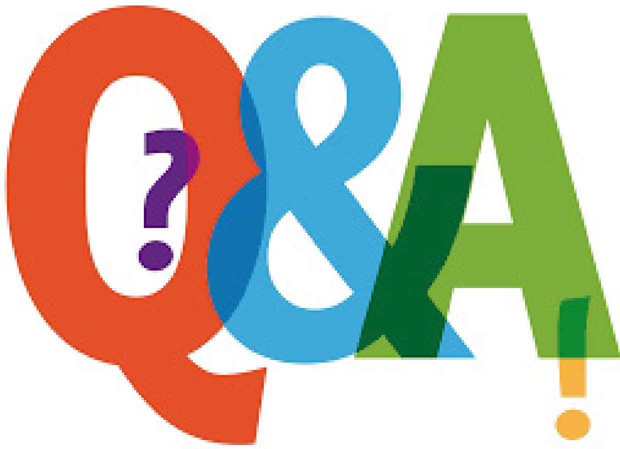

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Question: 1265

A patient presents with a severe allergic reaction after consuming shellfish. The physician documents anaphylaxis and administers epinephrine. What is the significance of CAC in this coding scenario?

A. It can suggest relevant diagnosis and procedure codes.
B. It can provide alerts for potential drug interactions.
C. It can generate patient education materials.
D. It can track the patient's allergy history.

Answer: A
Explanation: CAC's significance lies in its ability to suggest relevant diagnosis and procedure codes based on the physician's documentation of anaphylaxis and the administration of epinephrine. This ensures that the coding accurately reflects the patient's acute condition.

Question: 1266

A patient is admitted with acute renal failure due to dehydration secondary to vomiting. What is the principal diagnosis for coding?

A. N18.9
B. N17.9
C. E86.0
D. R11.2

Answer: B
Explanation: The principal diagnosis is N17.9 (Acute kidney failure, unspecified), as it directly relates to the patient's condition leading to the admission. Dehydration can be documented as a secondary diagnosis.

Question: 1267

A healthcare provider is conducting an internal audit of its compliance with HIPAA privacy rules. Which of the following practices should be prioritized to ensure adherence to the Minimum Necessary Standard?

A. Implementing role-based access controls
B. Allowing all staff to access all patient records
C. Storing all patient records in a single location
D. Using paper records instead of electronic records

Answer: A
Explanation: Implementing role-based access controls is essential for ensuring that only authorized personnel can access specific patient records based on their job responsibilities. This practice aligns with the Minimum Necessary Standard under HIPAA.

Question: 1268

A health system is evaluating its risk analysis process under the HIPAA Security Rule. Which element must be included for compliance?

A. Conduct regular and thorough evaluations of potential threats and vulnerabilities to ePHI
B. Assess risks to ePHI only when a breach occurs
C. Wait for federal audits to dictate security assessments
D. Limit the scope of assessment to physical security only

Answer: A
Explanation: HIPAA mandates ongoing risk analysis to identify potential threats to electronic protected health information and evaluate vulnerabilities so that adequate security plans can be implemented proactively.

Question: 1269

A patient with a history of hypertension is seen for a routine check-up. The physician documents “hypertensive heart disease” but does not specify the stage. What is the appropriate coding action?

A. Code hypertensive heart disease as unspecified
B. Code only hypertension
C. Do not code the condition
D. Query for the stage of hypertensive heart disease

Answer: A
Explanation: In the absence of specific staging information, the coder should code hypertensive heart disease as unspecified. This is compliant with coding guidelines when detailed documentation is lacking.

Question: 1270

In a case where "rule out deep vein thrombosis (DVT)" is documented in the discharge summary without confirmatory ultrasound, what is appropriate coding?

A. Code leg swelling symptom and do not code DVT
B. Code suspected DVT with discharge diagnosis
C. Query physician for diagnosis confirmation
D. Code DVT as principal diagnosis

Answer: A
Explanation: Coding guidelines prohibit coding "rule out" diagnoses. Without ultrasound confirmation or definitive physician diagnosis, coders should code symptoms like leg swelling, not the suspected DVT.

Question: 1271

A patient has a laparoscopic gastric bypass surgery performed. What is the appropriate ICD-10-PCS code?

A. 0DBD4ZZ
B. 0DBD3ZZ
C. 0DBD0ZZ
D. 0DBD1ZZ

Answer: C
Explanation: The correct code is 0DBD0ZZ, which indicates a laparoscopic gastric bypass. The root operation is "Bypass," and it is performed via a laparoscopic approach.

Question: 1272

Inpatient myositis: CK 5000 U/L, MRI muscle edema, EMG fibrillations. Rheum: "dermatomyositis probable." Skin rash photo missing. Ambiguous. Query for?

A. Confirm M33.00 with skin involvement for immunosuppressant
B. Use CK for rhabdo
C. Await biopsy
D. Code M62.81 muscle disorder

Answer: A
Explanation: Indicators support DM; query Bohan criteria, inpatient steroid dosing, vs. outpatient's ANA titer review.

Question: 1273

A facility's quarterly report shows SOI/ROM scores lagging national medians (SOI 1.8 vs. 2.1) due to undercaptured comorbidities in oncology cases, e.g., neutropenia (ANC 800/µL) not linked to

chemotherapy, affecting MS-DRG 847-849. How does targeted CDI impact CMI?

A. Decreases CMI due to higher scrutiny on query rates.
B. No significant change, as oncology DRGs are fixed-weight.
C. Increases CMI by elevating base DRG weight through CC addition for neutropenia.
D. Only affects ROM, not SOI or CMI.

Answer: C
Explanation: Neutropenia as CC (D70.3) in chemo patients elevates SOI/ROM per 3M APR-DRG logic and MS-DRG 847 (chemo w/o acute leukemia w CC), increasing relative weight from 1.2 to 1.8, thus CM**I.**
uplift per HFMA 2024 study) and OCM risk adjustment. Fixed-weight myth ignores CC impact.

Question: 1274

Under the Hospital-Acquired Condition Reduction Program, how is penalty status determined?

A. Hospitals in the worst performing quartile based on HAC measures receive payment reductions
B. Penalties are assessed only on procedures with documented infections
C. HAC reductions are voluntary and have no financial impact
D. Hospitals are penalized only if HAC rates exceed national average by 50%

Answer: A
Explanation: The program cuts payments for the lowest performing hospitals (bottom 25%) on HAC measures. The penalty is not solely based on fixed thresholds or specific procedures but overall performance. Penalties are mandatory, not voluntary.

Question: 1275

A 69-year-old with PVD admitted for claudication. ABI 0.6, duplex shows stenosis. Vasc: "critical limb ischemia, possible gangrene rule out." No tissue loss. Cilostazol started. Final: "PAD, gangrene absent." POA for ischemia?

A. Query for ABI interpretation
B. No code for ruled-out gangrene
C. I96 for gangrene
D. POA "Y" for I70.239 atherosclerosis

Answer: B
Explanation: No tissue loss unsupported for gangrene (I96). Code I70.21.

Question: 1276

A patient is diagnosed with a urinary tract infection (UTI) and has a history of recurrent UTIs. What is the best coding practice for this scenario?

A. N39.0, Z87.9
B. N39.0, Z91.89
C. N39.0, Z87.440
D. N39.0, Z89.9

Answer: C
Explanation: The appropriate codes are N39.0 (Urinary tract infection, site not specified) and Z87.440 (Personal history of urinary tract infections). This accurately captures the current condition and the history.

Question: 1277

During an inpatient admission, a cardiologist documents "NSTEMI confirmed by troponin I levels of 0.9 ng/mL," but no EKG abnormalities are noted. How should coding proceed?

A. Code acute myocardial infarction, unspecified
B. Query provider to confirm diagnosis due to lack of EKG changes
C. Code unstable angina instead of NSTEMI
D. Code NSTEMI based on elevated troponin regardless of EKG

Answer: D
Explanation: NSTEMI diagnosis relies heavily on elevated cardiac biomarkers such as troponin, even without EKG changes. Documentation confirming NSTEMI with troponin level supports coding NSTEMI.

Question: 1278

A health plan audits HEDIS measures for diabetes care. Patient J.K., 55-year-old with T2DM, has HbA1c

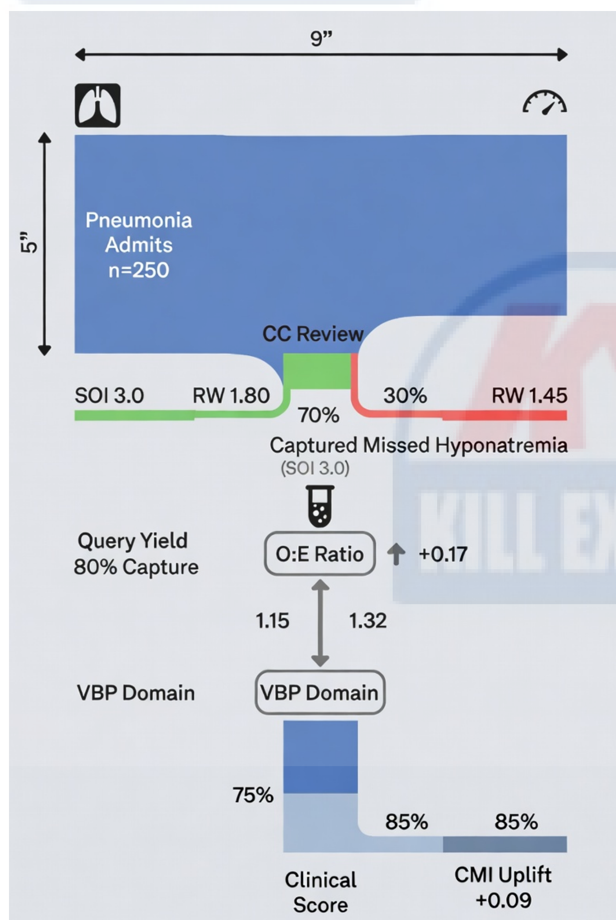
numerator?

A. No, HbA1c >9% excludes despite other elements
B. No, missing blood pressure control documentation
C. Yes, eye exam and nephropathy screening sufficient
D. Yes, if diabetes diagnosis coded with E11.9

Answer: B
Explanation: HEDIS CDC measure requires all three: HbA1c (any value), retinopathy screening, and BP <140/90 mmHg documented in the measurement year. HbA1c documentation alone does not exclude; the absence of controlled BP documentation fails the measure. Accurate ICD-10-CM E11.xx coding identifies the denominator, but numerator compliance demands all components for HEDIS reporting used in quality ratings. Labs like urine ACR confirm nephropathy screening.[5]

Question: 1279

Hospital Y's CDI program evaluates SOI/ROM via 3M Core Measures dashboard, where Q2 2026 pneumonia cohort (n=250) shows avg SOI 2.8/ROM 2.4 (MS-DRG 194 w CC, RW 1.45), but 30% undocumented hyponatremia (E86.0, CC) lowers observed vs. expected O:E ratio 1.15:1. The impact diagram is a Sankey flow chart: from 'Admit Cohort 250' wide band splitting to 'Documented CC 70%' narrow (SOI +0.5) vs. 'Missed 30%' (SOI static), merging to 'O:E Calc' (pre 1.15, post 1.32), then to 'Quality Penalty -0.75%'. If queries capture 80% missed CCs, boosting SOI to 3.2/ROM 2.9 (MS-DRG 193 w MCC, RW 2.13), what is the dual impact on CMI and VBP clinical domain score?



A. CMI +0.05, VBP +5% via elevated O:E and RW shift
B. CMI neutral, VBP +3% ignoring SOI for domain weighting

C. CMI -0.03, VBP -2% as ROM overstates mortality risk
D. CMI +0.09, VBP +8% from full CC integration

Answer: D
Explanation: SOI/ROM scoring in 3M grouper (1-4) refines DRG weights via CC/MCC, impacting CMI (RW avg) and quality (O:E = observed/expected mortality/readmits). Baseline SOI 2.8/ROM 2.4 (DRG 194 RW 1.45) for 250 cases contributes ~362.5 RW; 30% missed hyponatremia (75 cases, +0.68 RW to DRG 193) totals ~150 missed, CMI drag -0.06 facility-wide (assume 10k discharges). 80% query capture (60 cases) adds ~41 RW, net +0.0041 per case ×250 = +0.09 CMI boost annualized. O:E rises from 1.15 (understated severity) to 1.32, improving VBP clinical domain ~8% (pneumonia readmit/mortality measures risk-adjust higher SOI, exceeding threshold). Sankey visualizes flow losses/gains, guiding CDI prioritization of electrolyte docs in pneumonia (HAC/HRRP proxy), yielding $900K revenue (RW gain × base) +0.5% VBP incentive, dual financial/quality ROI.

Question: 1280

A 78-year-old with Parkinson's admitted for aspiration pneumonia. Swallow study abnormal. Labs: WBC 13 x 10^3/µL, pH 7.35. Pulm: "pneumonia, possible ARDS rule out." CXR bilateral opacities resolve with abx. Final: "aspiration PNA, ARDS ruled out." Code ARDS?

A. J80 for ARDS
B. R91.8 for abnormal CXR
C. No code for ruled-out ARDS
D. J96.01 for acute resp failure

Answer: C
Explanation: Resolution without vent/support rules out ARDS (Berlin criteria); unsupported. Code PNA J69.0.

Question: 1281

A patient with a diagnosis of colorectal cancer undergoes neoadjuvant chemotherapy followed by surgical resection. Which aspect of the cancer registry abstraction is most critical to ensure accurate staging?

A. Pathology report findings
B. Preoperative lab values
C. Surgical margins
D. Patient's age

Answer: A
Explanation: The pathology report findings are crucial for accurate staging of colorectal cancer, as they

provide detailed information on tumor characteristics, lymph node involvement, and metastasis, which are essential for AJCC staging.

Question: 1282

A hospital's coding department is evaluating its compliance with the RAC program. What is the primary goal of the RAC program?

A. To increase hospital revenue
B. To reduce claim denials
C. To streamline coding processes
D. To identify and correct improper payments

Answer: D
Explanation: The primary goal of the RAC program is to identify and correct improper payments made to healthcare providers. This program helps ensure that coding and billing practices are compliant with regulations.

Question: 1283

A hospital outpatient department bills CPT code 99284 for an emergency department visit with a high level of MDM. They also bill 96372 for an injection administered during the visit. How should these codes be reported?

A. Report 99284 with modifier -25 and 96372 without modifiers
B. Report 99284 with modifier -59 on 96372
C. Report only 99284 because 96372 is included in the E/M code
D. Report 99284 and 96372 separately without modifiers

Answer: D
Explanation: The injection (96372) is separately reportable with an E/M service like 99284 if performed. According to CPT guidelines, injections are separately billable unless bundled explicitly, and no modifier is required unless payer policies state otherwise. Modifier -59 is not required to separate these services here because injection is distinct. Modifier -25 would apply if a significant, separately identifiable E/M service occurred along with a procedure.

Question: 1284

A patient is admitted for acute pancreatitis. The physician notes that the patient has a history of alcohol abuse. Should the history of alcohol abuse be coded?

A. Yes, as a principal diagnosis
B. Yes, as a secondary diagnosis
C. No, it should not be coded
D. Yes, only if it is current

Answer: B
Explanation: The history of alcohol abuse should be coded as a secondary diagnosis since it is relevant to the patient's acute pancreatitis and provides context for the condition.

Question: 1285

A patient is diagnosed with a drug overdose due to heroin. The physician notes the patient has a history of opioid use disorder. What codes should be assigned?

A. T40.1X5A, Z87.898
B. T40.1X5A, F11.21
C. T40.0X5A, F11.20
D. T40.1X5A, F11.20

Answer: B
Explanation: The correct codes are T40.1X5A (Poisoning by heroin, accidental) and F11.21 (Opioid use disorder, moderate). This reflects the acute condition and the relevant history.

Question: 1286

G. Risk?

A. None
B. FCA
C. Audit
D. Warning

Answer: B
Explanation: Work Plan targets leading queries inflating DRG; potential FCA if systematic, with penalties up to $23K per claim.

Question: 1287

A patient admitted for gastrointestinal bleeding shows a hemoglobin of 6.5 g/dL. In Optum CAC, what

coding strategy aligns best with documentation integration?

A. Code anemia only without reflecting bleeding source
B. Code gastrointestinal bleeding only ignoring anemia if documentation is inconsistent
C. Defer coding anemia until transfusion documentation is present
D. Assign gastrointestinal hemorrhage code along with anemia secondary to blood loss based on hemoglobin and clinical notes

Answer: D
Explanation: Optum CAC supports assigning multiple related codes when documentation and labs indicate acute blood loss anemia secondary to gastrointestinal hemorrhage. This improves coding accuracy and reimbursement alignment for complex clinical scenarios.

Question: 1288

HRRP ERR for HF 1.08, but hospital qualifies for socioeconomic adjustment (dually eligible >40%). Adjusted ERR 0.95. Impact on factor?

A. 2% reduction
B. 1% reduction
C. 3% reduction
D. No penalty

Answer: D

high-risk; 1.08 adjusts to 0.95 <1, avoiding penalty (factor 1.0). Includes MA readmits from 2023. Coding planned vs. unplanned critical.

Question: 1289

Which is the correct procedure when a physician query response is received that conflicts with previous documentation in the chart?

A. Code based on majority of documentation regardless of query response
B. Ignore the new clarification if previous documentation is more detailed
C. Use the physician's clarified response as final documentation, noting the conflict
D. Request a second query to resolve the conflict immediately

Answer: C
Explanation: Physician clarification through query response supersedes conflicting documentation and should be accepted as the official record. It is important to note discrepancies but final coding depends on

clarified documentation.

Question: 1290

A patient with a decubitus ulcer is admitted for wound debridement. Documentation identifies the ulcer as stage III. How is this coded?

A. Code the deep tissue injury only
B. Code pressure ulcer unspecified
C. Code the wound infection only
D. Code stage III pressure ulcer with site specified

Answer: D
Explanation: The coding guidelines require coding the pressure ulcer with specified stage and site when documented. Accurate staging helps in appropriate clinical and billing information reflecting severity.

Question: 1291

A hospital bills CCR 97110 for physical therapy services and wants to report a performance measure related to strength assessment. Which CPT code category should be used for the performance measure?

A. Modifiers only
B. Category III CPT code
C. Category I CPT code
D. Category II CPT code

Answer: D
Explanation: Category II codes are supplemental performance measures for quality tracking and reporting. Strength assessment for performance measurement would fall under Category II rather than Category I or III.

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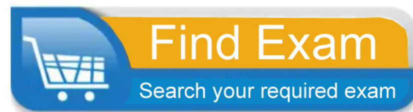

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