Name:_____ Class:_____ Date:_____

CHAPTER 1 - THE FLOW OF THE HOSPITAL ORGANIZATION

1. The admitting diagnosis is determined by the patient's chief complaint at the time of the admission.
   a. True
   b. False

   ANSWER: False

2. Outpatient services are typically provided outside the acute care hospital.
   a. True
   b. False

   ANSWER: False

3. Intermediate Care Facilities (ICF) are considered inpatient facilities.
   a. True
   b. False

   ANSWER: True

4. ASC is an acronym for ambulatory surgery coding.
   a. True
   b. False

   ANSWER: False

5. Advanced Directives are requests from the patient at the time of admission of what services they would like to have performed during their admission.
   a. True
   b. False

   ANSWER: False

6. As well as CPT codes, ICD-9-CM diagnosis and procedure codes are assigned by all hospital/facility coders.
   a. True
   b. False

   ANSWER: False

7. The form utilized for submitting charges to the insurance carrier is referred to as the CMS-1450.
   a. True
   b. False

   ANSWER: True

8. Coders in the Health Information Department of the hospital are the only individuals who need to have coding knowledge to successfully complete and understand their duties.
   a. True
   b. False

   ANSWER: False

9. The Certified Professional Coder (CPC) certification indicates that the individual who has successfully received this designation has concentrated knowledge in physician coding.
   a. True
   b. False

   ANSWER: True

10. Inpatient care usually takes place in the acute care facility such as a hospital, skilled nursing facility, or intermediate care facility.
    a. True
    b. False

    ANSWER: True

11. Physicians employed by the hospital are referred to as:
    a. hospital-based physicians. b. physician employees.
    c. administrative physicians. d. private practice physicians.

    ANSWER: b

12. What form would the patient be requested to sign in the event the services to be rendered may not be covered by Medicare or their insurance?
    a. Release of Medical Information b. Advanced Directive
    c. Advance Beneficiary Notice d. Assignment of benefits

    ANSWER: c

13. The process of gathering charge documents from all departments within the facility that have provided services to a patient is referred to as:
    a. charge capturing. b. utilization review.
    c. precertification. d. case management.

    ANSWER: a

14. The term *third-party contract*refers to a contract:
    a. with an entity other than the patient.
    b. with an entity other than the hospital.
    c. with a third-party liability carrier.
    d. between the patient, the facility, and the insurance carrier.

    ANSWER: d

15. When ancillary services such as x-rays or EKGs are performed, the resources necessary to provide the services by the facility are referred to as:
    a. the charge. b. the technical charge.
    c. the professional charge. d. the chargemaster charge.

    ANSWER: b

16. Hospital inpatient coders utilize which coding nomenclatures for assigning codes?
    a. CPT codes only
    b. ICD-9-CM diagnosis codes only
    c. CPT and ICD-9-CM codes
    d. ICD-9-CM diagnosis and procedure codes

    ANSWER: d

17. Inpatient coding certification is available through which organizations?
    a. AAPC (American Academy of Professional Coders)
    b. MGMA (Medical Group Management Association)
    c. AHIMA (American Health Information Management Association) and AAPC (American Academy of Professional Coders)
    d. AHA (American Hospital Association)

    ANSWER: c

18. Which department within the hospital setting is typically responsible for coding assignments?
    a. Health Information Management b. Business Office
    c. Utilization Review d. Case Management

    ANSWER: a

19. When claims are initially denied by the insurance carrier and the facility wishes to resubmit the claim to request additional consideration for payment, the process is referred to as:
    a. adjudication. b. appeal.
    c. claims processing. d. dispute.

    ANSWER: b

20. What is the acronym given to the electronic medical health record?
    a. EHR b. EMHR
    c. UB-04 d. CMS-1500

    ANSWER: a

CHAPTER 1 - THE FLOW OF THE HOSPITAL ORGANIZATION

21. Explain the difference between an inpatient and an outpatient facility.

ANSWER: Inpatient services typically are provided to an acute patient needing 24-hour skilled care such as acute care, skilled nursing, or intermediate care facilities. Outpatient facilities usually do not require the type of acute care needed in the inpatient setting. Typically, the patient is observed for severity and either released within a 24-hour to 48-hour period or admitted inpatient to an acute care area.

22. For services to be "medically necessary," they must meet certain criteria. Name at least three of these criteria.

ANSWER: Procedures must be appropriate for the patient's diagnosis.
Patient must not be an elective patient.
Procedure must not be considered experimental.
Procedure must not be performed at the patient's request for their convenience.
Procedure must be performed at the level of care needed.

23. In an inpatient setting, explain which services would be billed on the UB-04?

ANSWER: Room/Board
Operating Room/Board (if applicable)
Drugs/Supplies
Ancillary/Services Technical

24. Explain what coding nomenclature would be utilized for coding/billing for outpatient purposes.

ANSWER: ICD-9-CM Diagnosis Codes
ICD-9-CM Procedure Codes (when applicable)
CPT Procedure Codes

25. List those coding certifications that are appropriate for the hospital facility.

ANSWER: Certified Coding Specialist (CCS)
Inpatient Hospital (AHIMA)
CCO and CCI
Outpatient Hospital/Inpatient Hospital AAPC (American Academy of Professional Coders)