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Practice Materials & Tests

DEMO VERSION

Medical Technology

CCA-Examination Exam

Certified Coding Associate Examination

Exam Latest Version: 6.0

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Question 1. (Single Select)

The AHIMA Standards of Ethical Coding encourage which of the following actions?

A: Altering information within a health record to match the reported CPT code
B: Assigning diagnosis codes reported on a previous encounter for a current encounter
C: Taking measures to expose the negligent conduct of coworkers
D: Using a different encounter within a patient's health record to generate a physician query

Correct Answer: C

Explanation:

The AHIMA Standards of Ethical Coding is a set of guidelines and expectations set forth to ensure that moral decision-making, conduct, and activities are performed within the healthcare setting. This includes taking immediate action to discourage, prevent, expose, and correct unethical conduct if observed in the workplace. These guidelines apply not only to coding professionals, but also to auditors, educators, students, managers, and clinical documentation improvement professionals. All employees must work together to create a workplace environment that fosters honesty and adherence to local laws and government regulations.

Question 2. (Single Select)

Which of the following would be flagged in a qualitative analysis of a medical record?

A: Missing attestation
B: Unsigned documentation
C: Copying and pasting
D: Incomplete family history

Correct Answer: C

Explanation:

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Duplication or repetition in documentation, otherwise known as cloning or copying and pasting, would be flagged in a qualitative analysis of a medical record. Although some demographic information may be brought forward from an existing note, the actual history, evaluation, and plan of treatment for the patient should be originated on the date the patient was actually seen. When these aspects of the note are copied and pasted from previous dates of service, the actual author of the note and their thoughts on the patient's condition become ambiguous, which may adversely affect patient care.

Question 3. (Single Select)

A patient is seen in the emergency room complaining of chest pain. The physician performs a 12-lead ECG. How should this be coded?

A: 99282-59, 93005
B: 99282, 93005-59
C: 99282-25, 93005
D: 99282, 93005-25

Correct Answer: C

Explanation:

Modifier 25 is reported to indicate that an E/M service is separately identifiable to a procedure or other service done by the same physician on the same date and may be appended only to office or outpatient services (99201-99215), emergency department services (99281-99285), critical care services (99291), and office or other outpatient consultations (99241-99245). In this scenario, an E/M is performed (99282), in addition to a 12-lead ECG (93005). Modifier 59 is used to indicate that two independent, non-E/M services are being performed on the same day.

Question 4. (Single Select)

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Which of the following is NOT considered a valid exception to information blocking?

A: Content
B: Fees
C: Security
D: Time

Correct Answer: D

Explanation:

There are eight exceptions to information blocking, which may prevent or delay a healthcare entity from fulfilling a request to exchange, use, or access PHI:

• Preventing harm

• Privacy

• Security

• Infeasibility

• Health information technology performance

• Content and manner

• Fees

• Licensing

Question 5. (Single Select)

Which of the following terms represents all of the HCCs submitted for a member in an entire calendar year?

A: Risk adjustment performance
B: Financial risk management

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C: Risk adjustment factor score
D: Inherent risk measurement

Correct Answer: C

Explanation:

All of the HCCs submitted for a member in an entire calendar year cumulate to a risk adjustment factor (RAF) score. For a new member enrolled in a Medicare Advantage plan for fewer than 12 months, the RAF score is calculated based on their age, sex, and current disabilities. An RAF score for a healthy, adult patient is 1.0, and the score increases when the patient sustains a severe injury and/or chronic illness. Therefore, accurate coding for patients with Medicare Advantage plans is imperative because overcoding or falsely inflating diagnoses will result in higher government funding, whereas under- or incomplete coding may result in not enough funding.

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