**PEARSON’S COMPREHENSIVE MEDICAL CODING: A PATH TO SUCCESS 2/E**

**TEXTBOOK ANSWER KEY**

**CHAPTERS 1-24**

The words in parentheses ( ) following a code provide the Index entries for the Main Term and subterms of one coding path. Selections for additional characters in the Tabular List are listed after the subterms. Index entries vary among publishers.

To access the navigation pane in Word, press Ctrl-F, then click on the left hand tab.

# CHAPTER 1: YOUR CODING CAREER

**CODING PRACTICE**

**Exercise 1.1 What Is Coding?**

1. Coding is the process of accurately assigning codes to verbal descriptions of patients’ conditions and the healthcare services provided to treat those conditions.

2. Diagnosis codes describe patient illnesses, diseases, conditions, injuries, or other reason for seeking healthcare services. Procedure codes describe the services healthcare professionals provide to patients.

3. Abstract - determine which elements of the visit require codes

Assign – determine the codes that describe the patient’s condition and services

Arrange – sequence the codes in proper order

**Exercise 1.2 Understanding Patient Encounters**

1. after an encounter is completed

2. diagnosis, treatment plan, documentation

3. history, physical examination, testing

**Exercise 1.3 Certification**

1. Certification is a voluntary achievement which documents that a coder has attained a certain level of proficiency by passing a rigorous examination.

2. CPC - Certified Professional Coder (physician office coding)

COC - Certified Outpatient Coder

CPC-P - Certified Professional Coder-Payer

3. CCS – Certified Coding Specialist (hospital inpatient and outpatient coding)

CCS-P – Certified Coding Specialist-Physician

CCA – Certified Coding Associate

**Exercise 1.4 Coding Careers**

1. Student answers will vary, so any item from Table 1-3 is acceptable.

2. Student answers will vary and should include the concept that payment for services from insurance companies is based a high degree of accuracy and productivity.

3. 30 to 40 words per minute (wpm) or 9,000 to 12,000 keystrokes per hour (ksph)

4. Coders must be able to identify medical terms, a skill which includes breaking down unfamiliar words into a prefix, root, and suffix to define the meaning. It is not possible to code accurately without knowing the definition of medical terms used in clinical documentation.

**CONCEPT QUIZ**

**Completion**

1. Diagnosis

2. abstract, assign, arrange (answers must be in this order)

3. outpatient

4. inpatient

5. ancillary

6. attending

7. career path

8. treatment

9. query

10. Covered entities

**Multiple Choice**

1. C

2. D

3. B

4. D

5. B

6. B

7. A

8. B

9. A

10. A

# CHAPTER 2: CODING AND REIMBURSEMENT

**CODING PRACTICE**

**Exercise 2.1 Healthcare Payers**

1. most people age 65 and over, people of any age with end stage renal disease (ESRD), and people with disabilities

2. low income families

3. group, self-insured, individual

**Exercise 2.2 Documentation**

1. establishing the medical need for services

2. Student answers will vary and should include three of the following: improve a patient’s condition, evidence-based practice, rendered by appropriate provider, least restrictive setting.

3. The medical record is the comprehensive collection of all information on a patient at a particular facility. Progress notes are the record of a specific patient encounter.

**Exercise 2.3 Life Cycle Of An Insurance Claim**

1. It is the time when providers begin collecting insurance information.

2. The computer automatically determines which procedure codes are covered and how much the insurance company is obligated to pay, and then triggers the payment.

3. Student answers will vary and should include three of the following: Characters in a code are mistyped, creating an invalid code.

Codes have too many or too few characters.

Diagnosis does not match the procedure.

Codes are sequenced incorrectly.

Additional codes required by the Guidelines or Instructional Notes are missing.

Patient age or gender does not match the diagnosis or procedure.

The services described in one code are included (bundled) into another reported code.

A CPT procedure code requires a modifier in order to be paid.

## Exercise 2.4 Reimbursement Methods

1. Negotiated fee schedule is a fee schedule in which the payer specifies the percentage of the provider’s fee schedule it considers to be acceptable.

2. Prospective payment system is a reimbursement method in which payment is made based on a predetermined, fixed amount per case.

3.Capitation is a prospective payment method in which physicians are paid a fixed amount per month for each member assigned to them, regardless of whether that person requests services.

## Exercise 2.5 Healthcare Claims

1. Version 5010A1 is the current version of the electronic standards for healthcare transactions.

2. CMS-1500 is used to bill physician services.

3. 837P is the electronic format used to bill physician services.

4. UB-04 or CMS-1450 is the claim form used to bill inpatient hospital services

5. 837I is the electronic format used to bill inpatient hospital services.

**Exercise 2.6 Federal Compliance**

1. When providers are overpaid they are legally obligated to report the overpayment to Medicare, to refund the money, and may even have to pay interest on it.

2. Overcoding is coding for a more complex diagnosis or procedure than is documented

3. False Claims Act (FCA)

## Exercise 2.7 Health Information Technology

1. Any five of the following are acceptable:

Code first

Diagnosis-procedure mismatch

Invalid characters (I and O in PCS)

Manifestation codes

Medicare medical necessity

Mutually exclusive diagnoses

Mutually exclusive procedures

Patient age

Patient gender

Seven characters required (PCS)

Unacceptable principal diagnosis

Use additional code

Use additional digit(s)

2. Student answers will vary but should include the concept that coders need to understand what information they must give the software in order for it to provide accurate feedback. An untrained user can make coding errors with an encoder, just as they would using the physical manuals.

3. Student answers will vary but should resemble the following examples:

A physician can view medications prescribed by other providers to avoid duplication or medication interactions.

An emergency department can access a patient’s medical history to more quickly identify a problem.

A provider can access imaging studies that may help explain the progression of a patient’s condition.

4. An encoder requires people to conduct an electronic search for each individual code to be assigned, whereas CAC automatically generates codes based on documentation.

5. Student answers will vary but should include the concept that technology elevates coders’ professionalism and enables them to focus on tasks requiring judgment and critical thinking, while computers assist them with the repetitive tasks.

**CONCEPT QUIZ**

**Completion**

1. Part A

2. Medigap

3. TC (Tricare)

4. Family history

5. DRG

6. RA

7. Fraud

8. Abuse

9. OIG

10. compliance

**Multiple Choice**

1. A

2. B

3. D

4. A

5. A

6. C

7. A

8. C

9. C

10. B