Chapter 1 Exam

Introduction to Medical Coding

Name: _____ Date: _____

Score (instructor): _____ / 15

Choose the best answer for each question. Mark one choice per question. Each question is worth 1 point.

1. Which description best matches “ICD-10-CM”?

[ ] A. The code set used to report diagnoses and reasons for care

[ ] B. Intentional deception or misrepresentation to obtain an unauthorized benefit

[ ] C. A physician payment framework based on relative value units, geographic adjustments, and a conversion factor

[ ] D. The requirement that a service be reasonable and necessary for the patient's condition

2. Which description best matches “CPT”?

[ ] A. An improper practice that may cause unnecessary cost or payment without the same proof of intent as fraud

[ ] B. A compliant, nonleading request for clarification of incomplete or conflicting documentation

[ ] C. Individually identifiable health information protected under HIPAA

[ ] D. The code set used mainly to report physician and professional services and procedures

3. Which description best matches “HCPCS Level II”?

[ ] A. The provider's documentation together with current official coding rules

[ ] B. The principle of limiting many PHI uses and disclosures to information reasonably needed

[ ] C. The alphanumeric code set used for many drugs, supplies, equipment, and services

[ ] D. Reporting a higher service level than the documentation supports

4. Which description best matches “Medical necessity”?

[ ] A. Intentional deception or misrepresentation to obtain an unauthorized benefit

[ ] B. The requirement that a service be reasonable and necessary for the patient's condition

[ ] C. Improperly reporting components separately when rules require a comprehensive service

[ ] D. The code set used to report diagnoses and reasons for care

5. Which description best matches “PHI”?

[ ] A. Individually identifiable health information protected under HIPAA

[ ] B. Edits that help prevent improper procedure-code combinations

[ ] C. The code set used mainly to report physician and professional services and procedures

[ ] D. An improper practice that may cause unnecessary cost or payment without the same proof of intent as fraud

6. Which description best matches “Minimum necessary”?

[ ] A. A notice used in applicable Medicare situations when noncoverage and patient responsibility are expected

[ ] B. The alphanumeric code set used for many drugs, supplies, equipment, and services

[ ] C. Reporting a higher service level than the documentation supports

[ ] D. The principle of limiting many PHI uses and disclosures to information reasonably needed

7. Which description best matches “Fraud”?

[ ] A. The requirement that a service be reasonable and necessary for the patient's condition

[ ] B. Improperly reporting components separately when rules require a comprehensive service

[ ] C. Intentional deception or misrepresentation to obtain an unauthorized benefit

[ ] D. A physician payment framework based on relative value units, geographic adjustments, and a conversion factor

8. Which description best matches “Abuse”?

[ ] A. Edits that help prevent improper procedure-code combinations

[ ] B. An improper practice that may cause unnecessary cost or payment without the same proof of intent as fraud

[ ] C. A compliant, nonleading request for clarification of incomplete or conflicting documentation

[ ] D. Individually identifiable health information protected under HIPAA

9. Which description best matches “Upcoding”?

[ ] A. Reporting a higher service level than the documentation supports

[ ] B. The provider's documentation together with current official coding rules

[ ] C. The principle of limiting many PHI uses and disclosures to information reasonably needed

[ ] D. A notice used in applicable Medicare situations when noncoverage and patient responsibility are expected

10. Which description best matches “Unbundling”?

[ ] A. The code set used to report diagnoses and reasons for care

[ ] B. Intentional deception or misrepresentation to obtain an unauthorized benefit

[ ] C. A physician payment framework based on relative value units, geographic adjustments, and a conversion factor

[ ] D. Improperly reporting components separately when rules require a comprehensive service

11. Which description best matches “NCCI edits”?

[ ] A. An improper practice that may cause unnecessary cost or payment without the same proof of intent as fraud

[ ] B. A compliant, nonleading request for clarification of incomplete or conflicting documentation

[ ] C. Edits that help prevent improper procedure-code combinations

[ ] D. The code set used mainly to report physician and professional services and procedures

12. Which description best matches “ABN”?

[ ] A. The provider's documentation together with current official coding rules

[ ] B. A notice used in applicable Medicare situations when noncoverage and patient responsibility are expected

[ ] C. The alphanumeric code set used for many drugs, supplies, equipment, and services

[ ] D. Reporting a higher service level than the documentation supports

13. Which description best matches “RBRVS”?

[ ] A. A physician payment framework based on relative value units, geographic adjustments, and a conversion factor

[ ] B. The requirement that a service be reasonable and necessary for the patient's condition

[ ] C. Improperly reporting components separately when rules require a comprehensive service

[ ] D. The code set used to report diagnoses and reasons for care

14. Which description best matches “Provider query”?

[ ] A. Individually identifiable health information protected under HIPAA

[ ] B. Edits that help prevent improper procedure-code combinations

[ ] C. The code set used mainly to report physician and professional services and procedures

[ ] D. A compliant, nonleading request for clarification of incomplete or conflicting documentation

15. Which description best matches “Coder's primary source”?

[ ] A. A notice used in applicable Medicare situations when noncoverage and patient responsibility are expected

[ ] B. The alphanumeric code set used for many drugs, supplies, equipment, and services

[ ] C. The provider's documentation together with current official coding rules

[ ] D. The principle of limiting many PHI uses and disclosures to information reasonably needed