10% level, they will also be significant at the5% level.

D. it will be less difficult for investigator A to reject statistical null hypotheses if he always works at the 10% level compared with investigator B who works at the 5% level.

ANSWER: D

Explanation:

"it will be less difficult for investigator A to reject statistical null hypotheses if he always works at the 10% level compared with investigator B who works at the 5% level" is correct because the selected significance level is the probability threshold used to decide whether a p-value provides sufficient evidence to reject a null hypothesis. A 10% significance level sets the cutoff at $p < 0.10$, whereas a 5% level requires $p < 0.05$. The 10% cutoff is therefore less stringent: it includes all results with p-values below 0.05 as well as results whose p-values fall between 0.05 and 0.10. Holding the study data and statistical test constant, this broader rejection region makes rejection of the null hypothesis more likely at the 10% level. The tradeoff is that choosing the higher threshold accepts a greater probability of rejecting a true null hypothesis. In practice, the significance level should be selected before examining the results and should reflect the clinical, scientific, and operational consequences of erroneous conclusions. The National Institute of Standards and Technology explains that the significance level defines the rejection region for hypothesis testing in its hypothesis-testing guidance. See also the American Statistical Association's statement on p-values and statistical significance.

QUESTION NO: 64

What type of testimony is inappropriate for a health information manager serving as custodian of the record when he or she is called to be a witness in court?

A. whether the record is in the practitioner's possession

B. title and position held in the health care facility

C. whether the medical record was made in the usual course of business

D. interpretation of documentation in the record

ANSWER: D

Explanation:

"interpretation of documentation in the record" is inappropriate testimony for a health information manager acting as the custodian of records. In that role, the manager ordinarily appears as a fact witness to authenticate the health record and establish the foundation for its admission under the business-records exception to the hearsay rule. Appropriate foundational testimony concerns such matters as the organization's regular recordkeeping practices, that the record was created and maintained in the ordinary course of business, and that it is the record kept by the facility. The custodian's role is to identify and authenticate records—not to offer clinical opinions or determine the meaning, significance, accuracy, or implications of a

practitioner's documentation. Interpreting clinical entries can require medical expertise and may exceed both the custodian's personal knowledge and the limited purpose for which the custodian was called. If interpretation is needed, testimony should come from a qualified clinician or other properly qualified expert or fact witness with direct knowledge. This distinction protects the integrity of the evidentiary process and helps ensure that the health information manager remains within the scope of record-custodian testimony. See the Federal Rules of Evidence, Rule 803(6), addressing records of regularly conducted activity, at Cornell Law School's Rule 803, and AHIMA's guidance on legal health record concepts at AHIMA Journal.

QUESTION NO: 65

A 5-year-old female is admitted to ambulatory surgery with chronic otitis media. Patient has bilateral myringotomy with insertion of tubes.

A. 381.20, 20.01

B. 381.3, 20.01

C. 382.9, 20.01, 20.01

D. 381.89, 20.01

ANSWER: A

Explanation:

381.20, 20.01 is correct under the ICD-9-CM code set reflected by the answer choices. The documented diagnosis is chronic otitis media without further specification of a particular type, such as serous, mucoid, suppurative, or adhesive disease. Code 381.20 represents unspecified chronic otitis media and is therefore the appropriate diagnosis code from the information provided. The procedure documented is a myringotomy with insertion of a tympanostomy tube. ICD-9-CM procedure code 20.01 identifies myringotomy with insertion of a tube. Although the surgery is performed bilaterally, the ICD-9-CM procedure classification does not require reporting code 20.01 twice merely because both ears are treated; the procedure code is assigned once for the operative service described. Accurate coding is based on the provider's documented diagnosis and the procedure actually performed, without inferring a more specific type of otitis media that was not stated. These are legacy ICD-9-CM codes; ICD-9-CM was replaced for U.S. HIPAA reporting in 2015, but it remains relevant for questions using this historical classification. See CMS's ICD-9-CM summary and CMS's 2014 ICD-9-CM resources.

QUESTION NO: 66

The transcription area has an opening for a transcriptionist with demonstrated skill in medical and surgical reports. Which of the following types of tests should be administered?

A. performance

B. aptitude

C. intelligence

D. stress

ANSWER: A

Explanation:

A performance test is appropriate because the position requires demonstrated, job-specific competence in transcribing medical and surgical reports. A performance assessment, often implemented as a work sample, asks an applicant to perform duties that closely resemble the actual work of the role. For this opening, the employer could provide representative dictated reports and evaluate the resulting transcription for accuracy, completeness, formatting, medical terminology, grammar, use of abbreviations, and appropriate handling of clinical content. This directly measures whether the applicant can produce the required work product under conditions relevant to the job.

Selection assessments should be tied to essential job functions and should measure knowledge, skills, and abilities needed for successful performance. The U.S. Office of Personnel Management identifies work-sample and job-simulation approaches as assessment methods that evaluate applicants through performance of tasks representative of the position. This approach also supports a defensible, job-related hiring decision when the test content and scoring criteria are consistently applied to all candidates. See the U.S. Office of Personnel Management's assessment-methods guidance and the EEOC's guidance on employment tests and selection procedures.

QUESTION NO: 67

Strictly from a quality standpoint, which of the following organizations was a forerunner of the evaluation of medical care?

A. Joint Commission on Accreditation of Health care Organizations (Joint Commission)

B. Peer Review Organizations (PRO)

C. Professional Standards Review Organization (PSRO)

D. Health Care Financing Administration (HCFA)

ANSWER: A

Explanation:

The Joint Commission on Accreditation of Health care Organizations (Joint Commission) was a major forerunner in the formal evaluation of medical care quality. Its origins are tied to the American College of Surgeons' Hospital Standardization Program, launched in 1917 to establish minimum standards for hospitals and promote consistent, safe patient care. The Joint Commission was established in 1951 to continue and expand this work through an independent accreditation process.

Accreditation evaluates whether an organization meets defined standards for safe, effective care and uses structured surveys to assess systems such as patient safety, clinical performance, leadership, information management, and continuous improvement. This focus made accreditation an early, organized mechanism for evaluating healthcare quality across institutions rather than relying solely on individual practitioners' judgments. The Joint Commission's standards-based approach also helped establish the expectation that healthcare organizations should measure performance, identify quality concerns, and improve care processes over time. Its historical role in hospital standardization and accreditation therefore makes it the best answer when the question is limited specifically to the quality evaluation of medical care. See the Joint Commission's history and organizational information and the American College of Surgeons' overview of its history.

QUESTION NO: 68

All of the following need a proper authorization to access a patient's health information EXCEPT

A. local and state law enforcement officers.

B. IRS agents.

C. medical examiners or coroners.

D. FBI agents.

ANSWER: C

Explanation:

Medical examiners or coroners may receive relevant protected health information without the patient's written HIPAA authorization when the information is needed to identify a deceased person, determine a cause of death, or perform other duties authorized by law. This is a specific public-policy exception in the HIPAA Privacy Rule. It recognizes that coroners and medical examiners have legally assigned responsibilities in death investigations and public-health-related determinations, and those responsibilities can require timely access to clinical information.

The disclosure must be limited to information that is relevant to the official's lawful duties and should follow the organization's established privacy procedures, including verification of the requester's identity and authority. The exception does not permit

unrestricted disclosure for unrelated purposes; rather, it supports the official functions of identifying decedents and investigating or certifying deaths. AHIMA professionals should ensure that workforce members understand these permitted disclosures, apply the minimum necessary standard when it applies, and document disclosures as required by organizational policy and applicable law. The governing HIPAA provision is 45 C.F.R. § 164.512(g), available through the Electronic Code of Federal Regulations. HHS also summarizes permitted disclosures to coroners and medical examiners in its HIPAA Privacy Rule guidance.

QUESTION NO: 69

Patient is admitted for chemotherapy, for treatment of breast cancer with liver metastasis. Patient had a mastectomy 4 months ago. Chemotherapy is given.

A. 197.7, V10.3, 99.25

B. 174.9, 197.7, 99.25

C. V58.11, V10.3, 197.7, 99.25

D. V58.11, 174.9, V45.71, 197.7, 99.25

ANSWER: D

Explanation:

The correct code sequence is **V58.11, 174.9, V45.71, 197.7, 99.25**. In the ICD-9-CM system, when a patient is admitted specifically to receive antineoplastic chemotherapy, V58.11 (Encounter for antineoplastic chemotherapy) is sequenced first. The malignancies being treated are reported as additional diagnoses. Breast cancer remains coded as an active primary malignancy (174.9) because the patient is receiving chemotherapy as active treatment, rather than follow-up care after completed treatment. The documented liver metastasis is coded with 197.7, identifying a secondary malignant neoplasm of the liver. The prior mastectomy is captured by V45.71, acquired absence of breast, because it is a relevant status affecting the patient's current care. Finally, administration of chemotherapy is reported with procedure code 99.25. This sequence reflects the reason for the inpatient admission while also fully representing the active primary cancer, metastatic disease, relevant surgical status, and chemotherapy administration. ICD-9-CM coding guidelines direct coders to sequence the encounter-for-chemotherapy code first when chemotherapy is the sole reason for admission and to assign codes for the malignancy being treated. See the CMS ICD-9-CM diagnosis and procedure code resources and the CDC ICD-9-CM information page.

QUESTION NO: 70

Dr. Zambrano ordered a CEA test for Mr. Logan. Dr. Zambrano may be considering a diagnosis

of

A. cancer.

B. carpet tunnel syndrome.

C. cardiomyopathy.

D. congestive heart failure.

ANSWER: A

Explanation:

The correct answer is **cancer.** CEA stands for carcinoembryonic antigen, a protein that may be present at higher-than-expected levels in some patients with malignancy. It is most commonly associated with colorectal cancer, although elevated CEA can also occur with cancers involving sites such as the pancreas, breast, lung, stomach, ovary, thyroid, and liver. Clinicians commonly order a CEA measurement after a cancer diagnosis to establish a baseline, assess response to treatment, and monitor for possible recurrence over time. A rising or persistently elevated trend can prompt further clinical

assessment, imaging, or other diagnostic workup. CEA is a tumor marker rather than a stand-alone diagnostic test: its result must be interpreted in the context of the patient's history, examination, imaging, pathology, and other laboratory findings. Levels may also be elevated in certain nonmalignant conditions and in people who smoke. Nevertheless, when this question asks what diagnosis the ordering clinician may be considering, the intended association of a CEA test is cancer, particularly colorectal malignancy. The National Cancer Institute describes CEA as a tumor marker used in cancer care, and MedlinePlus summarizes its role in monitoring certain cancers: National Cancer Institute; MedlinePlus.

QUESTION NO: 71

The special form or view that plays the central role in planning and providing care at nursing psychiatric, and rehabilitation facilities is the

A. interdisciplinary patient care plan.

B. medical history and review of systems.

C. interval summary.

D. problem list.

ANSWER: A

Explanation:

The interdisciplinary patient care plan is correct because it is the integrated, patient-centered record used to organize, communicate, implement, and evaluate care across the disciplines involved in nursing, psychiatric, and rehabilitation settings. It brings together assessment findings, identified needs, measurable goals, planned interventions, responsible disciplines, and review or revision dates. As a living document, it enables nurses, physicians, therapists, social workers, behavioral health professionals, and other team members to coordinate their respective services around the individual's overall treatment and functional goals. This role is especially central in facilities where care requires ongoing collaboration and periodic reassessment as a patient's clinical, psychosocial, and rehabilitation needs change. For long-term-care residents, federal participation requirements require a comprehensive person-centered care plan that includes measurable objectives and timeframes, addresses services furnished, and is developed by an interdisciplinary team with resident participation. These requirements illustrate why the interdisciplinary patient care plan is the primary form or view for planning and delivering coordinated facility-based care. See the CMS requirements for comprehensive person-centered care planning and CMS's Nursing Homes regulations and guidance.

QUESTION NO: 72

You are determining the sample size for a quality study. Which of the following factors should you consider first?

A. cost

B. personnel

C. size of the target population

D. confidentiality of the record

ANSWER: C

Explanation:

The **size of the target population** should be considered first because it defines the complete group of records, encounters, patients, or other units to which the quality study's findings are intended to apply. Identifying that population establishes the sampling frame and determines the maximum number of units available for review. It also determines whether sampling is necessary at all: when the population is small, reviewing every eligible record may be more appropriate than selecting a sample.

After the target population has been clearly defined and counted, the study team can select an appropriate sampling approach and calculate a sample size using additional statistical specifications, such as the expected rate of the characteristic being measured, the desired confidence level, and the acceptable margin of error. For a finite population, population size may affect the calculation through a finite-population adjustment, particularly when the planned sample represents a substantial proportion of all eligible records. Defining the population first also supports a valid, reproducible quality-study design because inclusion and exclusion criteria can be applied consistently before records are selected. Guidance on defining the study population and obtaining a representative sample is available from the CDC Field Epidemiology Manual and the CDC's epidemiologic data guidance.

QUESTION NO: 73

A clerical-level employee reports an incident in which the clerk felt the first-line supervisor discriminated on the basis of the clerk's gender. The best action for you to take at this time is to

A. thoroughly investigate the matter and document your findings.

B. talk with the first-line supervisor to determine what happened.

C. ask the other clerical level staff if they have had similar experiences.

D. ask the clerk to provide objective evidence of the discrimination.

ANSWER: A

Explanation:

"thoroughly investigate the matter and document your findings" is the best immediate action because a report of possible gender discrimination requires a prompt, impartial, and appropriately documented response. The employee has raised a workplace concern involving a protected characteristic, so the organization should take the report seriously, preserve relevant information, establish what occurred, and create a reliable record of the complaint, investigative steps, evidence reviewed, interviews conducted, findings, and any responsive action. A thorough investigation is not limited to one conversation; it is a fact-finding process conducted without prejudging the report or requiring the reporting employee to prove the case before the organization acts. Documentation supports consistency, accountability, and compliance with the organization's equal-employment policies and applicable nondiscrimination obligations. It also helps leadership determine whether corrective measures, further review, or preventive education are needed. The Equal Employment Opportunity Commission explains that employers should take prompt and effective action when they learn of potential unlawful workplace harassment or discrimination. In addition, its enforcement guidance emphasizes that an employer's response should be timely and appropriate to the circumstances. See the EEOC's sex-based discrimination guidance and the EEOC Enforcement Guidance on Harassment in the Workplace.

QUESTION NO: 74

In preparing a capital budget request, the first priority will be to document

A. the specific type of equipment requested.

B. where the new equipment will be located.

C. the need for the new equipment.

D. the cost of the new equipment.

ANSWER: C

Explanation:

The need for the new equipment is the first priority because a capital budget request must begin with a clearly defined operational or strategic problem that requires investment. The request should establish the service, clinical, regulatory, capacity, replacement, safety, or efficiency need; identify the affected population or process; and describe the expected

organizational benefit. This documented need provides the foundation for evaluating whether a capital expenditure aligns with organizational priorities and whether it should compete successfully with other proposed investments.

Once the need is established, the organization can develop supporting details such as functional requirements, equipment alternatives, location and implementation needs, acquisition and lifecycle costs, projected benefits, funding sources, and return-on-investment analysis. Beginning with the need helps ensure that the requested asset is justified by a business case rather than by a preference for a particular item or vendor. Capital-planning guidance similarly emphasizes identifying and prioritizing needs and linking proposed capital projects to strategic objectives before finalizing project scope and financial estimates. See the Government Finance Officers Association's Capital Planning and Budgeting guidance and the U.S. Government Accountability Office's Guide for Evaluating Capital Planning Processes.

QUESTION NO: 75

This information is printed on the UB-04 claim form to represent the cost center (e.g, lab, radiology, cardiology, respiratory, etc.) for the department in which the item is provided. It is used for Medicare billing.

A. modifier

B. revenue code

C. charge code

D. general ledger key

ANSWER: B

Explanation:

Revenue code is correct. On the UB-04 (CMS-1450) institutional claim, revenue codes identify the facility department or cost center that provided a service or item, such as laboratory, radiology, pharmacy, emergency department, or respiratory therapy. The code is reported in Form Locator 42, with the associated service date, HCPCS or HIPPS code when required, service units, and charges reported in related revenue-detail fields. Revenue codes provide the standardized means for institutional providers to describe where services were furnished and to allocate charges to the appropriate hospital revenue center for Medicare and other payer billing. These four-digit codes are maintained through the National Uniform Billing Committee's revenue code structure and are used with applicable billing requirements to support accurate claim processing, reimbursement, utilization review, and reporting. Medicare's institutional billing guidance specifically identifies revenue codes as required claim data used to report accommodations and ancillary services on the CMS-1450 claim. Therefore, the term that represents the departmental cost center printed on the UB-04 is revenue code.

References: CMS: Institutional Paper Claim Form (CMS-1450/UB-04); National Uniform Billing Committee.

QUESTION NO: 76

Patient comes in through the emergency room with a wound that was caused by an electric saw. Patient is taken to the operating room where two ulna nerves are sutured.

A. 64837

B. 64892; 69990

C. 64836; 64837

D. 64856; 64859

ANSWER: C

Explanation:

The correct coding is **64836; 64837**. CPT code 64836 represents suture (repair) of one nerve in the arm or leg, excluding the sciatic nerve. The ulnar nerve is an upper-extremity peripheral nerve, so repair by suturing is reported with this primary nerve-repair code. Because the operative documentation states that two ulnar nerves were sutured, the repair of the second

nerve is additionally reported with 64837, the add-on code for each additional nerve repaired in the arm or leg (other than the sciatic nerve). The primary code is reported once for the initial nerve repair, followed by the applicable add-on code for the additional repaired nerve. This code combination reflects the documented operative work and follows CPT's convention of using a primary procedure code with its designated add-on code when multiple qualifying nerves are repaired during the same encounter. The emergency department presentation and the mechanism of injury establish the clinical context, but the reported procedure codes are based on the definitive operative nerve repairs. CPT coding resources and payment-file information can be reviewed through the CMS Physician Fee Schedule Relative Value Files and the American Medical Association CPT overview.

QUESTION NO: 77

Employing the SOAP style of progress notes, choose the "assessment" statement from the following:

A. patient states low back pain with sciatica is as severe as it was on admission.

B. patient moving about very cautiously, appears to be in pain.

C. adjust pain medication; begin physical therapy tomorrow.

D. sciatica unimproved with hot pack therapy.

ANSWER: D

Explanation:

"sciatica unimproved with hot pack therapy." is the assessment statement because it communicates the clinician's evaluative judgment about the patient's condition and response to treatment. In the SOAP framework, the Assessment section synthesizes the subjective history and objective observations into a clinical impression, including whether a problem is improving, stable, worsening, or not responding as expected. Here, the statement identifies the ongoing clinical problem—sciatica—and evaluates its response to the intervention already used—hot pack therapy—by documenting that improvement has not occurred. That conclusion helps establish the patient's current status and supports subsequent care decisions. SOAP documentation is designed to make clinical reasoning visible: subjective information captures what the patient reports, objective information records observable or measurable findings, assessment states the provider's interpretation of those data, and the plan describes intended next steps. This wording therefore belongs in Assessment because it is an interpretation of treatment effectiveness rather than a raw patient report, physical observation, or future treatment instruction. See the NCBI StatPearls overview of SOAP notes and the American Academy of Family Physicians guide to SOAP documentation.

QUESTION NO: 78

Office visit for 43-year-old male, new patient, with no complaints. Patient is applying for life insurance and requests a physical examination. A detailed health and family history was obtained and a basic physical was done. Physician completed life insurance physical form at patient's request. Blood and urine were collected.

99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient, infant (age under 1 year)
99386	Initial comprehensive preventive medicine evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient, 40-64 years
99396	Periodic comprehensive preventive medicine re-evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient, 40-64 years
99450	Basic life and/or disability examination that includes completion of a medical history following a life insurance pro forma

A. 99450

B. 99386

C. 99396

D. 99381

ANSWER: A

Explanation:

99450 is the appropriate code because the encounter is specifically a basic examination performed in connection with an application for life insurance. The documented purpose is not diagnosis, treatment, or routine preventive care; rather, the patient requested an insurer-related physical and the physician completed the life-insurance form. CPT 99450 describes basic life and/or disability examination services, including completion of forms. The detailed history, basic physical examination, and collection of blood and urine support the performance of the insurance examination but do not change the fundamental purpose of the service. Coding should reflect the reason the service was furnished, which in this case is evaluation for life-insurance underwriting. This type of examination is generally an administrative or third-party service rather than a medically necessary clinical service, so payment responsibility and reporting requirements should be confirmed with the requesting insurer and applicable payer policies. The CPT code listing for this service is available through AAPC's CPT 99450 reference. Medicare's policy framework also distinguishes examinations and services performed for insurance or other third-party administrative purposes from covered medically necessary care; see the CMS Medicare Claims Processing Manual, Chapter 16.

QUESTION NO: 79

The purpose of the new security awareness program is(are)

A. to help staff realize the importance of security.

B. remind users of procedures.

C. lock down PHI.

D. both A and B

ANSWER: D

Explanation:

Both A and B is correct because an effective security awareness program has the complementary goals of building workforce understanding of why security matters and reinforcing the procedures personnel must follow in their day-to-day work. In a healthcare environment, this includes helping staff recognize that protecting electronic protected health information is an organizational and individual responsibility, while also reminding them how to apply established safeguards, such as appropriate access practices, password management, incident reporting, and phishing awareness.

HIPAA's Security Rule specifically requires covered entities and business associates to implement a security awareness and training program for all workforce members, including periodic security updates. A program should therefore be ongoing rather than a one-time orientation activity: it promotes informed security-minded behavior and keeps users current on policies, procedures, and emerging threats. These purposes support administrative safeguards by reducing preventable human errors and encouraging consistent adherence to the organization's security policies. See the HIPAA Security Rule's workforce training standard at 45 CFR § 164.308 and HHS guidance on HIPAA cybersecurity and Security Rule resources.

QUESTION NO: 80

Blindness due to an allergic reaction to ampicillin administered 6 years ago would be reported as a(n)

A. poisoning.

B. adverse reaction to a drug.

C. late effect of a poisoning.

D. late effect of an adverse reaction.

ANSWER: D

Explanation:

"late effect of an adverse reaction" is correct because the blindness is a residual condition that remains after an allergic reaction to ampicillin that occurred years earlier. In ICD-10-CM terminology, a late effect is called a *sequela*: a condition produced by a prior injury, poisoning, or other external cause after the acute phase has ended. The six-year interval and the continuing blindness establish that the encounter concerns the lasting consequence rather than treatment of the original acute allergic reaction.

Ampicillin was administered as a drug, and an allergic reaction occurring with proper administration is classified as an adverse effect. For sequela coding, the manifestation or residual condition—in this case, the applicable blindness code—is reported first, followed by the adverse-effect code for the drug with the seventh character *S* to identify a sequela. For penicillins, the applicable adverse-effect category is T36.0X5S, subject to the specificity supported by the record. This approach communicates both the present disability and its causal relationship to the remote medication reaction. The ICD-10-CM Official Guidelines describe sequela coding and adverse-effect coding conventions in the injury, poisoning, and external-cause section. See the ICD-10-CM Official Guidelines for Coding and Reporting and the CDC ICD-10-CM resources.

QUESTION NO: 81

Though you work in an integrated delivery network, not all systems in your network communicate with one another. As you meet with your partner organizations, you begin to sell them on the concept of an important development intended to support the exchange of health information across the continuum within a geographical community. You are promoting that your organization join a

A. data warehouse.

B. regional health information organization.

C. continuum of care.

D. data retrieval portal group.

ANSWER: B

Explanation:

A regional health information organization is correct because it is designed to facilitate the electronic exchange of health information among independent healthcare organizations within a defined geographic region or community. This directly addresses the interoperability gap described: although organizations may participate in an integrated delivery network, their separate information systems may not exchange data effectively. A regional health information organization provides a collaborative governance and exchange framework through which hospitals, physician practices, laboratories, payers, public-health entities, and other partners can share appropriate patient information across care settings.

Participation supports continuity of care by making relevant information available when patients receive services from different organizations. It can also help reduce avoidable duplicate testing, improve care coordination, and support more complete information for clinical decision-making, subject to applicable privacy, security, consent, and data-use requirements. The Office of the National Coordinator for Health Information Technology describes health information exchange as the electronic movement of health-related information among organizations according to nationally recognized standards. Regional exchange organizations are a community-level model for enabling that exchange. See the ONC overview of health information exchange and the National Library of Medicine glossary entry on regional health information organizations.

QUESTION NO: 82

Patient was seen for excision of two interdigital neuroma from the left foot.

28080	Excision, interdigital (Morton) neuroma, single, each
64774	Excision of neuroma; cutaneous nerve, surgically identifiable
64776	Excision of neuroma, digital nerve, one or both, same digit

A. 64774

B. 64776

C. 28080

D. 28080, 28080

ANSWER: D

Explanation:

28080, 28080 is correct because CPT code 28080 represents excision of an interdigital (Morton) neuroma and is defined as a single procedure for each neuroma treated. The documentation states that two interdigital neuromas in the left foot were excised. Therefore, the service is reported twice to reflect the two separately treated neuromas. On a professional claim, the second line may require an appropriate distinct-procedural-service modifier, such as modifier 59 or the more specific X{EPSU} modifier accepted by the payer, to show that the repeated code represents a separate lesion/site rather than a duplicate billing entry. The code selection is based on the actual excision of each interdigital neuroma, not merely on the fact that both procedures occurred on the same foot. CPT code information is available through AAPC's CPT 28080 listing. CMS's National Correct Coding Initiative guidance also explains the use of modifiers to identify distinct services when procedures that would otherwise be bundled are separately reportable: CMS NCCI Policy Manual, Chapter 4.

QUESTION NO: 83

The legislation that required all federally funded facilities to inform patients of their rights under rights under state law to accept or refuse medical treatment is known as____.

A. advance directives.

B. living wills.

C. Patient Self-determination Act.

D. Durable power of attorney.

ANSWER: C

Explanation:

The **Patient Self-determination Act** is the federal legislation that requires Medicare- and Medicaid-participating healthcare facilities to provide adult patients with written information about their rights under state law to make decisions about medical care, including the right to accept or refuse treatment. Enacted in 1990 and effective beginning in 1991, the Act also requires these providers to ask whether the patient has an advance directive and to document that information in the medical record. Facilities must ensure that care is not conditioned on whether a patient has executed an advance directive and must provide education to staff and the community regarding advance directives. The law does not create a single national substantive law governing treatment decisions; rather, it ensures that patients are informed of the decision-making rights available under the applicable state law. In health information practice, compliance involves appropriate notice, documentation, and policies supporting patient autonomy. The statutory requirements are codified in the Social Security Act at 42 U.S.C. § 1395cc(f), available through GovInfo. CMS also describes advance-directive requirements for participating providers in its Medicare regulations and guidance resources.

QUESTION NO: 84

Amanda, the Coding Supervisor at Mission Medical Center, wants to increase the problem.

solving skills among the coders. Which of the following approaches is likely to have the best and most long-lasting results?

A. hiring a consultant to assess the coding area

B. developing a coding work team

C. taking a field trip to a neighboring facility known for quality coding

D. request that Human Resources conduct a training session on program solving

ANSWER: B

Explanation:

Developing a coding work team is most likely to produce sustained improvement in coders' problem-solving skills because it embeds learning, collaboration, and accountability into routine work. A functioning team gives coders a structured way to discuss difficult records, identify recurring documentation or workflow issues, compare authoritative coding guidance, and jointly develop consistent solutions. These repeated activities build individual analytical capability while also creating shared processes that remain available after a specific issue is resolved. A coding work team can use peer review, case discussion, trend analysis, and feedback loops to turn coding errors or productivity barriers into opportunities for continuous improvement. Team-based work also supports knowledge sharing across experience levels, reducing reliance on a single supervisor or one-time outside intervention. In healthcare settings, effective teams are associated with improved communication, mutual support, and organizational learning—core conditions for solving complex operational problems over time. The Agency for Healthcare Research and Quality identifies team structure, communication, leadership, situation monitoring, and mutual support as key competencies for effective teamwork; these competencies provide a durable foundation for collaborative problem solving. See AHRQ TeamSTEPPS fundamentals and AHRQ TeamSTEPPS program resources.

QUESTION NO: 85

Cheryl has had chronic worsening pain of her left knee from rheumatoid arthritis. She has decided to undergo a total knee replacement as recommended by her physician. The surgery goes well; however, she develops a urinary tract infection that requires an additional day of stay in the hospital.

599.0	Urinary tract infection, site not specified
714.0	Rheumatoid arthritis
714.31	Polyarticular juvenile rheumatoid arthritis, acute
715.96	Osteoarthritis, unspecified whether generalized or localized, low leg
81.53	Revision of hip replacement, not otherwise specified
81.54	Total knee replacement

A. 715.96, 599.0, 81.54

B. 714.0, 599.0, 81.54

C. 714.31, 81.53

D. 714.31, 81.54

ANSWER: B

Explanation:

714.0, 599.0, 81.54 correctly represents the inpatient ICD-9-CM diagnosis and procedure coding for this admission. Rheumatoid arthritis is the condition chiefly responsible for the admission and the decision to perform the knee replacement; code 714.0 identifies rheumatoid arthritis in this code set. The urinary tract infection arose during the hospitalization, was clinically significant because it required treatment and extended the stay, and therefore is reported as an additional diagnosis using 599.0 when no more specific urinary infection documentation is provided. The total knee replacement is coded with procedure code 81.54, which identifies total knee replacement. The fact that the knee pain is chronic and left-sided does not replace coding the documented underlying rheumatoid arthritis as the reason for admission. Accurate inpatient reporting captures both the condition established after study as chiefly responsible for admission and conditions that develop during the stay when they affect care, treatment, length of stay, or resource use. Historical ICD-9-CM diagnosis and procedure code resources are available from the CDC's ICD-9-CM page and the CMS ICD-9-CM resources.

QUESTION NO: 86

Patient was admitted with a cystocele and rectocele. An anterior colporrhaphy was performed.

A. 57250

B. 57260

C. 57240

D. 57110

ANSWER: C

Explanation:

57240 is the appropriate CPT code because the documented procedure is an anterior colporrhaphy, also termed anterior colporrhaphy repair of a cystocele. This vaginal repair reinforces the anterior vaginal wall and is reported based on the procedure actually performed, rather than on every condition noted at admission. Although both cystocele and rectocele are documented, the operative statement specifies only an anterior repair. Accurate procedural coding requires the coder to assign the code that matches the surgeon's documented work and to query the provider if the operative record is unclear or if an additional posterior repair may have been performed but was not documented.

CPT coding is based on the complete operative report, including the approach, anatomic site, and type of repair. The American Medical Association explains that CPT is the standardized code set used to report medical procedures and services; coders should apply the code descriptor supported by the documentation. CMS likewise requires claims to be supported by medical-record documentation. See the American Medical Association CPT overview and CMS National Correct Coding Initiative resources.

QUESTION NO: 87

The medical malpractice crisis of the 197Os prompted development of what type of programs in health care facilities?

A. utilization management

B. financial analysis programs

C. quality improvement programs

D. risk management

ANSWER: D

Explanation:

The medical malpractice crisis of the 1970s prompted healthcare facilities to establish **risk management** programs. Rapid growth in malpractice claims, escalating settlement and insurance costs, and concern about preventable patient injuries created a need for an organized, facility-wide approach to identifying and reducing sources of legal and clinical risk. Risk management programs systematically investigate adverse events and incidents, identify patterns and contributing conditions, recommend corrective actions, support safe clinical practices, and coordinate with legal counsel and insurance personnel when necessary. Health information is central to these activities because complete, accurate, timely documentation is essential to patient care, event review, and defense of malpractice claims. Although modern risk management is closely integrated with patient safety and quality activities, its historical development was strongly associated with the malpractice insurance crisis and the need to minimize institutional liability. The American Society for Health Care Risk Management describes healthcare risk management as a profession focused on protecting patients, staff, organizations, and communities from risks, while AHRQ identifies risk-management activities as part of patient-safety infrastructure. See ASHRM: About Health Care Risk Management and AHRQ PSNet: Patient Safety 101.

QUESTION NO: 88

Kari works 40 hours per week at Rocky Mountain Radiology Associates, which pays time- and-ahalf for overtime and double-time for holidays. During the past week, Kari took 6 hours of unpaid personal leave, and worked an 8-hour holiday. How many hours will Kari be paid for?

A. 34

B. 50

C. 42

D. 48

ANSWER: C

Explanation:

42 is correct. Kari's normal weekly schedule is 40 hours, but the 6 hours of unpaid personal leave reduce the hours worked and paid at the regular rate to 34 hours. The 8-hour holiday falls within those 34 worked hours; it is not added as an additional shift. Because the employer pays double-time for holiday work, the holiday hours receive two times pay rather than one times pay. Put another way, the 8 holiday hours are already included in the 34 hours at the base rate, and double-time adds an additional 8 paid-hour equivalents as the premium. Thus, 34 regular paid-hour equivalents plus 8 additional holiday-premium equivalents equals 42 paid hours.

No overtime premium applies because Kari worked only 34 actual hours during the week after taking unpaid leave. Under federal wage-and-hour guidance, overtime is generally based on hours actually worked, and paid time not worked does not count toward the overtime threshold. The employer's stated holiday double-time policy governs the premium for the holiday hours. See the U.S. Department of Labor's overtime guidance and its holiday pay guidance.

QUESTION NO: 89

A distribution is said to be positively skewed when the mean is

A. bimodal.

B. multimodal.

C. shifted to the left.

D. shifted to the right.

ANSWER: D

Explanation:

"shifted to the right." is correct. A positively skewed distribution, also called a right-skewed distribution, has most observations concentrated at lower values and a longer tail extending toward higher values. The relatively few large values in that right-hand tail exert a disproportionate pull on the arithmetic mean, moving it toward the right side of the distribution. Therefore, in a typical positively skewed distribution, the mean lies to the right of the median; the usual relationship is mean greater than median, with the mode generally located farther left. This concept is important in health information analysis because measures such as length of stay, charges, reimbursement amounts, and some utilization measures often include a small number of exceptionally high observations. Those values can make the mean higher than the value that represents the experience of a typical patient or encounter. Recognizing right skew helps an analyst select and interpret summary statistics appropriately, including reporting the median when it better represents the center of an asymmetrical distribution. The National Institute of Standards and Technology describes positive skewness as a distribution with a longer right tail, and Penn State's statistics materials similarly explain that the mean is pulled toward the skewed tail. See NIST Engineering Statistics Handbook and Penn State STAT 200.

QUESTION NO: 90

Jackie has developed a lesion on her right shoulder. A biopsy was obtained and was positive for malignant melanoma. She is now admitted for radical excision of the melanoma lesion and fullthickness skin graft.

172.6	Malignant melanoma of skin, upper limb, including shoulder
173.5	Other malignant neoplasm of skin of trunk, except scrotum
173.6	Other malignant neoplasm of skin of upper limb, including shoulder
86.3	Other local excision or destruction of lesion or tissue of skin and subcutaneous tissue
86.4	Radical excision of skin lesion
86.63	Full thickness skin graft to other sites

A. 172.6, 86.4, 86.63

B. 172.5, 86.4, 86.63

C. 173.5, 86.3, 86.63

D. 172.6, 86.3, 86.63

ANSWER: A

Explanation:

The correct code set is **172.6, 86.4, 86.63**. In ICD-9-CM diagnosis coding, malignant melanoma of the skin of the upper limb, including the shoulder, is assigned code 172.6. The documented right shoulder establishes the anatomic site as the upper limb/shoulder category; laterality was not represented in this ICD-9-CM diagnosis code. The pathology-confirmed malignant melanoma supports coding the malignancy rather than a nonspecific skin lesion.

For the inpatient procedures, radical excision of a skin lesion is reported with ICD-9-CM procedure code 86.4, radical excision of skin lesion. The operative treatment also includes a full-thickness skin graft. Code 86.63 specifically identifies a full-thickness skin graft to another site, which encompasses a shoulder recipient site. Both procedures are reportable because the radical excision removes the malignant lesion and the graft reconstructs the resulting defect. The diagnosis and procedure codes therefore accurately capture the documented melanoma site, definitive radical excision, and full-thickness graft reconstruction. See the ICD-9-CM listing for 172.6 and the ICD-9-CM procedure listing for skin and subcutaneous tissue procedures.

QUESTION NO: 91

As an HIM supervisor at Bayview Hospital, you supervise five employees. One of y employees reports that a co-worker has returned from lunch on numerous occasions with smell of alcohol on his breath. What is the best approach in handling this problem?

A. Confront the employee and place him on suspension for 1 week.

B. Terminate the employee immediately.

C. Ignore the report because it is hearsay.

D. Handle the situation the same as you would any other disease that affects an employee' work.

ANSWER: D

Explanation:

“Handle the situation the same as you would any other disease that affects an employee' work.” is the best answer because alcohol use disorder is a health condition that can affect an employee’s ability to perform work safely, reliably, and effectively. The supervisor should respond professionally and consistently, focusing on observed or reported workplace-performance concerns rather than making a moral judgment or assuming misconduct. A report of alcohol odor provides a basis to address a possible fitness-for-duty issue under the hospital’s established policies, including documenting objective observations, consulting Human Resources or the appropriate employee-health resource, and maintaining confidentiality. The employee should be treated with the same respect, procedural fairness, and opportunity for appropriate assistance that would apply when another health condition may be impairing work performance. This approach also supports a safe work environment while avoiding stigmatization and preserving the employee’s privacy. Federal employment guidance recognizes that alcohol use disorder may be protected as a disability, while employers may still enforce conduct and workplace-safety standards. See the EEOC guidance on alcohol use disorder and employment and SAMHSA workplace employer resources.

QUESTION NO: 92

What would be the most cost-effective and prudent course of action for the storage or disposition of 250,0000 records at a large teaching and research hospital?

A. storing the records off-site at a cost of $25,000 per year

B. microfilming all 250,000 records of the cost of $195,000

C. purging all death records and storing them off-site

D. destroying all records older than the time frame required by the statute of limitations

ANSWER: B

Explanation:

Microfilming all 250,000 records of the cost of $195,000 is the most prudent long-term choice because it converts a very large volume of paper records into a durable, compact preservation medium while avoiding continuing annual storage expenses. At $25,000 each year for off-site storage, the one-time microfilming cost is recovered in approximately 7.8 years, after which the organization avoids the recurring expense of maintaining the same volume of paper records. A large teaching and research hospital also has a strong operational reason to preserve records for extended periods: records may support patient care, research, education, quality activities, and legal or regulatory needs. Microfilm is a recognized preservation format when it is created and maintained under appropriate quality-control, indexing, security, and retrieval procedures. The hospital should apply its approved records-retention schedule and any applicable state-law requirements before disposition, but the scale of the collection and likely long-term value make microfilming an economically sound preservation strategy. AHIMA emphasizes that retention decisions should be based on legal, regulatory, operational, and research needs, as reflected in its guidance on retention of health information. Federal recordkeeping requirements also recognize microfilm as an acceptable records-storage medium when managed properly; see the National Archives regulations on records management.

QUESTION NO: 93

Ulcerations of the small intestine are characteristic of

A. Appendicitis.

B. Crohn's disease.

C. Diverticulitis.

D. Graves' disease.

ANSWER: B

Explanation:

Crohn's disease is correct because it is a chronic inflammatory bowel disease that commonly involves the terminal ileum and may affect any portion of the gastrointestinal tract. Its inflammation is transmural, meaning it can extend through the full thickness of the intestinal wall. This process produces characteristic mucosal ulcerations, often described endoscopically as aphthous ulcers, linear ulcers, and areas of intervening normal mucosa that can create a cobblestone appearance. Involvement of the small intestine can lead to abdominal pain, diarrhea, weight loss, malabsorption, strictures, fistulas, and obstruction. The ileum is especially important in clinical documentation and coding because disease location, complications, and associated manifestations may affect the specificity of the diagnosis reported in the health record. The National Institute of Diabetes and Digestive and Kidney Diseases notes that Crohn's disease may cause inflammation and damage in any part of the digestive tract, most often in the small intestine and beginning of the large intestine. Merck Manual further describes the characteristic ulceration and transmural inflammation of Crohn disease. These clinical features make small-intestinal ulcerations a classic finding of Crohn's disease. See NIDDK: Crohn's Disease and Merck Manual: Crohn Disease.

QUESTION NO: 94

Outsourcing information systems results in which of the following?

A. increased accessibility of competent IT staff

B. reduced equipment investment

C. reduction in time to implement

D. all of the above

ANSWER: D

Explanation:

all of the above is correct because outsourcing an information-system function commonly gives an organization access to a vendor's specialized technical workforce, infrastructure, and established implementation processes. Rather than recruiting, retaining, and continuously training every required information technology professional internally, the organization can use personnel whose core work is operating and supporting these systems. Outsourcing also commonly reduces the organization's direct capital commitment to hardware, data-center space, system platforms, and related equipment because the vendor supplies or manages much of that infrastructure under a service agreement. In addition, a vendor that has already deployed the solution for multiple clients can provide configured technology, experienced project teams, and repeatable implementation methods, which can shorten the time needed to put the system into operation. These are potential operational and financial benefits that should be assessed alongside governance, privacy, security, service-level, and business-continuity requirements. Health information leaders remain accountable for ensuring that a business associate appropriately safeguards protected health information; HHS discusses these required contractual safeguards in its Business Associates guidance. The NIST Cybersecurity Supply Chain Risk Management guidance also supports the need to manage risks arising from external service providers.

QUESTION NO: 95

Ronald is admitted for stenosis of his tracheostomy. He is a quadriplegic, C1-C4 secondary to spinal cord injury suffered in a diving accident. He has chronic respiratory failure and is maintained on mechanical ventilation. He undergoes revision of his tracheostomy.

344.00	Quadriplegia, unspecified
344.01	Quadriplegia, C1-C4, complete
518.83	Chronic respiratory failure
519.02	Mechanical complication of tracheostomy
519.09	Other complications of tracheostomy
907.2	Late effect of spinal cord injury
V46.11	Dependence on respirator status
31.74	Revision of tracheostomy
31.79	Other repair and plastic operations on trachea
96.71	Continuous invasive mechanical ventilation for less than 96 consecutive hours
96.72	Continuous invasive mechanical ventilation for 96 consecutive hours or more

A. 518.83, 519.09, 907.2, 31.74

B. 344.01, 518.83, 519.02, 31.79, V46.11

C. 519.02, 344.01, 518.83, 907.2, V46.11, 31.74, 96.72

D. 519.02, 518.83, 907.2, 31.74

ANSWER: C

Explanation:

519.02, 344.01, 518.83, 907.2, V46.11, 31.74, 96.72 is correct because the admission is chiefly for tracheostomy stenosis requiring revision. In ICD-9-CM, a mechanical complication of a tracheostomy is reported with 519.02, making it the principal diagnosis when it is the condition established after study to be responsible for the admission. The documented C1-C4 quadriplegia is captured with 344.01, and 907.2 identifies the late effect of the prior spinal cord injury responsible for the residual neurologic deficit. Chronic respiratory failure is separately reportable with 518.83 because it is an ongoing, clinically significant condition managed during the stay. V46.11 reports the patient's dependence on a respirator/ventilator. The tracheostomy revision is coded as procedure 31.74. Because the patient is maintained on continuous invasive mechanical

ventilation, 96.72 reports continuous invasive mechanical ventilation for 96 consecutive hours or more, as documented in the record. This code set fully represents the reason for admission, relevant chronic conditions, ventilator dependence, and inpatient procedures. ICD-9-CM's official coding materials and tabular resources are available through the CMS ICD-9-CM archive and the CDC ICD-9-CM resources.

QUESTION NO: 96

Which statistical analysis would be the best technique to use on the following problem?

A study compared the effects of retesting on the scores of students who failed a writing test. Students who did not pass on their first attempt were allowed to retest. Results showed that students had higher mean scores at at retest whether they attended additional tarinig before retesting or not.

A. descriptive stats

B. ANOVA

C. regression

D. T test

ANSWER: D

Explanation:

T test is the best choice because the central comparison is between mean writing-test scores obtained at two occasions: the initial failed attempt and the retest. Each student's retest score is naturally linked to that same student's original score, so the appropriate form is a paired (dependent-samples) t test. This analysis evaluates the mean of the within-student score differences and accounts for the fact that the two observations are not independent. Its result directly addresses whether scores were higher on retesting, rather than merely describing the observed averages. The statement that higher retest means occurred whether or not students attended additional training does not change the primary repeated-measure comparison posed in the scenario. A paired t test is commonly used when the same participants are measured before and after an event, intervention, or repeat assessment, provided the distribution of the paired differences is reasonably appropriate for the method. The National Institute of Standards and Technology describes paired-comparison designs as ones in which each observation in one sample is paired with a related observation in the other sample and discusses analyzing the differences between paired measurements. See the NIST paired-comparison guidance and the NIST Engineering Statistics Handbook.

QUESTION NO: 97

Skilled nursing facilities may choose to submit MDS data using RAVEN software, or software purchased commercially through a vendor, provided that the software meets

A. Joint Commission standards

B. NHIN standards

C. HL-7 standards

D. CMS standards

ANSWER: D

Explanation:

CMS standards is correct because the Centers for Medicare & Medicaid Services establishes the technical and data-submission requirements that Minimum Data Set software must satisfy for skilled nursing facility reporting. The MDS is a federally required, standardized resident assessment instrument used in the Medicare and Medicaid long-term-care programs. Facilities must transmit assessment records to their state's MDS database in the format, with the edits, and through the submission processes specified by CMS. Consequently, a facility may use a commercial vendor product only

when it supports the applicable CMS MDS specifications and permits accurate, compliant electronic submission. CMS publishes the MDS assessment instructions, item sets, technical information, and related submission resources so that facilities and software developers can implement current requirements. This approach promotes standardized collection of resident assessment information, supports payment and quality-reporting activities, and enables consistent exchange of required data between facilities and state and federal systems. CMS's current Skilled Nursing Facility MDS resources are available at CMS Minimum Data Set Technical Information, and its broader MDS program materials are available at CMS Minimum Data Set.

QUESTION NO: 98

A patient who is HIV positive and currently asymptomatic is admitted with a compound fracture of the tibia. The patient was treated previously for pneumocystis carinii pneumonia. Given the following codes, which is the correct coding and sequencing?

042	Human Immunodeficiency Virus (HIV) disease
136.3	Pneumocystosis (pneumonia due to Pneumocysfis carinii)
V08	Asymptomatic HIV infection status
823.80	Fracture of tibia alone, unspecified part, closed
823.90	Fracture of tibia alone, unspecified part, open

A. 823.90, V08

B. 823.90, 042

C. 823.80, V08, 136.3

D. 823.80, 042

E. 823.92, 042

ANSWER: E

Explanation:

823.92, 042 is the correct coding and sequencing. This question uses ICD-9-CM codes. A compound fracture is an open fracture. With no tibial segment specified, code 823.92 identifies an open fracture of an unspecified part of the tibia alone. The fracture is sequenced first because it is the condition chiefly responsible for the admission and the condition receiving treatment during this encounter.

Although the patient is currently asymptomatic, a prior episode of pneumocystis carinii pneumonia establishes HIV disease rather than merely asymptomatic HIV-positive status. Pneumocystis pneumonia is an AIDS-defining opportunistic illness; therefore, ICD-9-CM code 042 is assigned for HIV disease. Code 042 remains applicable after an AIDS-defining diagnosis has been documented, even if the patient has no current HIV-related symptoms and the opportunistic infection was treated previously. Since the prior pneumonia is not being treated during this admission, no code for current pneumocystis pneumonia is assigned. The applicable ICD-9-CM guidance directs coders to sequence the unrelated condition responsible for admission first and report HIV disease as an additional diagnosis. See the ICD-9-CM Official Guidelines for Coding and Reporting and the CDC ICD-9-CM code set archive.

QUESTION NO: 99

The nursing staff would most likely use which of the following to facilitate aggregation of data for comparison at local, regional, national, and international levels?

A. READ codes.

B. ABC codes.

C. SPECIALIST Lexicon.

D. LOINC.

ANSWER: D

Explanation:

LOINC is the appropriate terminology because it provides universal identifiers and standardized names for health measurements, observations, and documents. It is designed to make clinical data interoperable across different systems and organizations, so that a nursing observation recorded in one setting can be recognized consistently when data are exchanged or combined with records from other facilities. This normalization supports meaningful aggregation and comparison across local, regional, national, and international datasets.

For nursing staff, LOINC can represent assessments, screening instruments, clinical observations, and other structured data elements. Its coded terms identify the essential attributes of an observation, such as the component being measured, property, timing, system, scale, and method. These common identifiers reduce ambiguity created by local naming conventions and enable data submitted from multiple sources to be grouped, analyzed, and reused for quality measurement, population health, research, and reporting. The Regenstrief Institute describes LOINC as an international standard for identifying health measurements, observations, and documents, with broad use in health information exchange. See the official LOINC website and the LOINC overview.

QUESTION NO: 100

Excision of 2.5 cm bladder tumor with cystoscopy.

A. 51550

B. 51530

C. 52235

D. 51060

ANSWER: C

Explanation:

The correct code is 52235. This code represents cystourethroscopy with resection of a bladder tumor in the size range of more than 2 cm and up to 5 cm. Because the documented tumor measures 2.5 cm, it falls squarely within that range. In this setting, “excision” of a bladder tumor performed with cystoscopy is coded as the endoscopic resection service; the cystoscopic access and visualization are integral to the procedure and are not reported separately. Accurate CPT selection for transurethral bladder-tumor procedures depends primarily on the documented tumor size, so the provider’s stated 2.5-cm measurement is the key fact supporting 52235. Documentation should clearly identify that a bladder tumor was resected endoscopically and include the tumor’s greatest dimension, since this supports assignment to the appropriate size-based code family. CPT coding guidance and annual code updates are maintained by the American Medical Association; coding professionals should also apply current payer and facility-specific requirements when submitting the claim. See the American Medical Association CPT overview and the CMS Medicare Physician Fee Schedule resources for authoritative coding and payment-reference information.

QUESTION NO: 101

The _____ is a statement sent to the provider to explain payments made by third party payers.

A. remittance advice.

B. advance beneficiary notice.

C. attestation statement.

D. acknowledgement notice.

ANSWER: A

Explanation:

A remittance advice is the statement a third-party payer sends to a healthcare provider after adjudicating a claim. It communicates how the payer processed the claim and explains the payment decision, including the amount allowed, the amount paid, patient responsibility, contractual adjustments, denials, and applicable reason or remark codes. Providers use this information to post payments accurately to patient accounts, reconcile expected reimbursement with actual reimbursement, determine any remaining balance, and identify claims that may need correction, appeal, or follow-up. In electronic transactions, this function is commonly performed through the HIPAA standard electronic remittance advice, the ASC X12N 835 transaction; a paper remittance advice may also be issued. CMS describes the Electronic Remittance Advice as the HIPAA-standard transaction used by health plans to provide claim payment and remittance information to providers. The remittance advice therefore directly matches the definition of a statement sent to explain payments made by third-party payers. See CMS guidance on remittance advice transactions and CMS electronic data interchange transaction information.

QUESTION NO: 102

In order to alter the facility's health record format to achieve a record that is strictly chronological, the committee would recommend a(n)

A. integrated medical record.

B. universal chart order.

C. problem-oriented medical record.

D. source-oriented medical record.

ANSWER: A

Explanation:

An integrated medical record is the appropriate format when the goal is a strictly chronological arrangement of documentation. In an integrated record, entries from all clinical disciplines and services are filed together in date-and-time sequence. For example, physician progress notes, nursing documentation, therapy notes, consultation reports, and other relevant clinical observations for the same period appear together according to when they were created. This organization lets a reviewer follow the patient's course of care as events occurred, supporting efficient review of treatment, responses, and changes in condition across disciplines.

Chronological integration also supports the health record's role as a communication tool: clinicians can see the sequence of assessments, interventions, and outcomes without first navigating separate sections organized by document source or type. A complete, organized medical record is essential for continuity and quality of care, as recognized in the Medicare hospital Conditions of Participation. Further background on health-record documentation and its clinical purpose is available from CMS's Hospital Conditions of Participation resources and the NCBI overview of medical records.

QUESTION NO: 103

A health information manager develops a formal plan or record retention schedule for the automatic transfer of records to inactive storage and potential destruction based on all but which one of the following factors?

A. statute of limitations

B. volume of research

C. readmission rate

D. file area staffing

ANSWER: D

Explanation:

file area staffing is correct because staffing levels in the filing area are an operational resource issue, not a defensible basis for setting how long health records must be retained. A retention schedule must establish retention periods that support legal, regulatory, accreditation, clinical, and organizational needs before records may be moved to inactive storage or destroyed. The schedule should account for applicable statutes of limitation, which can affect the period during which records may be needed for litigation; anticipated secondary uses, including research; and patient-care considerations such as patterns of readmission that may make older records useful and accessible for continuing care. It also must be applied consistently across comparable records and supported by a documented destruction process once the approved retention period expires. Staffing may influence how an organization organizes, retrieves, scans, or stores inactive records, but it cannot shorten or otherwise determine a legally and operationally appropriate retention requirement. For example, Medicare's hospital condition of participation requires hospitals to retain medical records for at least five years, demonstrating that retention requirements arise from governing standards rather than personnel availability. See the CMS medical-records condition of participation and AHIMA's guidance on retention and destruction of health information.

QUESTION NO: 104

Elderly man was admitted through the emergency department for severe urinary retention. Upon study, it was determined that his hypertension was uncontrolled (215/108). Prior medical records show admission 8 weeks ago for the same problem. As per conditions on previous admission, his BPH is complicated by acute cystitis. He is noncompliant with medications. Medication for the hypertension was immediately started and his hypertension was quickly brought under control.

Urinary retention was relieved by placement of a Foley

600.00	Hypertrophy, (benign) of prostate without urinary obstruction and other lower urinary tract symptoms (LVTS)
600.01	Hypertrophy (benign) of prostate with urinary obstruction and other lower urinary tract symptoms (LVTS)
600.3	Cyst of prostate
595.0	Acute cystitis
595.9	Cystitis, unspecified
788.20	Retention of urine, unspecified
401.9	Essential hypertension, unspecified
401.0	Essential hypertension, malignant
V15.81	Non-compliance with medical treatment
57.94	Insertion of indwelling urinary catheter
57.92	Dilation of bladder neck
60.29	Other transurethral prostatectomy
60.61	Local excision of lesion of prostate

A. 600.01, 595.0, 788.20, 401.9, V15.81, 57.94, 60.29

B. 600.3, 595.0, 401.0, V15.81, 57.92, 60.61

C. 600.00, 595.9, 788.20, 401.9, V15.81, 57.94, 60.61

D. 600.3, 595.0, 788.20, 401.0, V15.81, 57.94, 60.61

ANSWER: A

Explanation:

600.01, 595.0, 788.20, 401.9, V15.81, 57.94, 60.29 correctly captures the documented conditions and interventions using ICD-9-CM. The benign prostatic hypertrophy is associated with urinary obstruction/retention, supporting 600.01, and the

acute cystitis is documented as a complicating condition, supporting 595.0. Urinary retention is clinically significant in this encounter because it prompted emergency treatment and Foley catheter placement, so 788.20 is also reported. The record describes uncontrolled hypertension but does not document a hypertensive crisis or a specific malignant designation; 401.9 accurately represents essential hypertension when no further type is stated. The established medication noncompliance is captured by V15.81. For inpatient procedures, 57.94 reports insertion of an indwelling urinary catheter, consistent with relief of retention by Foley catheter. The transurethral prostate procedure is reported with 60.29. Code assignment should reflect provider-documented diagnoses and procedures, as well as conditions that required treatment, monitoring, or otherwise affected care. The official ICD-9-CM materials remain available through the CDC ICD-9-CM resources; CMS also maintains coding information at CMS Coding Resources.

QUESTION NO: 105

As the Director of Health Information Services, you manage the department with the assistance of four supervisors. One day you observe a coder coding charts from the face sheet without reviewing the record for additional documentation. The most appropriate course of action would be to

A. discuss your concerns with the Supervisor of Coding and direct her to address this issue immediately.

B. discuss the problem with the CFO.

C. discuss the matter directly with the coder and instruct him to review the entire record for correct assignment of codes.

D. do nothing because the coding area is extremely productive.

ANSWER: A

Explanation:

Discussing your concerns with the Supervisor of Coding and directing her to address the issue immediately is the appropriate management response. The director is responsible for the overall integrity, compliance, and quality of the health information function, while the coding supervisor has direct operational responsibility for coder performance, training, monitoring, and corrective action. Raising the concern through the established supervisory structure preserves accountability and enables the supervisor to promptly investigate the coder’s practice, ensure the affected records are reviewed, and reinforce the required coding workflow.

Accurate code assignment requires review of the complete health record and application of applicable coding conventions and official guidelines. A face sheet may contain administrative or summary information, but it is not a substitute for the clinical documentation needed to substantiate reportable diagnoses and procedures. The supervisor should ensure immediate remediation, such as education, concurrent or retrospective audit of potentially affected accounts, and follow-up monitoring to confirm that coding staff review all relevant documentation before assigning codes. This response protects data quality, reimbursement integrity, compliance, and the reliability of information used for patient care and organizational decision-making. CMS publishes the official ICD-10-CM coding guidance at CMS ICD-10 Codes; AHIMA provides professional practice and ethics resources at AHIMA Ethics.

QUESTION NO: 106

A disadvantage of adopting SNOMED for diagnosis coding is that it

A. is too difficult to use as a reimbursement system.

B. is not compatible with computer technology.

C. would hinder communication among diverse computer systems.

D. is not possible to conduct outcomes research with SNOME

ANSWER: A

Explanation:

“is too difficult to use as a reimbursement system” is correct because SNOMED CT is a comprehensive, concept-based clinical terminology rather than a classification designed to support payment grouping. Its extensive granularity, compositional structure, and multiple possible ways to represent a patient’s condition provide valuable clinical detail for documentation, decision support, interoperability, and analytics. However, reimbursement systems need diagnoses to be assigned consistently to a limited set of standardized categories that can be used with payment methodologies, coverage rules, and reporting requirements. SNOMED CT concepts therefore commonly require mapping to classification systems, such as ICD-10-CM, when diagnoses must be used for administrative reporting or reimbursement. Mapping and maintaining those relationships can be complex, and the terminology’s detailed clinical representation does not inherently produce the mutually exclusive, aggregation-oriented groupings needed for payment. This is why its use as the direct reimbursement coding system is a practical disadvantage, despite its substantial clinical strengths. SNOMED International describes SNOMED CT as a clinical terminology that supports electronic health information, while the National Library of Medicine identifies mapping as an important mechanism for relating SNOMED CT to other coding systems. See SNOMED International: What is SNOMED CT? and National Library of Medicine: SNOMED CT.

QUESTION NO: 107

The physician who performed the highest number of services overall last Tuesday was Doctor The physicians at Sunset Shore Clinic reported the following statistics last Tuesday.

Physician	Service A	Service B	Service C
Truba	10	18	14
Wooley	14	22	9
Howe	18	5	6
Masters	12	20	7

A. Truba.

B. Wooley.

C. Howe.

D. Masters.

ANSWER: B

Explanation:

Wooley is correct because determining the physician who performed the highest number of services overall requires combining that physician’s reported service counts across every service category shown in the clinic statistics. The appropriate method is to read each value associated with a physician, add those values to obtain one total per physician, and then compare the totals. Based on the data displayed in the image, Wooley’s aggregate service total is the largest for last Tuesday. This type of calculation is an important health information management competency: operational data must be accurately aggregated before it is used to report productivity, evaluate resource utilization, or support management decisions. The conclusion concerns the overall total, rather than performance in only one category of service. Accurate interpretation also requires retaining the defined reporting period—last Tuesday—so that counts from a different date or period are not inadvertently included. AHIMA identifies data analysis and use of health information for organizational decision-making as part of RHIA-level practice expectations. See AHIMA’s RHIA certification overview and the AHIMA education resources for related health information and data-management competencies.

QUESTION NO: 108

Mallory, the coding supervisor, must determine the number of full-time employees (FTEs) needed to code 600 discharges per week. It takes an average of 20 minutes to code each record and each coder will work 40 hours per week. How many coders are needed?

A. 6.0

B. 5.0

C. 12.0

D. 4.5

ANSWER: B

Explanation:

The correct answer is **5.0**. Staffing needs are calculated by first determining the total weekly workload in productive time. Coding 600 discharged records at an average of 20 minutes per record requires 12,000 minutes of coding work per week (600 × 20). Converting this workload to hours gives 200 hours (12,000 ÷ 60). Each full-time coder is available for 40 work hours per week, so dividing the required 200 coding hours by 40 hours per coder yields 5.0 full-time equivalents. Thus, five coders are needed to perform this volume of work under the stated assumptions. This calculation treats every scheduled work hour as available for record coding because the question does not identify nonproductive time, such as meetings, training, breaks, paid time off, quality review, or other duties. In actual workforce planning, a coding manager would typically adjust productive capacity and account for case complexity, technology, turnaround-time standards, and expected absences before establishing a final staffing budget. AHIMA's resources on workforce and productivity management support using workload and available labor hours to inform HIM staffing decisions. See AHIMA and the U.S. Bureau of Labor Statistics overview of healthcare management work.

QUESTION NO: 109

John Doe is an information specialist in the Department of Information Technology. He has been asked to assist with the Joint Commission survey process, which accounts for approximately 75% of his time. He also receives project assignments supervisor, as well as the overall project manager. relationship?

A. functional

B. parallel

C. matrix

D. divisional

ANSWER: C

Explanation:

The matrix relationship is correct because John Doe has responsibilities to both a functional supervisor in the Department of Information Technology and an overall project manager for the Joint Commission survey work. A matrix organizational structure combines functional departments with project-based management. Staff members retain their professional home, reporting relationships, and technical oversight within a functional area while also being assigned to projects that require coordination across departments. In this scenario, the Joint Commission survey consumes most of John Doe's work time, making the project-management dimension significant, yet he continues to receive assignments through his departmental supervisory structure. This dual authority and shared allocation of staff are central features of a matrix arrangement. Matrix structures are especially useful in healthcare organizations because accreditation, implementation, quality, and information-governance projects commonly need specialized expertise from departments such as IT, health information, compliance, and quality management. The project manager can direct project priorities, timelines, and deliverables, while the functional supervisor remains responsible for technical standards, staffing, and professional development. The Project Management Institute describes matrix organizations as structures in which the project manager and functional manager share authority, with the balance varying by the strength of the matrix. See the Project Management Institute's discussion of matrix organizational structures and the Joint Commission for accreditation context.

QUESTION NO: 110

The childhood viral disease that unvaccinated pregnant women should avoid because it may be passed to the fetus, causing congenital anomalies such as mental retardation, blindness, and deafness, is

A. rickets.

B. rubeola

C. rubella

D. tetanus

ANSWER: C

Explanation:

Rubella is correct. Maternal infection with rubella virus, particularly during early pregnancy, can cross the placenta and cause congenital rubella syndrome in the developing fetus. This syndrome classically includes sensorineural hearing loss, eye disease such as cataracts or retinopathy that can impair vision, and congenital heart defects. Infection can also cause serious neurologic and developmental effects, fetal growth restriction, miscarriage, stillbirth, or neonatal death. The severity of fetal effects is greatest when infection occurs in the first trimester, when major organs are developing.

Because rubella may cause these severe congenital outcomes, immunity should be assessed before pregnancy when possible. The measles-mumps-rubella vaccine is a live attenuated vaccine and is recommended for people without evidence of immunity before conception or after delivery; it is not administered during pregnancy. Public-health vaccination programs have made congenital rubella syndrome rare in the United States, but susceptibility remains clinically important among unvaccinated individuals and during outbreaks or international travel. The CDC provides clinical information on rubella and congenital rubella syndrome, and its vaccine guidance is available through the adult immunization schedule.

QUESTION NO: 111

A service provide by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician is referred to as

A. a referral.

B. a consultation.

C. risk factor intervention.

D. concurrent care.

ANSWER: B

Explanation:

The correct answer is **"a consultation."** In CPT terminology, a consultation is a type of evaluation and management service provided by a physician or other qualified healthcare professional when another appropriate source requests their opinion or advice concerning the evaluation and/or management of a specific patient problem. The consulting clinician evaluates the patient, develops an opinion or recommendation, and communicates that opinion back to the requesting clinician or source, with documentation supporting the service. This definition directly matches the scenario described: another physician requests expert opinion or advice for a particular clinical problem.

For coding and health information management purposes, the medical record must support the request for the consultation, the consulting provider's evaluation and opinion, and a written report or communication of findings to the requesting provider. Although Medicare does not recognize CPT consultation codes for payment and instructs practitioners to bill other appropriate evaluation and management services instead, "consultation" remains the term that accurately describes the service in the question and remains relevant in CPT coding guidance and in many non-Medicare payment contexts. See the CMS Medicare Claims Processing Manual and the American Medical Association CPT overview.

QUESTION NO: 112

The attending physician requests a consultation from a cardiologist. The cardiologist takes a detailed history, performs a detailed examination, and utilizes moderate medical decision making. The cardiologist orders diagnostic tests and prescribe medication. He documents his findings in the patient's medical record and communicates in writing with the attending

physician. The following day the consultant visits the patient to evaluate the patient' sresponse to the medication, to review results from the diagnostic test, and to discuss treatment options. What codes should the consultant report for the two visits?

A. an initial inpatient consult and a follow-up consult

B. an initial inpatient consult for both visits

C. an initial inpatient consult and a subsequent hospital visit

D. an initial inpatient consult and initial hospital care

ANSWER: C

Explanation:

An initial inpatient consult and a subsequent hospital visit is correct. The first encounter meets the essential elements of an inpatient consultation: it was requested by the attending physician, the cardiologist evaluated the patient and rendered an opinion or treatment recommendations, and the consultant documented the service and communicated findings to the requesting physician. Under CPT consultation reporting principles, this initial service is reported as an initial inpatient consultation when the payer recognizes consultation codes. The detailed history, detailed examination, and moderate medical decision making support selecting the appropriate level within the initial inpatient consultation code family under the documentation rules applicable to the date of service.

The next-day encounter is not another initial consultation because the cardiologist is continuing to manage and reassess issues identified during the original consult. Reviewing diagnostic results, evaluating the medication response, and discussing ongoing treatment are subsequent hospital care. Therefore, the consultant reports a subsequent hospital visit for that later service. Payer policy matters: Medicare does not pay CPT consultation codes and directs practitioners to use the applicable initial hospital care codes instead for services that otherwise meet consultation requirements. The question's consultation terminology and requested written communication support the CPT consultation-based reporting convention. See the CMS consultation billing guidance and the AMA Evaluation and Management resources.

QUESTION NO: 113

The Privacy Act of 1974 permits patients to request amendments to their medical record in which type of facility?

A. private proprietary health care facility

B. mental health and chemical dependency facility

C. university-based teaching facility

D. Department of Defense health care facility

ANSWER: D

Explanation:

The Privacy Act of 1974 applies to records maintained in systems of records by U.S. federal agencies. It gives an individual the right to request amendment of an agency record about that individual when the person believes the record is not accurate, relevant, timely, or complete. A Department of Defense health care facility is part of a federal executive-branch agency and maintains patient information subject to the Privacy Act when it is held in an applicable system of records. Therefore, a patient may use the Privacy Act amendment process to seek correction or amendment of a medical record maintained by such a facility.

This is an important distinction in health information management because the legal basis for an amendment request can depend on the organization that maintains the record. Department of Defense policy implements Privacy Act requirements for DoD records and establishes procedures for individuals to access and request amendment of those records. The statutory amendment provision is found at 5 U.S.C. § 552a(d), which requires agencies to permit an individual to request amendment and to review a denial through an agency process. See the U.S. Department of Justice Privacy Act overview and 5 U.S.C. § 552a.

QUESTION NO: 114

You will be choosing the type of encryption to be used for the new EHR. What are your choices?

A. symmetric and conventional

B. asymmetric and public key

C. symmetric and asymmetric

D. public key and integrity

ANSWER: C

Explanation:

The correct choice is **symmetric and asymmetric**. These are the two fundamental categories of cryptographic encryption used to protect electronic health record information. Symmetric encryption uses one shared secret key to encrypt and decrypt data. Because it is efficient for large volumes of information, it is commonly used to protect data at rest, such as databases, backups, and stored EHR files. Asymmetric encryption uses a mathematically related public-key and private-key pair. A public key can encrypt information or verify a digital signature, while the corresponding private key decrypts information or creates the signature. This approach supports secure key exchange, authentication, and digital signatures, which are important when EHR data are transmitted or exchanged between authorized parties. In operational EHR environments, these approaches are frequently combined: asymmetric cryptography securely establishes or exchanges a symmetric session key, and symmetric cryptography then encrypts the clinical data efficiently. This combination helps organizations implement reasonable and appropriate technical safeguards for the confidentiality and integrity of electronic protected health information under the HIPAA Security Rule. See the HHS HIPAA Security Rule guidance and NIST's definition of asymmetric cryptography.

QUESTION NO: 115

In order for the EHR and other systems to be interoperable, the systems must meet certain

A. rules.

B. guidelines.

C. standards.

D. alerts.

ANSWER: C

Explanation:

"standards." is correct because interoperability depends on systems using agreed-upon technical and semantic specifications that enable health information to be exchanged, received, and used meaningfully across different applications and organizations. Interoperability standards establish consistent requirements for such elements as data structure, terminology, identifiers, messaging, application programming interfaces, privacy, and security. For example, standards can specify how a clinical observation is represented, which code identifies a diagnosis or laboratory test, and how an EHR makes data available through an exchange interface. Using common standards reduces ambiguity and allows information sent by one system to be correctly interpreted and incorporated by another system without manual re-entry or loss of meaning. The Office of the National Coordinator for Health Information Technology describes interoperability as the ability of different systems to exchange and use electronic health information, with standards and implementation specifications serving as essential enablers. The U.S. Core Data for Interoperability also identifies standardized data classes and elements that support nationwide exchange. See the ONC overview of interoperability and ONC's USCDI resource.

QUESTION NO: 116

Fibrocystic disease of the breast; needle biopsy of breast

610.1	Diffuse cystic mastopathy (fibrocystic disease of breast)
610.2	Fibroadenosis of breast
610.3	Fibrosclerosis of breast
610.9	Benign mammary dysplasia, unspecified
85.11	Closed (percutaneous) (needle) biopsy of breast
8512	Open biopsy of breast

A. 610.1, 85.11

B. 610.3, 85.12

C. 610.2, 85.11

D. 610.9, 85.12

ANSWER: A

Explanation:

The correct code pair is **610.1, 85.11**. In ICD-9-CM diagnosis coding, fibrocystic disease of the breast is indexed to diffuse cystic mastopathy, which is reported with code 610.1. This code describes the fibrocystic change documented by the provider and does not require a more specific cyst type or other breast condition when none is stated.

For the procedure, a needle biopsy is a closed/percutaneous biopsy of the breast. ICD-9-CM procedure code 85.11 specifically identifies a closed (percutaneous/needle) breast biopsy. The wording “needle biopsy” establishes the approach needed to assign this procedure code; the image guidance, if any, does not alter the basic biopsy code in this question. Diagnosis and procedure codes are reported together because the scenario supplies both a condition treated or evaluated and the procedure performed.

ICD-9-CM remains relevant for historical-record and legacy-coding questions, even though current U.S. diagnosis reporting generally uses ICD-10-CM. CMS maintains historical ICD-9-CM resources at CMS ICD-9-CM Archives. The National Center for Health Statistics also provides the historical ICD-9-CM classification materials at CDC ICD-9-CM.

QUESTION NO: 117

If HIPAA and state law conflicts, which prevails:

A. HIPAA always

B. state law always

C. whichever is more protective of the patient's privacy

D. HIPAA unless the state law is weaker

ANSWER: C

Explanation:

“whichever is more protective of the patient's privacy” is correct because the HIPAA Privacy Rule establishes a federal baseline for protecting individually identifiable health information, while preserving state requirements that provide greater privacy protection. Under HIPAA’s preemption framework, a contrary provision of state law is generally preempted; however, a state law that is “more stringent” than the applicable HIPAA Privacy Rule requirement is not preempted and must be followed. In practical terms, a more protective state requirement may give an individual stronger rights to access information, require a more restrictive authorization before a disclosure, impose tighter limits on disclosures, or otherwise provide greater privacy safeguards than HIPAA.

The determination is made by comparing the particular HIPAA requirement and the applicable state-law requirement, rather than treating either source of law as automatically controlling in every situation. This approach supports HIPAA's purpose as a national floor for privacy protections while allowing states to retain stronger privacy rules. The governing preemption rule appears at 45 CFR § 160.203, and the definition of a "more stringent" state law is provided at 45 CFR § 160.202.

QUESTION NO: 118

Sally has been diagnosed with panic attacks and is prescribed Xanax. She has been taking the medication as prescribed by her physician for 3 days and is now having hallucinations. Her physician advises her to stop taking the medication and her symptoms abate. Her doctor determines that the hallucinations were due to the Xanax.

292.12	Drug-induced psychotic disorder with hallucinations
300.01	Panic disorder without agoraphobia
E939.4	Benzodiazepine-based tranquilizers

A. 292.12, E939.4, 300.01

B. 292.12

C. E939.4, 292.12

D. 300.01, 292.12

ANSWER: A

Explanation:

292.12, E939.4, 300.01 is correct under the ICD-9-CM classification used in this question. The documented hallucinations are the condition requiring care and are specifically linked by the physician to Xanax, a benzodiazepine. Code 292.12 identifies a drug-induced psychotic disorder with hallucinations and is sequenced first because ICD-9-CM adverse-effect conventions direct coders to report the manifestation of the adverse effect before the external-cause code. E939.4 then identifies the drug involved: benzodiazepine-based tranquilizers, including Xanax (alprazolam), when the medication was correctly prescribed and taken as directed. This is an adverse effect rather than a poisoning because there is no indication of an overdose, wrong substance, wrong route, or administration error.

Code 300.01 is also reported to retain the patient's diagnosed panic disorder without agoraphobia, the condition for which the Xanax was prescribed and clinically relevant to the encounter. Together, these codes convey the manifestation, the responsible therapeutic drug, and the underlying treated condition. The historical ICD-9-CM code set and its instructional conventions are available through the CMS ICD-9-CM resources; CMS also provides coding-policy materials through its ICD-9 coding resources.

QUESTION NO: 119

When designing a computer view for information capture, all of the following should be considered except for which one?

A. external standards such as those developed by HL7 and NCVHS

B. standardized vocabularies

C. size of the document

D. forms committee membership

ANSWER: D

Explanation:

forms committee membership is the appropriate exception because it is an organizational governance consideration, rather than a direct design requirement for the on-screen view used to capture information. A computer view must be designed around the data that need to be collected, the workflow of the user entering the data, and the ability of the resulting information to be exchanged, reused, and analyzed reliably. This calls for attention to applicable external standards, such as interoperability standards, and to standardized vocabularies that provide consistent, computable meaning for captured data. Screen and document size also affects usability: users must be able to locate fields, review information, and enter data efficiently without an unnecessarily fragmented or cluttered display.

A forms committee may establish policies, approve forms, and coordinate stakeholders in an organization, but the particular membership of that committee does not itself determine the content or layout principles of a computer data-capture view. The distinction is important for RHIA practice: governance can support the design process, whereas standards, vocabulary, and display constraints are substantive design inputs. HL7 maintains standards supporting interoperable health information exchange, and the National Library of Medicine describes value sets as defined collections of coded concepts used to support consistent data capture. See HL7 International and NLM information on value sets.

QUESTION NO: 120

The HIM department frequently experiences a backlog in loose report filing. A quality improvement team is assembled to identify the outcome variables and the major or root causes. What visual QI tool is helpful to report the findings?

A. PDCA method

B. run chart

C. fishbone (cause and effect) diagram

D. scatter diagram

ANSWER: C

Explanation:

The fishbone (cause and effect) diagram is the appropriate visual quality-improvement tool because the team's purpose is to organize and communicate potential causes of a defined performance problem: the backlog in loose report filing. Also called an Ishikawa diagram, this tool places the observed outcome or effect at the "head" of the diagram and groups contributing causes along major branches. For an HIM filing backlog, the team can systematically explore cause categories such as people, workflow methods, technology, materials or record volume, policies, and the work environment. Subcauses can then be added beneath each category, making the relationships between the backlog and its possible root causes visible to all team members. This structured display supports brainstorming without prematurely selecting a single cause, helps identify areas where further data collection is needed, and provides a clear report of the team's findings for leadership and staff. Once likely causes are identified and validated, the organization can prioritize corrective actions and monitor whether process changes reduce the backlog. The American Society for Quality describes fishbone diagrams as a tool for identifying many possible causes of an effect and sorting ideas into useful categories: ASQ: Fishbone Diagram. CMS likewise recognizes root-cause analysis as a systematic approach to identifying underlying process contributors in quality improvement: CMS: QAPI at a Glance.

QUESTION NO: 121

Protected health information includes

A. only electronic individually identifiable health information.

B. only paper individually identifiable health information.

C. individually identifiable health information in any format stored by a health care provider.

D. individually identifiable health information in any format stored by a health care provider or business associate.

E. individually identifiable health information in any form or medium that is transmitted or maintained by a covered entity or its business associate.

ANSWER: E

Explanation:

Individually identifiable health information in any form or medium that is transmitted or maintained by a covered entity or its business associate is protected health information (PHI), subject to the HIPAA Privacy Rule. “Any form or medium” encompasses oral communications, paper records, and electronic information; therefore, PHI is not limited to a particular record format. The information must identify the individual, or provide a reasonable basis to believe that it could be used to identify the individual, and it must relate to the person’s past, present, or future physical or mental health, healthcare provided, or payment for healthcare. A covered entity includes a healthcare provider, health plan, or healthcare clearinghouse, so the scope is broader than information handled only by healthcare providers. Business associates that create, receive, maintain, or transmit PHI for a covered entity are also subject to applicable HIPAA requirements. This definition supports appropriate privacy and security safeguards throughout healthcare operations and across all media. The governing regulatory definition appears at 45 CFR §160.103; HHS also summarizes the Privacy Rule’s application to PHI at HHS HIPAA Privacy Rule.

QUESTION NO: 122

Patient comes into the outpatient department at.the local hospital for an MRI of the cervical spine with contrast. Patient is status post automobile accident.

A. 72156

B. 72142

C. 72149

D. 72126

ANSWER: A

Explanation:

72156 is the correct CPT code because the documented service is magnetic resonance imaging of the cervical spine performed with contrast. In the MRI spine code family, code selection depends on the spinal region imaged and whether contrast was administered. The cervical-spine MRI codes distinguish among a study performed without contrast, a study performed with contrast, and a study performed both without contrast and then with contrast. Code 72156 specifically represents MRI of the spinal canal and contents in the cervical region, performed without contrast followed by with contrast, or with contrast when the code descriptor and payer coding guidance support that service. For this question, the intended contrast-enhanced cervical MRI service is represented by 72156. The fact that the encounter is outpatient and follows an automobile accident may support medical necessity and diagnosis reporting, but it does not alter the procedure code assigned for the MRI itself. Accurate reporting requires matching the imaging modality, anatomic region, and contrast status documented in the radiology order and final report. See the code listing at AAPC CPT 72156 and CMS guidance on using the current procedure-code descriptors through the Medicare Physician Fee Schedule.

QUESTION NO: 123

A 75-year-old man is admitted to your facility with acute cerebral embolism with infarction. He had hemiplegia and dysphagia. Physical therapy was given for the hemiplegia. Dysphagia was resolved at the time of discharge

434.11	Cerebral embolism with cerebral infarction
342.90	Hemiplegia, unspecified, affecting unspecified side
787.20	Dysphagia, unspecified
V57.1	Other physical therapy

A. 434.11, 342.90, V57.1

B. 434.11, 342.90,787.20

C. 434.11, 342.90

D. 434.11, 342.90, 787.20, V57.1

ANSWER: C

Explanation:

434.11, 342.90 is the appropriate code assignment. Code 434.11 identifies the acute cerebrovascular event documented as cerebral embolism with cerebral infarction. During the acute admission, hemiplegia is a clinically significant manifestation: it required physical therapy and therefore affected the patient's care, treatment, and resource use. Code 342.90 captures hemiplegia when neither the affected side nor whether it is dominant or nondominant is documented. The neurologic deficit is coded as part of the acute-care record rather than as a late effect, because the patient is being treated during the acute stroke episode.

For inpatient reporting, additional diagnoses are conditions that coexist at admission or arise during the stay and affect clinical evaluation, therapeutic treatment, diagnostic procedures, nursing care, monitoring, or length of stay. The documented physical therapy establishes that hemiplegia meets this reporting standard. The record as presented supports the acute infarction and the treated hemiplegia. CMS's archived ICD-9-CM materials are available through CMS ICD-9-CM and GEMs resources. General inpatient coding principles for reporting conditions that affect care are also reflected in the CMS Official Coding Guidelines resources.

QUESTION NO: 124

To enter the results of a CBC into the computer system, you would use a:

A. laboratory system

B. radiology system

C. pharmacy system

D. order entry/results reporting system

ANSWER: A

Explanation:

The correct answer is **laboratory system**. A complete blood count (CBC) is a laboratory test that measures blood components such as red blood cells, white blood cells, hemoglobin, hematocrit, and platelets. Results generated by laboratory instruments are entered, interfaced, verified, and managed in the laboratory information system (LIS), which supports the laboratory workflow from specimen accessioning through result reporting. The LIS maintains test-specific information, applies reference ranges and result-validation rules, documents the responsible laboratory personnel, and transmits finalized results to the patient's electronic health record or other clinical results-reporting tools. This specialized functionality helps ensure that laboratory data are accurate, traceable, timely, and available to authorized clinicians for patient care. The Office of the National Coordinator for Health IT describes laboratory information systems as systems that manage laboratory testing information and reporting, while CMS's CLIA materials emphasize the importance of reliable laboratory testing and reporting processes. See HealthIT.gov's laboratory information system overview and CMS's CLIA program information.

QUESTION NO: 125

A hospital reported the following statistics during a nonleap year. Calculate the percentage of occupancy for the entire year.

Time Period	Bed Count	Inpatient Service
January 1 – May 31	200	28,690
June 1 – October 15	250	27,400
October 16 – December 31	275	19,250

A. 85.2%

B. 88%

C. 90.0%

D. 91.2%

ANSWER: B

Explanation:

88% is the percentage of occupancy obtained by applying the annual occupancy-rate formula to the reported statistics: divide total inpatient service days (also called inpatient days or patient days) by total bed days available, then multiply by 100. For an entire nonleap year, total bed days available reflect the available bed count for each day of the 365-day reporting period; if the bed count changed during the year, the calculation uses the sum of available beds for each applicable day or period. The numerator represents the accumulated daily census of inpatients, rather than admissions or discharges. Using the hospital's reported annual inpatient service days and annual bed days available produces a quotient of 0.88. Converting that decimal to a percentage gives 88%. This measure expresses the proportion of staffed/available bed capacity that was occupied on average throughout the year and is a standard hospital-utilization statistic used in performance monitoring, planning, and reporting. CMS cost-report materials identify occupancy statistics as inpatient days in relation to available bed days, and AHRQ describes occupancy as a hospital-capacity utilization measure. See the CMS Hospital Cost Report instructions and AHRQ's hospital capacity and occupancy guidance.

QUESTION NO: 126

Which of the following is an example of the breach of confidentiality?

A. a nurse speaking with the physician in the patient's room

B. staff members discussing patients in the elevator

C. the admission clerk verifying over the phone that the patient is in-house

D. the hospital operator paging code blue in room 3 north

ANSWER: B

Explanation:

"staff members discussing patients in the elevator" is an example of a confidentiality breach because an elevator is a public or semi-public setting where individuals who are not involved in a patient's care can overhear protected health information. The HIPAA Privacy Rule requires covered entities to use reasonable safeguards to protect protected health information from impermissible uses or disclosures. Conversations about a patient's condition, identity, treatment, or other identifiable health information must therefore occur in locations and in a manner that reasonably limits access to workforce members with a legitimate need to know the information. Even if the staff members do not intend for others to hear the discussion or do not use the patient's full name, details shared in a public setting can potentially identify the patient and expose information to unauthorized listeners. Appropriate safeguards include moving patient-specific discussions to private work areas, lowering one's voice where a conversation is necessary, and limiting the information discussed to the minimum necessary for the purpose. Protecting confidentiality is an ongoing responsibility for every member of the workforce, not only staff who maintain or release the health record. See the HHS guidance on the HIPAA Privacy Rule and reasonable safeguards at HHS HIPAA Privacy Rule and HHS Reasonable Safeguards guidance.

QUESTION NO: 127

Case study #6

You are helping the Nursing Department to write indicators, to determine appropriate formulas ratios and to determine data collection time frames. One important aspect of care is documentation of education of patients. More specifically, the nursing department would like assess its documentation of education on colostomy care for patients with new colostomies.

Referring to Case Study #6, which of the following ratios would you recommend?

A. number of records with documentation of colostomy-care teaching total number of patients on surgery unit

B. number of records with documentation of teaching total number of discharges

C. number of records with documentation of colostomy-care teaching total number of patients with new colostomy

D. number of records reviewed with documentation of colostomy-care teaching total number of records reviewed

ANSWER: C

Explanation:

The appropriate ratio is *number of records with documentation of colostomy-care teaching total number of patients with new colostomy*. A well-designed quality indicator uses a numerator that counts cases meeting the desired criterion and a denominator that represents the complete population eligible for that criterion during the defined measurement period. Here, the desired criterion is documented patient education regarding colostomy care, so the numerator is the number of applicable records containing that documentation. The eligible population is specifically patients with newly created colostomies, because these are the patients for whom initial colostomy-care teaching is expected.

Aligning the numerator and denominator in this manner makes the resulting percentage meaningful: it measures the proportion of patients with new colostomies whose records show the required education. The nursing department can define the reporting interval, such as monthly or quarterly, and apply consistent inclusion criteria to ensure the measure is reliable and suitable for monitoring improvement over time. This structure follows the fundamental quality-measure approach of clearly specifying the target population and the event or process being measured. CMS describes quality measures as tools that quantify healthcare processes, outcomes, and patient perceptions for defined populations; see CMS Quality Measures. Additional guidance on using measures to evaluate care quality is available from AHRQ TalkingQuality: Quality Measures.

QUESTION NO: 128

Which of the following employees would be considered exempt under the Fair Labor Standards Act?

A. the head of the Department of Health Information Services who is involved in decision making and planning 90%, of the time

B. the coding supervisor who has responsibility for three employees and performs analysis and coding 80% of the time

C. the departmental secretary who is responsible for performing a variety of clerical and administrative tasks

D. the sole employee in the physician's workroom who has responsibility for maintaining and tracking medical record deficiencies

ANSWER: A

Explanation:

The head of the Department of Health Information Services who is involved in decision making and planning 90%, of the time is the best answer because the position’s primary duty is management-level work rather than routine production or clerical work. Leading a distinct health information department and spending the overwhelming majority of work time on organizational decisions and planning are consistent with the executive or administrative exemption concepts: management of a recognized department, participation in policy or operational planning, and the exercise of discretion on significant matters. In a health information setting, this type of leader commonly establishes departmental goals, allocates resources, develops procedures, and makes decisions affecting the organization’s information-management operations. Those

responsibilities reflect the level of independent judgment that distinguishes exempt management work from nonexempt task-focused work. In actual employment practice, exemption also depends on the applicable salary-basis and salary-level requirements and on the complete duties of the position. The U.S. Department of Labor explains the executive exemption's management-duty framework in its Executive Exemption Fact Sheet and summarizes the white-collar exemption requirements in Fact Sheet 17A.

QUESTION NO: 129

LCDs and NCDs are review policies that describe the circumstances of coverage for various types of medical treatment. They advise physicians which services Medicare considers reasonable and necessary and may indicate the need for an advance beneficiary notice. They are developed by the Centers for Medicare and Medicaid Services (CMS), Medicare carriers, or fiscal intermediaries LCD and NCD are acronyms that stand for

A. local covered determinations and non-covered determinations.

B. local coverage determinations and national coverage determinations.

C. list of covered decisions and non-covered decisions.

D. local contractor's decisions and national contractor's decisions.

ANSWER: B

Explanation:

"local coverage determinations and national coverage determinations" is correct. An NCD is a National Coverage Determination: a nationwide Medicare coverage policy issued by the Centers for Medicare & Medicaid Services (CMS). It specifies whether a particular item or service is covered under Medicare, may define covered indications and limitations, and is binding on Medicare Administrative Contractors (MACs). An LCD is a Local Coverage Determination: a coverage policy made by a MAC when no applicable NCD exists or when local policy is needed within the contractor's jurisdiction. LCDs explain the circumstances in which Medicare considers a service reasonable and necessary and often identify documentation, diagnosis-code, or other clinical criteria that support coverage. Health information leaders and coding professionals use these policies to support compliant billing, documentation practices, medical-necessity review, and appropriate issuance of an Advance Beneficiary Notice of Noncoverage when applicable. CMS maintains Medicare coverage-policy resources, including NCDs and MAC LCD information, through its Medicare Coverage Database. See the CMS coverage guidance and the Medicare Coverage Database.

QUESTION NO: 130

Virginia is the Record Processing Coordinator, which is a lead position. She has an excellent w record and is able to assist in most work areas of the department. She knows that she could e get another job within the hospital for the asking. Recently she has been arriving late and has uncooperative in dealing with others. As her immediate supervisor, what is the BEST first step dealing with this situation?

A. Institute progressive discipline.

B. Ignore the situation and hope she will improve because she is a good employee.

C. Counsel her by encouraging self-analysis and problem-solving processes.

D. Suggest that she transfer to another department.

ANSWER: C

Explanation:

Counsel her by encouraging self-analysis and problem-solving processes. is the best first step because the supervisor has observed a recent, meaningful change in an otherwise strong employee's attendance and interactions. A private, timely counseling discussion permits the supervisor to describe the specific observable behaviors, invite Virginia to identify contributing circumstances, and clarify the expected standards for punctuality and professional collaboration. This approach

treats the issue as a performance-management matter while recognizing that a sudden decline may have an underlying work or personal cause that can be addressed through support, resources, or a mutually developed improvement plan.

Effective counseling is not merely an informal conversation. The supervisor should prepare factual examples, listen actively, agree on concrete expectations and follow-up dates, and document the discussion according to organizational policy. This creates a fair foundation for any later corrective action if the behavior does not improve. It also aligns with health information leadership responsibilities to foster a respectful workplace, maintain dependable operations, and address performance concerns consistently. The U.S. Office of Personnel Management describes supervisory performance management as ongoing communication, feedback, and development: OPM Performance Management Cycle. Guidance on constructive feedback and difficult workplace conversations is also available from SHRM's Managing Employee Performance toolkit.

QUESTION NO: 131

In your department employee performance is rated using a continuous scale range unsatisfactory through average to outstanding. Some other departments use a discrete system which the supervisor assigns "does not meet standards," "meets standards," and "exc standards." Both systems being used are

A. rating scales.

B. checklists.

C. critical incident methods.

D. ranking methods.

ANSWER: A

Explanation:

rating scales. is correct because both examples evaluate employee performance by placing performance on an ordered continuum or within ordered performance categories. A continuous rating scale lets a supervisor indicate a point along a range, such as from unsatisfactory through outstanding. A discrete rating scale instead presents distinct, predefined levels, such as does not meet standards, meets standards, and exceeds standards. Although their formats differ, each approach provides a structured scale for judging the degree to which an employee's performance satisfies established expectations.

In performance management, rating levels support consistent appraisal decisions by translating observations about an employee's work into an evaluative result that can be communicated, documented, and used in subsequent personnel processes. The labels may be numerical or descriptive, and the number of available levels may vary among departments, but the essential feature remains the same: the supervisor assigns a rating that reflects the employee's level of performance against standards. Federal performance-management regulations likewise recognize appraisal systems that establish performance standards and assign summary levels based on performance. See 5 CFR Part 430, Subpart B and the U.S. Office of Personnel Management's Performance Management Cycle.

QUESTION NO: 132

Which patient numbering system(s) always assign(s) the next new number in the system to new or readmitted patient to his or her health history?

A. unit numbering system

B. both unit and serial numbering systems

C. both serial and serial-unit numbering systems

D. terminal digit numbering system

ANSWER: C

Explanation:

Both serial and serial-unit numbering systems is correct because each system assigns the next available number to every admission or encounter, including a readmission. Under serial numbering, the health record created for each encounter is assigned a newly generated number in chronological sequence. Under serial-unit numbering, the patient likewise receives a new number at each admission; however, the patient's prior health-record documents are retrieved and consolidated with the current record under the most recently assigned number. Thus, the defining feature shared by these systems is that a readmitted patient does not continue using the number from the prior admission: the next new number in the facility's sequence is assigned. Accurate patient-number assignment and record linkage are essential health information management functions because they support reliable patient identification, complete longitudinal documentation, retrieval of records, and continuity of care. This topic falls within the RHIA examination's health information and data-management knowledge base; see AHIMA's RHIA certification examination information. AHIMA also identifies health information management as the professional practice concerned with acquiring, analyzing, and protecting health information; see AHIMA.

QUESTION NO: 133

A patient was discharged from the acute care hospital with a final diagnosis of bronchial asthma. As the coder reviews the record, she notes that the patient was described as having prolonged and intractable wheezing, airway obstruction that was not relieved by bronchodilators and the lab values showed decreased respiratory function. The coder queried the physician to determine whether the code for _____ is appropriate to be added to the final diagnoses.

A. acute and chronic bronchitis

B. chronic obstructive pulmonary disease

C. respiratory failure

D. status asthmaticus

ANSWER: D

Explanation:

Status asthmaticus is the appropriate diagnosis to query because the documentation describes a severe, prolonged asthma exacerbation with persistent airway obstruction that did not respond to bronchodilators. This clinical presentation is characteristic of status asthmaticus: an acute asthma episode that is refractory to initial standard treatment and may progress to significant respiratory compromise. The decreased respiratory function further supports the need for the physician to clarify whether this serious asthma condition was present and should be reported as a final diagnosis. Coding should be based on the provider's documented diagnostic statement after the query response, with the specific ICD-10-CM asthma code selected according to the documented asthma type, severity, persistence, and whether status asthmaticus is present. In ICD-10-CM, asthma codes in category J45 include code choices that distinguish an acute exacerbation from status asthmaticus. The query is therefore clinically supported and helps ensure that the coded record accurately reflects the severity and resource implications of the hospitalization. See the CDC ICD-10-CM browser for category J45 code selection and the NCBI StatPearls review of status asthmaticus for its clinical characteristics.

QUESTION NO: 134

Reporting the number of incomplete charts over a 6-month period using a run or line chart will prove valuable in the following two ways:

A. The run or line chart data can show how much and how far service goes.

B. Over time, the data can reveal trends and point out areas for improvement.

C. The data in the run or line chart can indicate the level of customer satisfaction related to transcription errors.

D. Over time, the data can reveal an increase in office morale and productivity.

ANSWER: B

Explanation:

Over time, the data can reveal trends and point out areas for improvement. A run chart or line chart plots a measure sequentially over time, making it useful for monitoring the number of incomplete health records across the six-month period. This display allows health information management leaders to see whether performance is improving, worsening, or remaining stable. For example, a sustained upward pattern in incomplete charts may identify a documentation-completion process that needs review, while a downward pattern after an intervention can provide evidence that the intervention is associated with improvement. Charts displayed over time also help distinguish ordinary variation from meaningful changes in process performance, supporting data-driven quality-management decisions. In this setting, the measure is specifically incomplete-chart volume; therefore, the chart supports identification of temporal patterns and opportunities to improve record-completion workflows, provider follow-up, transcription turnaround, or deficiency-management processes. The Institute for Healthcare Improvement describes run charts as simple tools for displaying data over time and determining whether improvement has occurred. AHIMA's practice resources likewise emphasize using data and analytics to monitor performance and drive improvement in health information functions. See the Institute for Healthcare Improvement run chart guidance and AHIMA policy and practice resources.

QUESTION NO: 135

The prospective payment system based upon resource utilization groups (RUGs) is used for reimbursement to _____ for Medicare patients.

A. freestanding ambulatory surgery centers

B. hospital-based outpatients

C. intermediate care facilities

D. skilled nursing facilities

ANSWER: D

Explanation:

Skilled nursing facilities is correct because Medicare's Skilled Nursing Facility Prospective Payment System establishes a per-diem payment methodology for covered Part A SNF services. Historically, the system used Resource Utilization Groups (RUGs), which classified residents according to their clinical characteristics and expected resource use. RUG-based case-mix classification supported payment rates intended to reflect the relative intensity of nursing, therapy, and ancillary services a Medicare beneficiary required during a covered SNF stay. Thus, when the question refers to a prospective payment system based on resource utilization groups, it identifies reimbursement for skilled nursing facility care.

For Medicare SNF payments, the RUG-IV case-mix methodology was replaced by the Patient-Driven Payment Model on October 1, 2019. PDPM still serves the same setting—skilled nursing facilities—but bases payment classifications on patient characteristics rather than therapy-service volume. The historical RUG terminology in the question therefore points directly to SNF reimbursement, while also reflecting the evolution of Medicare payment policy. CMS describes the current SNF PPS and PDPM framework at CMS: Skilled Nursing Facility PPS. Background on the transition from RUG-IV to PDPM is available at CMS: Patient-Driven Payment Model.

QUESTION NO: 136

Medical record information may be exempt from the Freedom of Information Act requirements if the request for information meets the test of being an unwarranted invasion of personal privacy. Which of the following is NOT one of the conditions of the test?

A. The information must be contained in a personal, medical, or similar file.

B. The information is generated from federally funded research conducted by a private health care organization.

C. Disclosure of the information constitutes an invasion of personal privacy.

D. The severity of the invasion must outweigh the public's interest in disclosure.

ANSWER: B

Explanation:

The information is generated from federally funded research conducted by a private health care organization. is the correct response because the source of funding for research and the private status of an organization are not elements of the Freedom of Information Act privacy-exemption analysis. Under FOIA Exemption 6, the relevant inquiry concerns personnel, medical, or similar files and whether disclosure would constitute a clearly unwarranted invasion of personal privacy. Agencies assess whether an identifiable individual has a meaningful privacy interest in the requested information, then balance that interest against the public interest served by disclosure—specifically, whether disclosure would shed light on the operations or activities of the federal government. Medical information commonly carries a substantial privacy interest because it can reveal highly sensitive details about an individual's health, treatment, or condition. The phrase "clearly unwarranted" reflects the required balancing of privacy and the cognizable public interest, not a rule based on research funding. The U.S. Department of Justice explains Exemption 6 and its privacy-balancing framework in its FOIA Guide: Exemption 6. The statutory text is available at 5 U.S.C. § 552.

QUESTION NO: 137

A patient was admitted with severe abdominal pain, elevated temperature, and nausea. The physical examination indicated possible cholecystitis. Acute and chronic pancreatitis secondary to alcoholism was recorded on the face sheet as the final diagnosis. The principal diagnosis is

A. alcoholism.

B. abdominal pain.

C. cholecystitis.

D. acute pancreatitis.

ANSWER: D

Explanation:

Acute pancreatitis is the principal diagnosis because it is the condition established after study as chiefly responsible for the patient's hospital admission. The patient's presenting symptoms support an acute abdominal process, and the final diagnostic statement specifically documents both acute and chronic pancreatitis. In this setting, the acute pancreatitis represents the active episode requiring inpatient evaluation and treatment, while chronic pancreatitis and alcoholism provide clinically important associated context and may require additional coding when documented and reportable. Principal-diagnosis selection is based on the condition found after study to be chiefly responsible for occasioning the admission, rather than solely on a presenting symptom or an initial possible diagnosis. The ICD-10-CM Official Guidelines define principal diagnosis using this "after study" standard and direct coders to report conditions documented by the provider that meet reporting requirements. The documented final diagnosis therefore supports sequencing acute pancreatitis as principal. See the CMS ICD-10-CM Official Guidelines for Coding and Reporting and the CDC ICD-10-CM resources for the official classification and coding-guideline materials.

QUESTION NO: 138

One of your new employees has just completed orientation, receiving basic HIPAA training. You are now providing more specific training related to her job. She asks whether the information she provided during the hiring process, as well as benefits claims, are also protected under HIPAA. Which of the following can you assure her that the Human Resources Department protects?

A. all personal health information (PHI)

B. benefits enrollment

C. Employee Assistance Program contacts

D. OSHA information

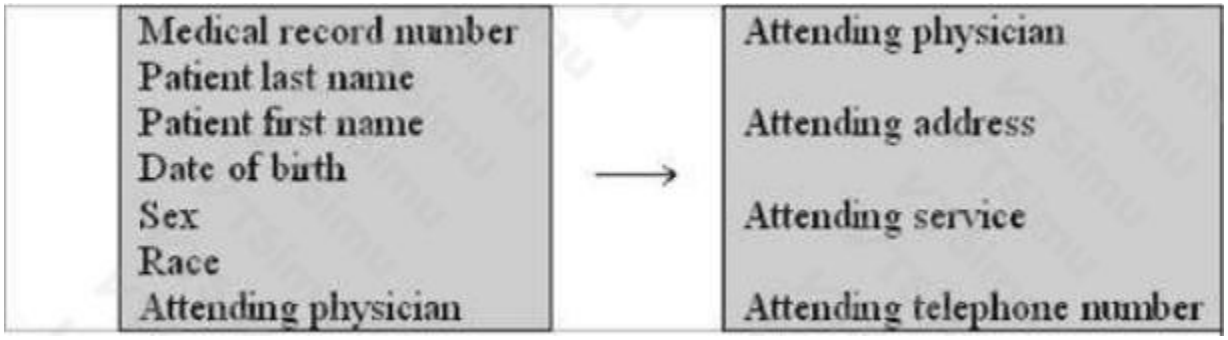
ANSWER: A

Explanation:

“all personal health information (PHI)” is the best answer because Human Resources personnel who perform functions for an employer-sponsored group health plan must safeguard protected health information they create, receive, maintain, or transmit in carrying out those functions. This includes individually identifiable health information associated with plan enrollment, eligibility, payment, and claims administration. HIPAA requires appropriate administrative, technical, and physical safeguards and limits uses and disclosures of PHI to permitted purposes, including plan administration when applicable. HR staff should be trained to recognize when they are handling information on behalf of the group health plan and to keep that information separate from ordinary employment decision-making records. The practical assurance is that PHI handled by HR is protected through the organization’s privacy practices, access controls, minimum-necessary processes, and confidential handling procedures. HIPAA’s Privacy Rule defines PHI and establishes the protections applicable to covered entities and their workforce members; see the HHS HIPAA Privacy Rule resources. The regulatory definition of protected health information is available at 45 CFR §160.103.

QUESTION NO: 139

What type of database model does this simple diagram depict?



A. hierarchical

B. network

C. relational

D. object oriented

ANSWER: C

Explanation:

The diagram depicts a relational database model. In a relational model, data are organized into separate tables (relations) made up of rows and columns. Tables represent distinct entities or subjects, while defined fields establish how records in one table are associated with records in another. A diagram that visually presents these table-based entities and their relationships is therefore characteristic of a relational database design. In health information settings, relational databases support structured storage and retrieval of patient, encounter, provider, diagnosis, and other data while using defined relationships to promote consistency and reduce unnecessary duplication. Relationships are commonly implemented through primary keys, which uniquely identify records in a table, and foreign keys, which store a related table’s identifier. This structure allows users and applications to combine related information through queries while maintaining data integrity. IBM describes a relational database as one that stores data in tables and uses relationships among those tables to organize and access the data. Microsoft similarly explains that relationships connect tables through common fields, supporting accurate, integrated data management. See IBM: What is a relational database? and Microsoft Support: Guide to table relationships.

QUESTION NO: 140

Phyllis saw Dr. Holland during a scheduled office visit. Dr. Holland prescribed a new medication; Jean called Dr. Holland with a question about her medication. Dr. Holland returned the telephone call and answered Jean's question; Howard was seen by Dr. Holland in the hospital emergency department after having a reaction to his medication; the pharmacy got telephone approval from Dr. Horton for a refill on Jackson's prescription. Which of these interactions fit the definition of a patient encounter?

A. Phyllis, Jean, Howard, and Jackson

B. Jackson, Howard, and Jean

C. Jean, Phyllis, and Howard

D. Phyllis and Howard

ANSWER: D

Explanation:

Phyllis and Howard is correct because each scenario describes a direct patient-provider interaction in which healthcare services are furnished and the patient's health status is assessed or managed. Phyllis's scheduled office visit is a classic ambulatory encounter: the physician evaluated the patient and initiated treatment by prescribing a medication. Howard's emergency-department visit is likewise an encounter because he was evaluated and treated by the physician following an adverse medication reaction. In both situations, the patient was present and received professional healthcare services from the provider. For health information management purposes, encounters are generally organized by the setting and type of service, such as office/ambulatory and emergency care, and support creation and maintenance of the clinical record for that episode of care. The U.S. Core Data for Interoperability describes an encounter as an interaction between a patient and healthcare provider(s) for the purpose of providing healthcare service(s) or assessing the patient's health status. This definition fits the office and emergency-department services described here. See the ONC USCDI Encounter data-class definition and the CMS overview of physician and other practitioner services for context on documented healthcare service interactions.

QUESTION NO: 141

At Great Plains Regional Hospital, record processing takes approximately 18 minutes. If there are 15,620 discharges for the month, how many personnel hours are needed for this volume of work?

A. 2,891

B. 4,686

C. 5,496

D. 3,394

ANSWER: B

Explanation:

4,686 is correct because personnel hours are determined by multiplying the monthly workload by the time required for each unit of work, then converting the resulting minutes to hours. The hospital has 15,620 discharges, and each discharge requires approximately 18 minutes of record processing. Thus, the total processing time is 15,620 × 18 = 281,160 minutes. Since one personnel hour contains 60 minutes, divide the total minutes by 60: 281,160 ÷ 60 = 4,686 personnel hours. This is a workload-volume calculation, not a staffing-FTE calculation; it represents the total productive labor hours needed to process the stated monthly discharge volume. If the organization later needed to determine staffing levels, it would apply its own productive-hours standard, accounting for paid time off, education, meetings, and other nonproductive time. Workload measurement and productivity analysis are core functions of health information management operations. For background on HIM practice and workforce responsibilities, see the AHIMA certification overview and the U.S. Bureau of Labor Statistics occupational overview for medical and health services managers.

QUESTION NO: 142

A patient with leukemia is admitted for chemotherapy 5 weeks after experiencing an acute myocardial infarction. How will the MI be coded?

A. acute MI with 5th digit 1—initial episode of care

B. acute MI with 5th digit 2—subsequent episode of care

C. history of MI

D. chronic MI

ANSWER: B

Explanation:

Under the ICD-9-CM conventions reflected in this question, the myocardial infarction is coded as an acute MI with 5th digit 2—subsequent episode of care. ICD-9-CM category 410 classified an acute myocardial infarction as acute for up to 8 weeks after onset. Because the patient's infarction occurred only 5 weeks earlier, it remains within that acute period. The fifth digit identified whether the current encounter was the initial episode of care for the infarction or a subsequent episode of care during the acute phase. This admission is for chemotherapy for leukemia, rather than for the active initial management of the MI; therefore, the MI is reported with the subsequent-episode designation. The clinical fact that the patient is now hospitalized for a different condition does not change the timing rule used to determine whether the infarction is still acute under this legacy classification. This item uses ICD-9-CM terminology, including the fifth-digit episode-of-care distinction. ICD-9-CM was replaced for U.S. HIPAA-covered reporting by ICD-10-CM on October 1, 2015, but historical coding questions may still test its conventions. CMS maintains information and archived resources related to the transition at CMS ICD-9-CM Codes; current ICD-10-CM resources are available from CDC ICD-10-CM.

QUESTION NO: 143

HIM professionals are bound to protect the confidentiality of patient information under the

A. Patient Bill of Rights.

B. AHIMA's Code of Ethics.

C. Hippocratic oath.

D. JCAHO standards.

ANSWER: B

Explanation:

AHIMA's Code of Ethics is correct because it establishes the profession's ethical duty to safeguard the privacy and confidentiality of health information. AHIMA members and credentialed health information professionals are expected to preserve the security and confidentiality of personal health information obtained in the course of professional duties, disclose it only as authorized or legally required, and prevent inappropriate access, use, or release. This obligation applies across health information governance activities, including record management, data quality, coding, release of information, analytics, and information-system administration.

The Code frames confidentiality as a professional responsibility, not merely a technical or organizational task. It requires HIM professionals to exercise sound judgment when handling identifiable information and to support practices that respect patients' privacy rights. In operational settings, this ethical responsibility works alongside applicable privacy laws, organizational policies, and security safeguards. AHIMA's ethical standards specifically guide the conduct of HIM professionals and provide the relevant professional basis for the duty described in the question. See AHIMA's Code of Ethics and its Code of Ethics document.

QUESTION NO: 144

The most common type of registry located in hospitals of all sizes and in every region of the country is the

A. trauma registry.

B. cancer registry.

C. AIDS registry.

D. birth defects registry.

ANSWER: B

Explanation:

The **cancer registry.** is correct because cancer registries are the most widely established hospital-based disease registries in the United States. They systematically collect, manage, and analyze data about patients diagnosed with malignant neoplasms, including tumor characteristics, diagnostic information, treatment, recurrence, and outcomes. This information supports continuity of cancer care, quality-improvement activities, outcomes research, program accreditation, and required reporting to central cancer registries.

Cancer reporting is supported by an extensive nationwide infrastructure. Hospital registries provide data to state and regional central registries, which in turn contribute to population-based surveillance programs. The National Cancer Institute's Surveillance, Epidemiology, and End Results program describes the role of cancer registries in collecting standardized cancer incidence and outcome data, while the Centers for Disease Control and Prevention's National Program of Cancer Registries supports comprehensive cancer surveillance across states and territories. These mature reporting and surveillance requirements make cancer registries a routine function in hospitals across geographic regions and facility sizes. See the National Cancer Institute SEER registry information and the CDC National Program of Cancer Registries.

QUESTION NO: 145

A 32-year-old female known to be HIV positive was admitted with lesions of the anterior trunk. Excisional biopsies of the skin lesions were positive for Kaposi's sarcoma. Further examination revealed thrush.

042	Human Immunodeficiency Virus (HIV) Disease
795.71	Non-specific serological evidence of HIV
176.0	Kaposi's sarcoma of skin
686.00	Pyoderma, unspecified
112.0	Candidiasis of month
528.9	Other and unspecified diseases of the oral soft tissues
86.11	Biopsy of skin and subcutaneous tissue
86.22	Excisional debridement of wound, infection or burn

A. 042, 686.00, 112.0, 86.22

B. 042, 176.0, 112.0, 86.11

C. 795.71, 176.0, 528.9, 86.] 1

D. 795.71, 686.00, 528.9, 86.22

ANSWER: B

Explanation:

042, 176.0, 112.0, 86.11 correctly reports the patient's documented HIV disease, its clinically established manifestations, and the skin biopsy procedure using ICD-9-CM. Code 042 is assigned when a patient with HIV has a documented HIV-related condition; here, Kaposi's sarcoma and oral thrush establish symptomatic HIV disease rather than merely HIV-positive status. Kaposi's sarcoma of the skin is reported with 176.0, which identifies Kaposi's sarcoma involving skin. Thrush is oral candidiasis and is reported with 112.0. ICD-9-CM instructions for HIV disease require coding the HIV disease code together with additional codes for the associated manifestations, providing a complete description of the conditions evaluated and managed during the admission.

The documented diagnostic procedure is a biopsy of skin lesions. Procedure code 86.11 identifies biopsy of skin and subcutaneous tissue and appropriately captures the tissue sampling performed to establish the diagnosis of Kaposi's

sarcoma. The fact that the biopsy was excisional does not change the documented biopsy-based procedure reporting in this coding scenario. The Centers for Disease Control and Prevention provides historical ICD-9-CM materials at CDC ICD-9-CM resources. Additional coding guidance on HIV diagnosis reporting is available from CMS coding resources.

QUESTION NO: 146

Patient has a Bartholin's gland cyst that was marsupialized.

A. 54640

B. 10060

C. 58999

D. 56440

ANSWER: D

Explanation:

The correct code is **56440**, which specifically reports marsupialization of a Bartholin's gland cyst. Marsupialization is a defined operative treatment in which the cyst is opened and the cyst wall is sutured to create a permanent drainage opening. Because the documented procedure is marsupialization, the code selected should identify both the anatomic site (the Bartholin gland) and the specific surgical service performed, rather than merely describing drainage of an unspecified skin lesion or a miscellaneous female-genital procedure.

Accurate procedure coding depends on the operative technique documented, not simply on the presence of a cyst. Clinical references describe marsupialization as an established management approach for Bartholin gland cysts and abscesses, supporting the direct relationship between the documented treatment and this CPT service. The health information professional should also verify the final code assignment against the current-year CPT code set and payer-specific requirements, since CPT codes and reporting guidance are updated periodically. For clinical context on this treatment, see the Merck Manual's discussion of Bartholin gland cysts and abscesses. CMS provides current Medicare coding and payment lookup resources through its Physician Fee Schedule Search.

QUESTION NO: 147

TO protect health information from catastrophes such as fire, flooding, bomb threats, and theft, Joint Commission-accredited facilities are required to maintain a _____ plan.

A. budget

B. disaster

C. case management

D. patient care

ANSWER: B

Explanation:

A disaster plan is correct because it establishes the organized procedures a healthcare facility uses to protect patients, personnel, operations, and health information when an emergency or catastrophic event occurs. For health information functions, the plan should address safeguarding paper and electronic records, maintaining availability of essential information, backing up data, restoring systems and records, securing alternate work areas or storage, and communicating roles and recovery actions. Events such as fire, flooding, security threats, and theft can disrupt access to records or cause loss, alteration, or unauthorized disclosure of protected health information; planning in advance supports continuity of care as well as compliance with privacy and security responsibilities.

Joint Commission emergency-management expectations require accredited organizations to prepare for emergencies through an all-hazards approach, including plans for continuing essential services and managing disruptions. A disaster plan

is the commonly used health information management term for the documented preparedness, response, and recovery procedures that protect records and information assets during such events. This approach also aligns with federal contingency-planning guidance, which emphasizes backup, recovery, and continuity capabilities for information systems. See The Joint Commission Emergency Management resources and NIST SP 800-34 contingency planning guidance.

QUESTION NO: 148

Latent schizophrenia, chronic with acute exacerbation

A. 295.52

B. 295.55

C. 295.54

D. 295.53

ANSWER: C

Explanation:

The correct code is **295.54**. In ICD-9-CM, category 295 identifies schizophrenic disorders, and the fourth digit **5** specifies latent schizophrenia. The required fifth digit describes the documented course or episode status. For latent schizophrenia, the fifth digit **4** means “chronic with acute exacerbation.” Therefore, the full code precisely represents a chronic latent schizophrenic condition that is currently experiencing an acute worsening of symptoms.

Accurate code selection requires assigning all available characters when the classification provides a more detailed code. Here, “latent” establishes the schizophrenia subtype, “chronic” establishes the duration/course, and “with acute exacerbation” establishes the current episode status. These documented clinical descriptors collectively support 295.54 rather than a less-specific category-level code. The ICD-9-CM tabular structure for schizophrenic disorders and the code description for 295.54 can be reviewed at ICD9Data: 295.54. CMS also maintains official historical ICD-9-CM diagnosis code resources at CMS ICD-9-CM and GEMs resources.

QUESTION NO: 149

A health information management department has approved destruction of a group of records that have met the applicable retention period. Before destruction begins, the facility receives notice of a lawsuit involving one of the patients whose record is included in the group. The facility should

A. suspend destruction of the affected record.

B. continue destruction because the retention period has expired.

C. release the original record to the patient’s attorney.

D. retain only the discharge summary and operative report.

ANSWER: A

Explanation:

suspend destruction of the affected record. is correct because a legal hold overrides the routine records-retention and destruction schedule. Once an organization reasonably anticipates litigation or receives notice of a claim, subpoena, investigation, or lawsuit, it must preserve relevant records and related information that may be needed as evidence.

The record should be identified, removed from the normal destruction process, and retained until the legal hold is released by authorized legal or compliance personnel. Destroying potentially relevant information after notice of litigation may expose the organization to allegations of spoliation. Retention policies should include procedures for suspending scheduled destruction when legal, audit, or investigation requirements arise. See the National Archives records management resources.

QUESTION NO: 150

What action(s) would assist the manager of a medical record department in improving customer perception of the quality of services provided by the department?

A. Establish a 2-week turnaround time for all dictated reports.

B. Refuse to fax patient information to protect confidentiality.

C. Have physicians and hospital staff retrieve their own medical records.

D. Identify specific customer needs in order to design value-added services.

ANSWER: D

Explanation:

Identifying specific customer needs in order to design value-added services is the appropriate action because perceived service quality is defined by how well a department understands and meets the requirements of the people it serves. A medical record department has multiple customers, including patients, clinicians, hospital departments, leadership, payers, and external requestors. Their needs may differ—for example, clinicians may need timely, complete records for care decisions, while patients need clear and efficient access to their information. The manager should gather feedback and service data, identify expectations and workflow barriers, and use those findings to improve services such as record-completion support, status updates, convenient request processes, or tailored reporting. This customer-focused approach turns service expectations into measurable improvements and demonstrates value beyond basic transactional functions. It also aligns with quality-management principles that emphasize understanding customer requirements, monitoring satisfaction, and continually improving processes based on customer feedback. AHIMA describes health information professionals as supporting access to quality health information and using information governance practices that serve organizational and patient needs. More broadly, the ISO quality-management principle of customer focus recognizes that sustained success depends on consistently meeting customer requirements and seeking to exceed expectations. See ISO: Customer focus and AHIMA.

QUESTION NO: 151

Mark Beck is a new graduate preparing for an interview. In school, he had the opportunity to roleplay a technique which requires applicants to give specific examples of how they have performed a specific task or handled a specific problem in the past. This technique is becoming more popular, and is known as:

A. audition interview.

B. behavioral interview.

C. structured interview.

D. targeted interview.

ANSWER: B

Explanation:

Behavioral interview is correct because this approach asks candidates to describe concrete situations from their prior experience and explain what they did, how they handled challenges, and what results they achieved. Its underlying premise is that demonstrated past behavior in relevant circumstances can help an employer assess competencies and anticipate how an applicant may perform in a comparable future role. Interviewers commonly prompt candidates to organize responses around the situation, the task or problem, the actions taken, and the result—often called the STAR framework. For a health information management position, a candidate might be asked to give an example of resolving a medical-record documentation issue, managing a difficult compliance situation, or collaborating with clinical staff to improve data quality. The candidate's specific example provides evidence of skills such as communication, judgment, ethics, problem solving, and leadership rather than relying solely on broad self-descriptions. The U.S. Office of Personnel Management describes structured behavioral interviewing as using questions that elicit examples of past job-related behavior and links responses to identified competencies. See OPM's structured interview guidance and CareerOneStop's overview of behavioral interviews.

QUESTION NO: 152

When a healthcare facility fails to investigate the qualifications of a physician hired to work as an independent contractor in the emergency room and is accused of negligence, the healthcare facility can be held liable under

A. respondent superior.

B. corporate negligence.

C. contributory negligence.

D. general negligence.

ANSWER: B

Explanation:

corporate negligence. is correct because it concerns a healthcare organization's own direct duty to patients, rather than liability based solely on an employment relationship with an individual clinician. A hospital or healthcare facility has an institutional responsibility to use reasonable care in selecting and retaining qualified practitioners, including verifying credentials, licensure, training, competence, and privileges. This duty is particularly important for emergency-department physicians, whose clinical decisions may immediately affect patient safety.

When the facility does not adequately investigate an independent contractor physician's qualifications, the alleged breach is the facility's failure to perform its own credentialing and oversight responsibilities. Corporate negligence therefore permits liability even though the physician is not a traditional employee. The theory recognizes that hospitals make critical operational decisions about which practitioners may provide care within the organization and must establish effective processes to protect patients. Credentialing and privileging are central patient-safety functions and are addressed in accreditation standards for healthcare organizations. See the Joint Commission's credentialing and privileging guidance and the NCBI StatPearls overview of medical malpractice.

QUESTION NO: 153

What criterion is critical in selecting performance indicators for a medical record department?

A. The indicators must include the most important aspects of performance.

B. Indicators must correlate with Deming's 14 points.

C. Identify at least 25 indicators that are reflective of all department functions.

D. Select only indicators that reflect positively on the department.

ANSWER: A

Explanation:

The indicators must include the most important aspects of performance. Performance indicators are decision-support tools: they should focus attention on the department's high-priority processes, objectives, risks, and outcomes. In a medical record or health information management department, this means selecting measures that meaningfully demonstrate whether essential work is being performed effectively, such as record completion timeliness, release-of-information turnaround time, data quality, coding quality, or privacy-related processes. A limited, purposeful set of indicators allows leaders to identify trends, establish improvement priorities, and assess whether operational changes produce better results.

Measure-selection guidance emphasizes that measures should be important, meaningful, and useful for accountability and improvement. The Centers for Medicare & Medicaid Services describes measure importance as a core evaluation domain, including whether a measure addresses a meaningful aspect of care or performance and has the potential to drive improvement. Similarly, the National Quality Forum's measure evaluation framework treats importance as a foundational criterion for selecting measures. Applying this principle to a medical record department ensures that measurement resources are directed toward performance areas that matter most to organizational goals, regulatory compliance, patient service, and information integrity. See the CMS Measure Evaluation guidance and the National Quality Forum Measuring Performance resources.

QUESTION NO: 154

Ralph is a 96-year-old nursing home resident who is admitted for malnutrition. Ralph has suffered a previous stroke that has left him with dysphagia. Ralph is treated for malnutritio_tij with hyperalimentation. Ralph was also found to have hypokalemia that was treated with IVY potassium replacement. On the day prior to discharge, Ralph underwent a PEG tube insertion.

263.9	Unspecified protein-calorie malnutrition
276.8	Hypokalemia/hypo potassemia
438.82	Dysphagia, late effect of cerebrovascular disease
787.20	Dysphagia, unspecified
43.11	Percutaneous endoscopic gastrostomy (PEG) insertion

A. 438.82, 263.9, 787.20, 43.11

B. 787.20, 276.8, 43.11

C. 263.9, 276.8, 438.82, 43.11

D. 263.9, 787.20, 276.8, 43.11

ANSWER: C

Explanation:

“263.9, 276.8, 438.82, 43.11” is correct under the ICD-9-CM code set reflected in this question. Malnutrition is the condition established after study as chiefly responsible for the inpatient admission and is reported with 263.9, Malnutrition of unspecified degree. Hypokalemia was clinically evaluated and treated with intravenous potassium replacement, supporting assignment of 276.8, Other specified disorders of fluid, electrolyte, and acid-base balance. The documented dysphagia is a residual deficit from a prior stroke, so 438.82, Other late effects of cerebrovascular disease; dysphagia, captures the causal relationship between the old cerebrovascular event and the current neurologic deficit. The PEG tube insertion performed before discharge is coded as 43.11, Percutaneous endoscopic gastrostomy [PEG]. In inpatient coding, conditions requiring treatment, monitoring, or care during the stay are reportable in addition to the principal diagnosis, and significant procedures performed during the admission are coded. Although ICD-9-CM has been replaced by ICD-10-CM/PCS for current U.S. reporting, the historical ICD-9-CM conventions apply to this legacy-code question. See the CMS 2014 ICD-9-CM and GEMs resources and the CDC’s ICD-9-CM information page.

QUESTION NO: 155

The most realistic approach that could encourage increased productivity in the tedious record file/ retrieval area is to

A. shorten the workday by 1 hour.

B. vary and rotate the work assigned to each file clerk.

C. have all the file clerks work on a part-time basis.

D. arrange for all the file clerks to have flex time.

ANSWER: B

Explanation:

Vary and rotate the work assigned to each file clerk is the most realistic approach because job rotation reduces the monotony and fatigue associated with repetitive filing and retrieval tasks while preserving the staffing coverage needed for daily record operations. Assigning clerks periodically to related functions—such as filing, retrieval, quality checks, loose-report processing, or responding to record-location requests—can increase engagement, broaden staff competence, and reduce the risk that performance declines because employees are doing one highly repetitive task continuously. Cross-training also strengthens operational resilience: more employees can competently cover absences, workload spikes, and backlogs without disrupting access to health records. In a health information department, this is particularly important because timely, accurate record retrieval supports continuity of care, revenue-cycle activities, regulatory compliance, and

patient safety. AHIMA's workforce-development resources emphasize building competency and supporting a skilled, adaptable health information workforce, while the U.S. Office of Personnel Management identifies job rotation as a developmental approach that expands employee skills through assignments in different functions. A planned rotation schedule should retain clear procedures and accountability for record tracking so that productivity gains do not compromise record availability or filing accuracy. See AHIMA Education and Events and U.S. Office of Personnel Management Career Development.

QUESTION NO: 156

Patient presents to the radiology department where a fine-needle aspiration of the breast is performed utilizing computer tomography.

A. 19120; 77012

B. 19102

C. 19125

D. 10022, 77012

E. 10009

ANSWER: E

Explanation:

The appropriate current CPT code is **10009**, which reports fine-needle aspiration biopsy, including computed tomography (CT) guidance, for the first lesion. The code descriptor incorporates both the aspiration-biopsy service and the CT imaging guidance; therefore, the imaging-guidance service is not separately reported for that initial lesion. The anatomic site, breast, does not change the selection of this CT-guided fine-needle aspiration code. If aspirations of additional separately identified lesions were performed using CT guidance during the same encounter, CPT code 10010 would be reported for each additional lesion, as applicable. This coding structure resulted from the revision of fine-needle aspiration biopsy codes effective in 2019. The former general fine-needle aspiration code 10022 and separately reported CT guidance code 77012 are no longer the current reporting method for this service. CMS includes 10009 in its physician fee schedule relative value files, supporting its active use in physician-service reporting. See the CPT 10009 descriptor and the CMS Physician Fee Schedule Relative Value Files.

QUESTION NO: 157

Gastric ulcer with hemorrhage resulting in acute blood-loss amnia Esophagogastroduodenoscopy performed.

A. 531.20, 285.1, 45.13

B. 285.1, 531.20, 45.13

C. 531.40, 280.0, 45.14

D. 531.40, 285.1, 45.13

ANSWER: D

Explanation:

The code set **531.40, 285.1, 45.13** accurately represents the documented diagnoses and procedure. Code 531.40 identifies a chronic or unspecified gastric ulcer with hemorrhage, without obstruction. Because the record states that a gastric ulcer bled but does not establish whether the ulcer is acute or chronic, the unspecified ulcer classification is appropriate. The hemorrhage is integral to this ulcer code and reflects the condition responsible for the acute clinical presentation.

Code 285.1 reports acute posthemorrhagic anemia, which is the appropriate diagnosis for acute blood-loss anemia resulting from the ulcer hemorrhage. It is coded in addition to the bleeding-ulcer diagnosis because the anemia is a documented, clinically significant condition caused by the blood loss. For the inpatient procedure, 45.13 reports other endoscopy of the

small intestine and includes diagnostic esophagogastroduodenoscopy when no biopsy or therapeutic intervention is documented. The procedure documentation only states that an esophagogastroduodenoscopy was performed, so the diagnostic EGD code is supported. See the ICD-9-CM entry for 531.40 and the ICD-9-CM procedure entry for 45.13.

QUESTION NO: 158

Which of the following techniques would a facility employ for access control?

1	automatic logoff
2	passwords
3	token
4	unique user identification

A. 1 and 4

B. 1 and 2 only

C. 2 and 4 only

D. all of the above

ANSWER: B

Explanation:

“1 and 2 only” is correct because access control consists of the administrative, physical, and technical mechanisms a facility uses to ensure that workforce members and other users can access only the systems, records, functions, and locations necessary for their authorized duties. In practical health information management operations, this includes establishing and managing user identities, authenticating users before access is granted, and assigning permissions according to a defined role or job function. These controls support the minimum-necessary principle by limiting health information access to an appropriate purpose and scope.

The HIPAA Security Rule requires covered entities and business associates to implement technical policies and procedures for electronic protected health information systems so that access is limited to authorized persons or software programs. A compliant access-control process also includes procedures for authorizing access, modifying permissions when responsibilities change, and terminating access promptly when a workforce member no longer requires it. NIST likewise identifies account management, least privilege, and access enforcement as core access-control practices. These safeguards protect the confidentiality and integrity of health information while allowing the organization to maintain an auditable, manageable security program. See the HHS HIPAA Security Rule and NIST SP 800-53 Access Control guidance.

QUESTION NO: 159

Patient came to the hospital from a local nursing home for a PEG tube placement via EGD.

436	Acute, but ill-defined, cerebrovascular disease
438.21	Late effect of CVA with hemiplegia affecting dominant side
438.81	Late effect of CVA with apraxia
438.82	Late effect of CVA with dysphagia
787.29	Dysphagia, neurogenic
43219	Esophagoscopy, rigid or flexible with insertion of plastic tube or stent
43246	Upper gastrointestinal endoscopy of esophagus, stomach, and either the duodenum and/or jejunum with directed placement of percutaneous gastrostomy tube
44372	Small intestine endoscopy, enteroscopy beyond second portion of duodenum with placement of percutaneous jejunostomy tube

A. 438.81, 43219

B. 438.82, 438.21, 787.29, 43246

C. 436, 787.29, 44372

D. 436, 43246

ANSWER: B

Explanation:

438.82, 438.21, 787.29, 43246 correctly captures the documented late effects of the patient's prior cerebrovascular disease and the PEG procedure performed. Code 438.82 identifies dysphagia resulting from cerebrovascular disease, while 438.21 reports the documented hemiplegia affecting the dominant side as another residual neurologic deficit. ICD-9-CM instructions for dysphagia due to cerebrovascular disease require an additional code to identify the specific dysphagia manifestation; 787.29 reports the documented "other dysphagia." These diagnoses establish the clinical reason nutritional access is needed.

Code 43246 accurately describes the procedure: esophagogastroduodenoscopy with directed placement of a percutaneous gastrostomy tube. PEG placement is not merely a diagnostic upper endoscopy; the endoscopic procedure includes placement of the gastrostomy tube, which is specifically represented by 43246. The coding reflects that the encounter is for treatment of chronic sequelae from a prior stroke, including impaired swallowing and hemiplegia, through endoscopic PEG-tube placement. CMS maintains historical ICD-9-CM code resources at CMS ICD-9 Codes Archive, and CPT code-set information is maintained by the American Medical Association.

QUESTION NO: 160

A HIM Department, currently using, 2,540 linear filing inches to store records, plans to purchase new open-shelf filing units. Each of the shelves in a new 6-shelf unit measures 36 linear filing inches. It is estimated that an additional 400 filing inches should be planned for to allow for 5-year expansion needs. How many new file shelving units should be purchased?

A. 11

B. 12

C. 13

D. 14

ANSWER: D

Explanation:

14 is correct because the department must first determine the total filing capacity required, including anticipated growth. Its current records occupy 2,540 linear filing inches, and the projected five-year expansion adds 400 linear filing inches, for a total requirement of 2,940 linear filing inches. Each six-shelf unit provides 216 linear filing inches of capacity: 6 shelves multiplied by 36 linear filing inches per shelf. Dividing 2,940 by 216 yields approximately 13.61 units. Because shelving cannot be purchased as a fraction of a unit and available capacity must meet or exceed the projected storage requirement, the result must be rounded up to the next whole unit. Purchasing 14 units provides 3,024 linear filing inches of capacity, which accommodates the current volume and the planned expansion. This type of calculation reflects core HIM storage-planning practice: quantify present volume, add forecasted growth, calculate usable capacity per storage unit, and round upward to ensure adequate space. AHIMA recognizes management of health information resources as a central HIM function; see AHIMA's RHIA certification information. For general records-storage guidance and capacity planning considerations, consult the National Archives records storage standards toolkit.

QUESTION NO: 161

Which of the following services is LEAST likely to be provided by a facility accredited by CARF?

A. chronic pain management.

B. palliative care.

C. brain injury management.

D. vocational evaluation.

ANSWER: B

Explanation:

palliative care. is the service least likely to be provided by a CARF-accredited facility. CARF, the Commission on Accreditation of Rehabilitation Facilities, is an accreditor whose core focus is person-centered rehabilitation and related community services. Its accreditation programs are structured around helping people achieve functional improvement, independence, community participation, and employment or vocational goals. CARF's Medical Rehabilitation standards and program areas encompass specialized rehabilitation populations and services, while its Employment and Community Services accreditation addresses evaluation, training, and supports related to work and community integration.

Palliative care, by contrast, is principally an interdisciplinary approach to improving quality of life and relieving symptoms, stress, and suffering associated with serious illness. It may be delivered in hospitals, outpatient settings, long-term-care settings, or alongside hospice services, but it is not a central CARF rehabilitation program category. Organizations that provide palliative care may pursue other forms of accreditation or certification depending on their setting and services. Accordingly, palliative care is the best answer when identifying the service least associated with CARF facility accreditation. CARF describes its rehabilitation-focused accreditation scope at CARF Medical Rehabilitation, and the clinical purpose of palliative care is summarized by the National Institute of Nursing Research.

QUESTION NO: 162

Melissa is an RHIA who has just been hired as systems analysts in Information Technology. At Orientation she receives her Employee Handbook. All of the following information about the Employee Handbook is true, EXCEPT:

A. it provides a contractual obligation to continued employment.

B. it provides policies and procedures developed by management.

C. a receipt must be documented in writing.

D. it must be reviewed periodically by legal counsel to avoid legal risk.

ANSWER: A

Explanation:

The statement “it provides a contractual obligation to continued employment” is the exception because an employee handbook should not create an implied employment contract or promise continued employment. In most U.S. workplaces, employment is presumed to be at will unless a specific contract, collective-bargaining agreement, statute, or other enforceable arrangement provides otherwise. A handbook is generally intended to communicate the organization’s workplace rules, benefits, standards of conduct, and administrative expectations; it is not ordinarily an assurance that employment will continue for a defined period or that termination can occur only for specified reasons.

Human resources and legal teams commonly include clear disclaimer language stating that the handbook is not a contract and does not alter the at-will employment relationship, where applicable. The organization should ensure that this disclaimer is consistent with its actual employment practices and any applicable state law, union agreement, or individual employment agreement. For an RHIA working in information technology, understanding this distinction is important because policy documents govern workplace expectations but do not independently guarantee job security. Cornell Law School’s Legal Information Institute summarizes the employment-at-will doctrine at Employment at Will.

QUESTION NO: 163

Jane Doe is 6 weeks post mastectomy for carcinoma of the breast. She is admitted for chemotherapy. What is the correct sequencing of the codes?

A. V58.11 (chemotherapy), 174.9 (malignant neoplasm of the breast), V45.71 (acquired absence of breast)

B. V58.11 (chemotherapy), V10.3 (personal history of malignant neoplasm of breast), V45.71 (acquired absence of breast)

C. V67.00 (follow-up exam after surgery), V58.11 (chemotherapy)

D. V10.3 (personal history of malignant neoplasm of breast)

ANSWER: A

Explanation:

V58.11 (chemotherapy), 174.9 (malignant neoplasm of the breast), V45.71 (acquired absence of breast) is the correct sequence under the ICD-9-CM code set used in this question. When a patient is admitted specifically to receive chemotherapy, the encounter-for-chemotherapy code is sequenced first. The breast malignancy remains an active cancer because the patient is receiving chemotherapy directed at that disease; surgical removal of the breast does not by itself establish a personal history of cancer while active treatment continues. The malignant-neoplasm code therefore follows the chemotherapy encounter code. V45.71 is additionally reported to identify the patient’s acquired absence of the breast following mastectomy, a status that may be clinically relevant to the current care. This sequencing principle is retained in current ICD-10-CM guidance, where an encounter for chemotherapy is first-listed and the malignancy being treated is coded as an additional diagnosis. See the official CMS ICD-10-CM Official Guidelines for Coding and Reporting, particularly the neoplasm guideline for encounters for chemotherapy, and the CDC’s ICD-9-CM archive information for the historical classification context.

QUESTION NO: 164

Patient presents with complaint of gross hematuria. Diagnosis of benign prostatic hypertrophy is made and patient undergoes transurethral prostatectomy.

A. 600.01, 60.21

B. 600.00, 60.29

C. 600.00, 599.71, 60.29

D. 600.00, 599.71, 60.21

ANSWER: C

Explanation:

The correct code assignment is **600.00, 599.71, 60.29**. In the ICD-9-CM diagnosis classification, benign prostatic hypertrophy documented without stated urinary obstruction is reported with code 600.00. The presentation of gross hematuria is also reportable as 599.71 because the record documents it as a distinct presenting complaint and does not establish that it is an inherent or integral manifestation of the diagnosed prostatic hypertrophy. For the inpatient procedure, a transurethral prostatectomy that is not specifically documented as an ultrasound-guided laser procedure is classified to 60.29, Other transurethral prostatectomy. This category includes the conventional transurethral resection/prostatectomy approach when no more specific technique is documented. Accurate assignment depends on coding the documented diagnosis, retaining clinically significant separately documented symptoms when appropriate under the applicable coding conventions, and selecting the procedure code that reflects the documented surgical approach. The ICD-9-CM system was maintained for historical U.S. diagnosis and inpatient procedure reporting; its official background and archived materials are available from the CDC's ICD-9-CM resource page and CMS's ICD-9 archived codes page.

QUESTION NO: 165

You are developing an entity-relationship diagram. The entity that you are currently working is "patient". Which of the following would be the primary key for the entity patient?

A. last name

B. address

C. attending physician number

D. health record number

ANSWER: D

Explanation:

The health record number is the appropriate primary key for the patient entity because a primary key is an attribute that uniquely identifies each occurrence of an entity. In a healthcare database, the health record number, often also called the medical record number, is assigned to distinguish one patient record from every other patient record within the organization. It provides a stable identifier that can be used to link the patient entity accurately to related data, such as encounters, diagnoses, procedures, providers, and billing records. A well-designed primary key must be unique, consistently available, and minimally subject to change. The health record number fulfills these requirements when it is governed by the organization's patient-identification and master patient index processes. Using this identifier supports data integrity by ensuring that each relationship involving a patient points to the intended patient record. In entity-relationship modeling, the primary key is conventionally designated as the attribute that establishes entity identity and supports relationships to other entities through foreign keys. For additional database-design guidance, see IBM documentation on primary keys and CMS information on electronic health records.

QUESTION NO: 166

The administrator has asked us to develop a patient satisfaction database internally. This data will be used to collect data that can be used to improve our services. He does not want this to long, drawn-out process. Which of the following could speed up this process?

A. RFI

B. RFP

C. prototyping

D. functional requirements

ANSWER: C

Explanation:

Prototyping is correct because it accelerates development by creating an early, working model of the patient-satisfaction database for users and stakeholders to review. Rather than attempting to define every screen, field, workflow, report, and validation rule in advance, the development team can quickly demonstrate a preliminary version and obtain focused feedback from the administrator and eventual users. This iterative approach helps clarify requirements as users see how data collection and reporting would work in practice. It also identifies needed changes early, when they are generally less disruptive and less costly to make.

For an internally developed database intended to support service improvement, a prototype can validate such practical needs as the survey elements to collect, allowable response values, data-entry workflow, required reports, and how results will be summarized for quality-improvement efforts. User feedback from each prototype iteration guides refinement until the design meets operational needs. The Project Management Institute describes iterative and incremental approaches as delivering work in repeated cycles to enable learning and adaptation; this is the core value of prototyping in requirements development. See the Project Management Institute discussion of agile and iterative practices and the NIST software development guidance.

QUESTION NO: 167

An oral consent is binding if it

A. can be proven or corroborated.

B. has the signature of the patient.

C. does not cause confusion.

D. Occurs only at the time of admission

ANSWER: A

Explanation:

An oral consent is binding if it *can be proven or corroborated*. Consent is a communication in which a capable patient voluntarily authorizes proposed care after receiving the information needed to make an informed decision. Although written documentation is generally the preferred evidence for procedures requiring informed consent, the legal effectiveness of consent does not inherently depend on a patient signature. An oral agreement can establish valid consent when reliable evidence demonstrates that the patient received an appropriate explanation, had the opportunity to ask questions, understood the decision, and voluntarily agreed.

Corroboration is essential because it supplies evidence of the oral exchange if the consent is later questioned. In practice, the clinician should document the discussion promptly in the health record, including the nature of the proposed treatment, material risks and benefits, alternatives, the patient's questions, and the patient's verbal authorization. A witness or contemporaneous record entry can further substantiate the event. Health information leaders should ensure that organizational policies specify when verbal consent is permitted and how it must be documented, while recognizing that state law and procedure-specific requirements may require a written form. See the American Medical Association's guidance on informed consent and HHS information regarding consent documentation.

QUESTION NO: 168

A data item to include on a qualitative review checklist of infant and children inpatient health records which need not be included on adult records would be

A. chief complaint.

B. condition on discharge.

C. time and means of arrival.

D. growth and development record.

ANSWER: D

Explanation:

“Growth and development record.” is the correct item because pediatric inpatient documentation must support assessment of the child’s developmental status and age-specific needs. Infants and children are continually progressing through physical, cognitive, emotional, and social developmental stages; therefore, their health record should include relevant growth measurements and developmental observations or history. These data help clinicians evaluate whether illness, injury, nutrition, treatment, or hospitalization is affecting expected development and help ensure that the care plan is appropriate to the patient’s developmental level. A qualitative review checklist for pediatric records should consequently verify that this information is documented when applicable. Growth data commonly include measures such as length or height, weight, and head circumference for younger children, interpreted against standardized pediatric growth references. Developmental information may address age-appropriate milestones, functional abilities, and developmental needs that affect communication, education, safety, and discharge planning. Federal pediatric preventive-care guidance recognizes developmental surveillance and screening as important components of child health care, and the Centers for Disease Control and Prevention provides the growth-chart standards used to monitor growth in children. These pediatric-specific requirements make a growth and development record an appropriate checklist element beyond the documentation routinely expected in adult inpatient records. See the CDC Clinical Growth Charts and the American Academy of Pediatrics guidance on developmental surveillance and screening.

QUESTION NO: 169

A bee stung little Bobby. He experiences itching, erythema, and respiratory distress caused by laryngeal edema and vascular collapse. In the emergency department, Bobby is diagnosed with

A. allergic rhinitis.

B. allergic sinusitis.

C. anaphylactic shock.

D. asthma.

ANSWER: C

Explanation:

Anaphylactic shock is the correct diagnosis because Bobby has a rapid, systemic, life-threatening allergic reaction after a bee sting. The combination of cutaneous findings (itching and erythema), upper-airway involvement (laryngeal edema causing respiratory distress), and circulatory compromise (vascular collapse) is characteristic of anaphylaxis with shock. Hymenoptera venom, including bee venom, is a recognized trigger of anaphylaxis. In this condition, mast-cell and basophil mediators cause vasodilation and increased vascular permeability, which can lead to hypotension and shock, while edema in the larynx can quickly compromise the airway. Clinical diagnostic criteria support anaphylaxis when an acute illness after exposure to a likely allergen includes skin or mucosal symptoms together with respiratory compromise or reduced blood pressure/end-organ hypoperfusion. Immediate recognition is essential because intramuscular epinephrine is the first-line treatment, with prompt airway and circulatory support as needed. The National Institute of Allergy and Infectious Diseases describes anaphylaxis as a serious allergic reaction that can include breathing difficulty and a sudden drop in blood pressure, and the World Allergy Organization identifies insect stings among common triggers. See NIAID: Anaphylaxis and World Allergy Organization: Anaphylaxis.

QUESTION NO: 170

Patient in late stages of labor arrives at the hospital. Her OB physician is not able to make the delivery and the house physician delivers the baby vaginally. Primary care physician resumes care after delivery. Code the delivery.

A. 59409

B. 59612

C. 59620

D. 59400

ANSWER: A

Explanation:

59409 is correct because it represents a vaginal delivery-only service. In this scenario, the house physician performs the actual vaginal delivery after the patient arrives in advanced labor, while the patient's primary obstetric physician resumes care after delivery. The delivering physician therefore reports only the discrete delivery service that physician personally furnished rather than a combined obstetric package. CPT maternity-care coding distinguishes delivery-only services from global obstetric services, which bundle specified antepartum, delivery, and postpartum care when those components are provided by the same reporting physician or qualified health care professional. Accurate reporting must reflect the division of services among clinicians and avoid assigning bundled care to a physician who did not provide the associated prenatal and postpartum components. The operative record and delivery documentation should support that the house physician performed the vaginal delivery and identify the delivering clinician. This approach follows the CPT descriptor for 59409 and the general principle that claims are based on the services actually rendered and documented. CMS makes physician-service code information available through its Physician Fee Schedule, and the American College of Obstetricians and Gynecologists provides maternity coding resources at ACOG Coding.

QUESTION NO: 171

Radiologist provides fluoroscopic guidance for facet joint injection.

A. 71023

B. 77002

C. 76001

D. 77003

ANSWER: D

Explanation:

77003 is the correct code in the coding context reflected by this question because it specifically described fluoroscopic guidance for needle placement in spinal injection procedures. Facet joint injections are spinal procedures, and fluoroscopy is used to confirm the needle's location at the intended facet joint before medication is delivered. Accurate image-guided placement supports both the clinical safety and the documentation of the service. The code descriptor for 77003 encompassed fluoroscopic guidance and localization of a needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures, which includes facet-joint injection work. This question uses a legacy CPT coding framework: CPT 77003 was deleted effective January 1, 2017, when imaging guidance became incorporated into the facet-joint injection procedure code family. Therefore, for a historical examination item presenting these code choices, 77003 is the intended and accurate selection. Current coding should always be verified against the CPT edition and payer policy applicable to the date of service. CMS's historical physician fee schedule materials list 77003 among fluoroscopic-guidance services, and the CMS code file documentation supports use of the applicable year's code set for reporting services: CMS Physician Fee Schedule Relative Value Files and CMS HCPCS Coding.

QUESTION NO: 172

Codes act as a primary means of communication with third-party payers. You look forward to the day that you will use

A. ICD-9-CM procedure codes for inpatients and HCPCS or CPT procedure codes for outpatients.

B. ICD-9-CM procedure codes for outpatients and HCPCS or CPT procedure codes for inpatients.

C. ICD-9-CM procedure codes for all patients, regardless of setting.

D. one universal procedure coding system for all patients, regardless of setting.

ANSWER: D

Explanation:

One universal procedure coding system for all patients, regardless of setting, is correct because it expresses the desirable goal of a single, consistent method for reporting procedures to payers across the continuum of care. A universal system would reduce the operational complexity created when procedure reporting requirements vary by site of service, support more uniform data collection, and make comparisons of utilization, outcomes, and costs more reliable across inpatient and outpatient settings. It would also simplify training, coding workflows, payer edits, and exchange of procedure information among providers, health plans, and government programs. In actual U.S. practice, procedure coding remains setting-dependent: hospital inpatient procedures are reported with ICD-10-PCS, while physician and many outpatient services use CPT and HCPCS Level II codes. Thus, the wording “look forward to the day” signals an aspirational future state rather than a description of the current coding environment. CMS describes ICD-10-PCS as the procedure classification used for inpatient hospital reporting and identifies CPT/HCPCS as the applicable code sets for other covered services. See CMS ICD-10 Codes and CMS HCPCS.

QUESTION NO: 173

Delirium tremens with alcohol dependence

A. 291.0, 303.90

B. 303.91, 291.0

C. 291.3, 303.90

D. 291.0, 303.00

ANSWER: A

Explanation:

The correct code pair is **291.0, 303.90**. In ICD-9-CM, delirium tremens is indexed as alcohol withdrawal delirium and is assigned code 291.0. This code captures the acute alcohol-induced delirious state associated with withdrawal. Because the diagnostic statement also documents alcohol dependence, a second code is needed to identify the underlying dependence. Code 303.90 represents alcohol dependence when no additional specification, such as continuous or episodic pattern, is documented. The combination therefore fully represents both the withdrawal manifestation—delirium tremens—and the documented alcohol-dependence condition. Accurate assignment of both codes is important because the manifestation code alone does not communicate the patient’s alcohol-dependence diagnosis, while the dependence code alone does not describe the acute delirium tremens. This coding approach follows the ICD-9-CM convention of assigning codes for documented alcohol-induced conditions and the associated dependence when both are present. The ICD-9-CM code set and related historical coding materials are available through the CDC ICD-9-CM resources and CMS’s ICD-9-CM archive.

QUESTION NO: 174

The teaching method selected by an instructor influences the student's ability to understand the material. Instructor-led classrooms work best when

A. in-depth training and interaction are desired.

B. there are three shifts of employees to train.

C. you want to minimize the cost for training.

D. employees from all departments must be trained.

ANSWER: A

Explanation:

Instructor-led classrooms work best when *in-depth training and interaction are desired.* This format places an instructor and learners together in real time, allowing the instructor to explain complex concepts, demonstrate processes, guide discussion,

and adjust the pace or examples in response to learner questions. It also supports immediate clarification and feedback, which are particularly valuable when learners must apply new knowledge, practice a skill, or resolve misunderstandings before progressing. Interaction among participants can further deepen learning through discussion, shared workplace examples, and collaborative exercises.

For health information management education, instructor-led training can be especially useful for content that requires interpretation, judgment, or guided application, such as privacy practices, coding conventions, documentation requirements, and workflow changes. The instructor can assess comprehension during the session and reinforce key points as needed. This aligns with adult-learning practice that emphasizes active participation, relevance, and feedback rather than passive receipt of information. The Association for Talent Development discusses instructor-led training as a live learning approach that enables facilitated engagement and learner interaction: ATD: Instructor-Led Training—The Basics. Guidance on effective learning design and active learning methods is also available from CDC Training and Development.

QUESTION NO: 175

Preterm infant born via Cesarean section admitted to Children's Hospital for severe birth asphyxia

A. V30.01, 765.10, 768.5

B. 765.10, 768.5, V30.01

C. 768.5, 765.10

D. 768.5

ANSWER: A

Explanation:

V30.01, 765.10, 768.5 is correct because this is a newborn birth admission and the single liveborn code is sequenced first. V30.01 identifies a single liveborn infant born in the hospital and delivered by cesarean section. ICD-9-CM newborn coding guidance directs assignment of a code from the V30–V39 series as the principal diagnosis on the birth record, with additional codes reported for conditions affecting the newborn.

Code 765.10 reports the documented prematurity when no birth-weight detail is provided. Code 768.5 captures severe birth asphyxia, the acute condition stated in the clinical scenario. These additional diagnoses are sequenced after the liveborn birth-status/delivery code because they describe conditions present in, or affecting, the newborn rather than replacing the required principal liveborn code for the birth episode.

The sequencing reflects the ICD-9-CM convention applicable to newborn records: first identify the liveborn infant and delivery circumstances, then report significant neonatal conditions requiring evaluation, monitoring, or treatment. The historical ICD-9-CM tabular materials and coding guidance are available through the CDC's ICD-9-CM resources and CMS's ICD-9-CM documentation archive.

QUESTION NO: 176

A surgeon left a clamp in a patient, resulting in a return to the operating room. In an integrated organizational quality management model, all of the following entities would receive data about the investigation EXCEPT the

A. Tissue Committee.

B. Credentials Committee.

C. Risk Management Program.

D. Pharmacy and Therapeutics Committee.

ANSWER: D

Explanation:

Pharmacy and Therapeutics Committee is the correct exception because its quality-management responsibility is focused on the safe, effective, and cost-conscious use of medications. Its work commonly includes medication formulary oversight, medication-use evaluation, adverse drug event review, and development of medication-related policies. A retained surgical clamp is a surgical patient-safety event rather than a medication-use event, so investigation data would not ordinarily be routed to this committee under an integrated quality-management structure.

The event is appropriately treated as a serious safety occurrence requiring systematic investigation, analysis of contributing processes, and organizational follow-up to prevent recurrence. The Joint Commission identifies unintended retention of a foreign object after surgery as a sentinel event category, reinforcing the need for a thorough response and performance-improvement action. Information should be shared with the organizational functions that have responsibility for patient safety, professional performance, risk exposure, and surgical-care oversight; pharmacy governance does not have a direct operational role in investigating a retained surgical item. See the Joint Commission's Sentinel Event resources and CMS's Quality Assurance and Performance Improvement overview.

QUESTION NO: 177

In the ICD-9-CM classification system, severe shock due to third-degree burns sustained in an industrial accident would be coded as a(n)

A. current injury.

B. late effect.

C. mechanical complication of an internal prosthetic device.

D. abnormal reaction of the body to the presence of an internal prosthetic device.

ANSWER: A

Explanation:

current injury. is correct because the third-degree burns and the severe shock are acute conditions receiving care as a direct result of the industrial accident. In ICD-9-CM, acute injuries are classified in the Injury and Poisoning chapter, which includes burns (category 940–949) and traumatic shock (category 958). The burn code is selected based on the anatomic site, degree, and extent of the burn, while traumatic shock associated with the injury may also be coded when documented. The industrial setting and mechanism of the event are captured separately with the applicable external-cause-of-injury code; those supplemental codes provide context but do not change the acute injury's classification as a current injury. Coding the encounter as a current injury accurately reflects that the patient has an active condition caused by a recent event, rather than a residual condition after the acute phase has ended. ICD-9-CM guidance and code materials remain available from CMS for historical coding reference, including the injury chapter and its instructional notes. See the CMS ICD-9-CM resources and the CDC/NCHS ICD-9-CM reference page.

QUESTION NO: 178

The quality improvement team for the HIM department meets to generate ideas to address physician complaints about missing dictation reports. What QI tool would prove useful in discussing various recommendations for solving this problem?

A. flowchart

B. scatter diagram

C. check sheet

D. brainstorming

ANSWER: D

Explanation:

Brainstorming is the appropriate quality-improvement tool because the team is at the idea-generation stage and needs to discuss possible recommendations for resolving missing dictation reports. In a brainstorming session, participants contribute as many potential causes, process changes, and solutions as possible before the group evaluates or prioritizes them. This approach encourages participation from team members with differing knowledge of the transcription, documentation-completion, physician-notification, and record-deficiency workflows. It can produce practical recommendations such as improving deficiency notifications, clarifying escalation steps, revising turnaround expectations, or changing how incomplete reports are tracked.

For an HIM quality-improvement team, brainstorming supports collaborative problem solving by separating creative generation of alternatives from later decision-making activities, such as selecting interventions, assigning responsibility, and measuring results. The Institute for Healthcare Improvement describes brainstorming as a way for groups to rapidly generate ideas and notes that judgment should be deferred while ideas are being collected. This makes it especially useful when a team has identified a problem but has not yet selected a solution. See the Institute for Healthcare Improvement's Brainstorming tool and ASQ's overview of brainstorming in quality improvement.

QUESTION NO: 179

Sybil has been admitted to Shady Acres Psychiatric facility for treatment of schizophrenia. Sybil is also manic depressive and has been noncompliant with her medications.

295.40	Schizophreni form disorder, unspecified
295.41	Schizophreniform disorder, subchronic
295.90	Unspecified schizophrenia
296.7	Bipolar I, disorder most recent episode (or current) unspecified
296.80	Bipolar disorder, unspecified
296.89	Other and unspecified bipolar disorders (manic-depressive psychosis, mixed type)
V15.81	Personal history of noncompliance with medical treatment

A. V15.81, 296.89, 295.40

B. 296.89, 295.41, V15.81

C. 296.7, 295.90

D. 295.90, 296.80, V15.81

ANSWER: D

Explanation:

The correct code set is **295.90, 296.80, V15.81**. In the ICD-9-CM classification used by this question, 295.90 represents schizophrenia when a specific schizophrenic type is not documented. The clinical statement identifies schizophrenia as the condition for which Sybil is admitted and treated, supporting its placement as the principal diagnosis. Code 296.80 represents unspecified bipolar disorder, a classification that includes the historical documentation term "manic depressive" when the record does not provide details needed to assign a more specific bipolar episode or subtype. The additional documented medication noncompliance is captured with V15.81, personal history of noncompliance with medical treatment. Reporting this status code communicates a clinically relevant factor affecting the patient's treatment plan and psychiatric care. These codes reflect the documentation as stated, without inferring a more specific schizophrenia subtype or bipolar episode. ICD-9-CM was replaced for U.S. HIPAA-covered reporting on October 1, 2015, but its code set remains applicable to historical coding questions such as this one. See CMS's ICD-9-CM code files and CMS's ICD-10 transition information.

QUESTION NO: 180

You have had a problem with duplicate medical record numbers in your facility's MPI. Now you are joining a health information exchange, so you will need to clean up your database and prevent the duplicates from happening again. If you want to find near matches as well as identical matches in your MPI, you should implement a _____ algorithm.

A. probabilistic

B. deterministic

C. fuzzy

D. none of the above

ANSWER: A

Explanation:

Probabilistic is correct because probabilistic patient-matching algorithms are designed to identify both exact and likely matches among records that may contain demographic variation, missing data, typographical errors, changed names, or inconsistent formatting. Rather than requiring every selected identifier to match exactly, the algorithm compares multiple attributes—such as name, date of birth, address, telephone number, and sex—and assigns weights based on how strongly agreements or disagreements support the likelihood that two records belong to the same person. The combined score can then be used to automatically link high-confidence matches, reject clear nonmatches, and route uncertain cases for human review. This approach is particularly appropriate when remediating duplicate records in a master patient index and exchanging information across organizations, where source-system data quality and formatting commonly differ. Effective governance should accompany the algorithm, including standardized registration practices, data-quality monitoring, thresholds appropriate to organizational risk, and a process for resolving records in the review range. The Office of the National Coordinator for Health Information Technology identifies patient matching as a central interoperability capability and describes the importance of accurate demographic data and matching practices for exchange. See ONC Patient Matching and ONC Advancing Patient Matching.

QUESTION NO: 181

Now that the EHR has been fully implemented, you are ready to move old records to base storage. You are ordering shelving for those old paper files. You have 18,000 records, they average three per filing inch. The shelf units you have selected have six shelves that will hold 34 in per shelf. You will have to plan for a 20% expansion rate to accommodate miscellaneous pa records over the next 10 years. How many shelving units should you order?

A. 30

B. 31

C. 35

D. 36

ANSWER: D

Explanation:

36 is correct because the storage calculation must include both the current filing volume and the planned expansion capacity, then round up to a whole shelving unit. First, convert the record count to filing inches: 18,000 records divided by an average of three records per filing inch equals 6,000 filing inches. Applying the required 20% expansion allowance produces 7,200 filing inches of needed capacity (6,000 × 1.20). Each selected shelving unit provides 204 filing inches because it has six shelves with 34 inches of usable filing length per shelf (6 × 34). Dividing 7,200 required filing inches by 204 filing inches per unit equals approximately 35.29 units. Since shelving cannot be ordered in a fraction and capacity must meet the full projected need, the result is rounded up to 36 units. This approach reflects sound health information management practice: records retained in paper form must remain accessible, protected, and stored with sufficient capacity for anticipated growth. AHIMA's professional resources address health information governance and stewardship principles at AHIMA, while the National Archives provides records-management guidance, including storage considerations, at National Archives Records Management.

QUESTION NO: 182

Kimberly Wolf wants a Mercedes and the position of Vice President of Information Services. feels that achieving these goals will provide her with a sense of achievement, prestige, reputation in the eyes of others. What level of Maslow's hierarchy of needs is she operating at?

A. esteem

B. safety

C. self-actualization

D. basic physiological

ANSWER: A

Explanation:

esteem is correct because the stated motivations are achievement, prestige, and reputation in the eyes of other people. In Maslow's hierarchy, esteem needs involve feeling capable and accomplished, gaining recognition, earning respect, and having status. A high-ranking leadership position can represent professional achievement and recognition, while an expensive luxury vehicle may be valued as a visible symbol of status and prestige. These goals therefore reflect a desire for both self-respect and respect from others, which are central components of esteem needs.

Maslow described esteem as including desires for achievement, competence, confidence, recognition, appreciation, and reputation. In a workplace context, employees motivated predominantly by esteem may seek promotions, titles, visible accomplishments, awards, authority, or other indications that their contributions are valued. The scenario specifically emphasizes how the accomplishments would make Kimberly feel and how they would affect others' perceptions of her, directly aligning with esteem motivation. For an overview of the hierarchy and its application to motivation, see Simply Psychology's Maslow hierarchy overview and OpenStax Organizational Behavior: Motivation.

QUESTION NO: 183

Using the SOAP style of documenting progress notes, choose the "subjective" statement from the following.

A. sciatica unimproved with hot pack therapy

B. patient moving about very cautiously, appears to be in pain

C. adjust pain medication; begin physical therapy tomorrow

D. patient states low back pain is as severe as it was on admission

ANSWER: D

Explanation:

"patient states low back pain is as severe as it was on admission" is the subjective statement because it documents the patient's own report of symptoms and perceived pain severity. In the SOAP format, Subjective information consists of history and symptoms described by the patient or, when necessary, by a caregiver or other historian. Pain intensity is inherently a personal experience; even when it is recorded in the health record, the clinician should clearly attribute it to the patient when it is based on the patient's statement. The wording "patient states" appropriately preserves that attribution and identifies the information as reported rather than directly observed or measured by the clinician.

A complete subjective entry supports continuity of care by showing the patient's perspective on whether symptoms have changed since admission. Here, the comparison with pain at admission provides clinically useful context for evaluating the course of the condition and later assessing the response to treatment. SOAP documentation organizes a progress note into subjective findings, objective findings, assessment, and plan, allowing each source and type of clinical information to be distinguished clearly. See the NCBI Bookshelf overview of the SOAP note and the American Academy of Family Physicians guidance on SOAP documentation.

QUESTION NO: 184

You are a researcher at the local university hospital. You will need to access patient information without patient authorization to conduct your research. Which of the following statements is true?

A. You cannot gain any information without patient consent.

B. You can obtain the information if the institutional review board waives the requirement for patient authorization.

C. You can access anything that you need as long as you sign a statement saying that you will only use it for the purpose described on the form.

D. You can access the information if you call the patients personally and get their written permission.

ANSWER: B

Explanation:

You can obtain the information if the institutional review board waives the requirement for patient authorization. Under the HIPAA Privacy Rule, a covered entity may use or disclose protected health information for research without an individual's signed authorization when an Institutional Review Board (IRB), or a Privacy Board, documents its approval of a waiver or alteration of authorization. The board must determine that the research presents no more than minimal risk to privacy, that the privacy risks are reasonable in relation to anticipated benefits and the importance of the knowledge expected from the research, and that there is an adequate plan to protect identifiers from improper use and disclosure. It must also determine that the research could not practicably be conducted without both the waiver and access to the protected health information. The researcher's request and the waiver documentation must identify the PHI needed and describe the approved research use. This process permits appropriately reviewed research while preserving HIPAA's protections for patients' identifiable health information. The governing HIPAA provision is 45 CFR §164.512(i), available through the Electronic Code of Federal Regulations. HHS also summarizes research-related Privacy Rule requirements in its HIPAA Research guidance.