Chapter 02: The Health Record as the Foundation of Coding
Lovaasen: ICD-10-CM/PCS Coding: Theory and Practice, 2017 Edition

MULTIPLE CHOICE

1. Which is an area of the record where the attending physicians, as well as physician consultants, give their directives to the house staff, nursing, and ancillary services?
   a. Nursing notes
   b. Anesthesia forms
   c. Physician orders
   d. Progress notes

   ANS: C DIF: D REF: p.16 OBJ: 1
   TOP: Sections of the Health Record

2. What does EKG stand for?
   a. Electrocardiogram
   b. Electroencephalogram
   c. Electrokariesogram
   d. Electromagnetic

   ANS: A DIF: E REF: p.36 OBJ: 1
   TOP: Abbreviations

3. Sometimes ____ will be used to help diagnose a patient's condition.
   a. X-rays
   b. history and physical
   c. documentation
   d. a discharge disposition

   ANS: A DIF: M REF: p.36 OBJ: 6
   TOP: Guidelines for Diagnosis

4. Which of these is NOT considered a physician?
   a. Internist
   b. Hospitalist
   c. Resident
   d. Medical student

   ANS: D DIF: E REF: p.39 OBJ: 6
   TOP: Coding from Documentation Found in the Health Record

5. If the condition of a patient is being clinically evaluated, the coder would expect to see ____.
   a. an admission date
   b. letters
   c. clinical observations
   d. an operative report

   ANS: C DIF: D REF: p.36 OBJ: 4
   TOP: Guidelines for Diagnosis

6. In some cases a patient is ready to be discharged from the hospital, but at the last minute the patient develops a condition that requires him or her to stay an additional night. An example of when a patient might have to stay an additional night is when the patient ____.
   a. is feeling better
   b. has no pain
   c. has no additional cough
   d. develops a fever

   ANS: D DIF: E REF: p.36 OBJ: 4
   TOP: Guidelines for Diagnosis

7. The AHIMA practice brief says that a physician query should____.
   a. "lead" the physician
   b. contain precise language
   c. be written on scratch paper
   d. sound presumptive

   ANS: B DIF: M REF: p.40 OBJ: 7
   TOP: Coding from Documentation Found in the Health Record

8. Chronic conditions include all of the following EXCEPT ____.
   a. hypertension
   b. congestive heart failure
   c. diverticulitis
   d. emphysema
   e. all of the above are correct

   ANS: C DIF: M REF: p.37 OBJ: 4
   TOP: Reasons for Assigning Other Diagnoses

9. A query should contain all of the following items EXCEPT ____.
   a. date of service
   b. amount of increased reimbursement due to query
   c. patient name
   d. area for provider signature

   ANS: B DIF: M REF: p.42 OBJ: 7
   TOP: Explain the Physician Query Process

TRUE/FALSE

1. It is the responsibility of a coder to extract from the health record the diagnoses and procedures for which a patient is being treated.

   ANS: T DIF: M REF: p.34 OBJ: 5
   TOP: Standards for Diagnosis and Procedures

2. Abnormal findings (laboratory, X-ray, pathologic, and other diagnostic results) are always coded and reported when they are found.

   ANS: F DIF: M REF: p.38 OBJ: 5
   TOP: Guidelines for Diagnosis

3. Every facility should have the same policies and procedures with regard to the query process.

   ANS: F DIF: M REF: p.40 OBJ: 7
   TOP: Physician Queries in the Coding Process

4. One of the most important aspects of developing an effective query form is the manner in which the form is worded.

   ANS: T DIF: E REF: p.41 OBJ: 7
   TOP: Physician Queries in the Coding Process

5. Principal diagnosis is one of the most important concepts for coders to understand and apply.

   ANS: T DIF: D REF: p.34 OBJ: 2
   TOP: UHDDS Reporting Standards for Diagnosis and Procedures

COMPLETION

1. The patient history and physical need to be performed and documented within _____ hours of admission for an inpatient encounter.

   ANS: 24

   DIF: E REF: p.16 OBJ: 1 TOP: Reports in Health Records

2. A _____ is usually written by the attending physician on a daily basis to describe how the patient is progressing and the plan of care.

   ANS: progress note

   DIF: M REF: p.16 OBJ: 1 TOP: Reports in Health Records

3. The reason, in the patient's own words, for presenting to the hospital is the _____.

   ANS: chief complaint

   DIF: M REF: p.12 OBJ: 1 TOP: Documentation

MATCHING

Match each item to one of the following definitions.

a. Accredits and certifies healthcare organizations
b. The problem in the patient's own words
c. The approach the practitioner is taking to solve the patient's problem
d. The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care
e. Codes reported on health insurance claim forms that should be supported by

documentation in the medical record

f. Person qualified by education and legally authorized to practice medicine
g. Requested by the attending physician to gain an expert opinion on the treatment of a particular aspect of the patient's condition that is outside the expertise of the attending physician
h. People who treat patients
i. The physician identifies the history, physical examination, and diagnostic tests
j. Where the subjective and objective combine for conclusion
k. Words of the patient; the reason the patient has presented to a healthcare facility for treatment

1. Chief complaint
2. Physician
3. Healthcare providers
4. Current Procedural Terminology (CPT) and International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
5. The Joint Commission
6. Subjective
7. Objective
8. Assessment
9. Plan
10. Consultations
11. Principal diagnosis

1. ANS: K DIF: M REF: p.12 OBJ: 1|2|4
   TOP: Health Record|UHDDS Reporting Standards for Diagnosis and Procedures
2. ANS: F DIF: M REF: p.39 OBJ: 1|2|4
   TOP: Health Record|UHDDS Reporting Standards for Diagnosis and Procedures
3. ANS: H DIF: M REF: p.11 OBJ: 1|2|4
   TOP: Health Record|UHDDS Reporting Standards for Diagnosis and Procedures
4. ANS: E DIF: M REF: p.12 OBJ: 1|2|4
   TOP: Health Record|UHDDS Reporting Standards for Diagnosis and Procedures
5. ANS: A DIF: M REF: p.12 OBJ: 1|2|4
   TOP: Health Record|UHDDS Reporting Standards for Diagnosis and Procedures
6. ANS: B DIF: M REF: p.16 OBJ: 1|2|4
   TOP: Health Record|UHDDS Reporting Standards for Diagnosis and Procedures
7. ANS: I DIF: M REF: p.16 OBJ: 1|2|4
   TOP: Health Record|UHDDS Reporting Standards for Diagnosis and Procedures
8. ANS: J DIF: M REF: p.16 OBJ: 1|2|4
   TOP: Health Record|UHDDS Reporting Standards for Diagnosis and Procedures
9. ANS: C DIF: M REF: p.16 OBJ: 1|2|4
   TOP: Health Record|UHDDS Reporting Standards for Diagnosis and Procedures
10. ANS: G DIF: M REF: p.22 OBJ: 1|2|4
    TOP: Health Record|UHDDS Reporting Standards for Diagnosis and Procedures
11. ANS: D DIF: M REF: p.34 OBJ: 1|2|4
    TOP: Health Record|UHDDS Reporting Standards for Diagnosis and Procedures

Match the following terms with their abbreviations/acronyms:

a. Centers for Medicare and Medicaid Services

b. Temperature, pulse, and respiration
c. Uniform Hospital Discharge Data Set
d. Gastroesophageal reflux disease

12. CMS
13. GERD
14. TPR
15. UHDDS

12. ANS: A DIF: E REF: p.11 OBJ: 5
TOP: Abbreviations
13. ANS: D DIF: E REF: p.10 OBJ: 5
TOP: Abbreviations
14. ANS: B DIF: E REF: p.16 OBJ: 5
TOP: Abbreviations
15. ANS: C DIF: E REF: p.34 OBJ: 5
TOP: Abbreviations

SHORT ANSWER

1. What does AHQA stand for?

   ANS:
   American Health Quality Association

   DIF: E REF: p.10 OBJ: 7 TOP: Abbreviations

2. What year did the Uniform Hospital Discharge Data Set (UHDDS) mandate that hospitals must report a common core of data?

   ANS:
   1974

   DIF: M REF: p.12 OBJ: 5
   TOP: Guidelines for Reporting Diagnoses|Procedures

3. How long after admission is it required by TJC that the admission history and physical be completed?

   ANS:
   Within 24 hours

   DIF: E REF: p.16 OBJ: 1
   TOP: Sections of the Health Record

4. What is the definition of subjective complaint as it applies to a patient coming to a healthcare facility?

   ANS:
   The problem stated in the patient's own words

DIF: E REF: p.16 OBJ: 1
TOP: Sections of the Health Record

5. What does MRI stand for?

ANS:
Magnetic resonance imaging

DIF: E REF: p.36 OBJ: 6 TOP: Abbreviations

6. What is the goal of the physician query process?

ANS:
To improve physician documentation and coding professionals' understanding of the unique clinical situation

DIF: M REF: p.40 OBJ: 7
TOP: Physician Queries in the Coding Process

7. Which report should be written or dictated immediately following a procedure.

ANS:
Operative report

DIF: M REF: p.22 OBJ: 1
TOP: Sections of the Health Record

8. When coding a record, where is one of the best places to begin?

ANS:
The discharge summary if available.

DIF: M REF: p.39 OBJ: 1
TOP: Coding from Documentation Found in the Health Record

9. What are three of the five purposes of a health record?

ANS:
The following are purposes of a health record:

Describes the patient's health history
Serves as a method for clinicians to communicate regarding the treatment plan of care for the patient
Serves as a legal document of care and services provided
Serves as a source of data
Serves as a resource for healthcare practitioner education

DIF: M REF: p.11 OBJ: 1 TOP: Health Record

10. Give three reasons why a provider should be queried.

ANS:

A provider should be queried when documentation is conflicting, incomplete, or ambiguous.

Following are six specific instances:

1. Clinical indicators of a diagnosis but no documentation of the condition
2. Clinical evidence for a higher degree of specificity or severity
3. A cause-and-effect relationship between two conditions or organisms
4. An underlying cause when the patient is admitted with symptoms
5. Only the treatment is documented (without a diagnosis)
6. Present on admission (POA) indicator status is unknown or unclear

DIF: M REF: p.40 OBJ: 7
TOP: Explain the Physician Query Process