

Healthcare RBCS

NCMA Registered Billing & Coding Specialist (RBCS)

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Question: 1

Joe Poe receives a diagnosis of retinoblastoma. Which of the following is the correct code for this diagnosis?

- A. 714.30.
- B. 005.9.
- C. 190.5.
- D. 163.9.

Answer: C

Explanation:

When assigning a medical diagnosis code, it is crucial to select the most accurate code that corresponds to the particular diagnosis given by a healthcare provider. In the scenario presented, Joe Poe has been diagnosed with retinoblastoma. The correct medical diagnosis code for retinoblastoma, according to the International Classification of Diseases (ICD), is 190.5. This code specifically categorizes malignancies of the retina, which is the precise location affected in retinoblastoma.

Retinoblastoma is a rare type of eye cancer that typically develops in early childhood, usually before the age of five. It originates from the retina, the light-detecting tissue of the eye. The code 190.5 is designated specifically for this type of cancer, ensuring that the diagnosis is accurately documented in medical records and that appropriate treatment plans can be devised.

It is also helpful to understand what the other codes represent, as incorrect coding can lead to inappropriate treatment strategies and misunderstandings in patient care. Code 714.30 is used for juvenile rheumatic arthritis, a completely different condition that affects joints but not the eyes. Code 005.9 pertains to food poisoning, an acute gastrointestinal condition resulting from contaminated food intake. Code 163.9 is designated for mesothelioma, a type of cancer that affects the lining of organs, primarily the lungs and chest wall.

Thus, for the diagnosis of retinoblastoma in Joe Poe, the correct ICD code is 190.5. Using this specific code helps in the accurate tracking of patient data, ensures compliance with health information systems, and assists in the correct billing and insurance processes. It is essential for healthcare professionals to use precise coding to facilitate effective communication across various medical and administrative systems.

Question: 2

Which of the following coding systems is a "prospective fixed Medicare fee structure for hospital billing of inpatient services based on principal diagnosis"?

- A. DRG.
- B. MS-DRG.
- C. RVS.

D. MS-RVS.

Answer: A

Explanation:

DRG, which stands for Diagnosis-Related Group, is a coding system used to classify hospital cases into one of originally 467 groups, with the number adjusting over time due to updates and reforms. The system's intent is to have a fixed fee structure that standardizes payments to hospitals for inpatient stays. Each DRG is assigned a payment weight based on the average resources required to treat patients in that group. This system allows Medicare to budget and predict expenses more effectively since payments are fixed regardless of the actual cost incurred by the hospital during the treatment.

The DRG system classifies cases into categories based on the principal diagnosis, secondary diagnoses, surgical procedures, comorbidities, and complications. This grouping mechanism is integral to the prospective payment system (PPS) implemented by Medicare in the United States. This fixed fee structure means that the hospital's reimbursement for a patient with a specific DRG is predetermined, regardless of the length of the hospital stay or the specific treatments provided, barring outlier cases that require exceptionally unusual expenses.

MS-DRG, or Medicare Severity-Diagnosis Related Group, is a refinement of the original DRG system that allows for differentiation based on the severity of the patient's condition. It introduces three levels of severity for each DRG, reflecting the resource intensity needed for the patient's care. This adaptation aims to more accurately match the payment to the expected cost of care, providing higher payments for sicker patients who likely require more intensive resources.

RVS, or Relative Value Scale, is another coding system entirely. Rather than focusing on hospital inpatient billing, RVS is used primarily for outpatient services. It assigns point values to services based on factors such as the time, knowledge, and skill required from healthcare providers. These points are then converted into a fee schedule, determining how much providers are paid for each service.

MS-RVS is not a recognized standard coding system within the medical billing and Medicare frameworks. It appears to be a fictitious term, likely included here as a distractor.

Therefore, the correct answer to the question regarding a "prospective fixed Medicare fee structure for hospital billing of inpatient services based on principal diagnosis" is DRG. This system simplifies the billing process, promotes fiscal predictability for hospital management, and attempts to ensure fair compensation for hospitals by standardizing payments according to the diagnosis and necessary care level, rather than the cost of service provided.

Question: 3

HCPCS Level II codes are updated how often?

- A. Twice a year.
- B. Once a year.
- C. Every 3 years.
- D. Every 5 years.

Answer: B

Explanation:

HCPCS (Healthcare Common Procedure Coding System) Level II codes are a standardized coding system that is primarily used to identify products, supplies, and services not included in the CPT (Current Procedural Terminology) codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. This coding system is essential for billing Medicare and Medicaid claims, and it helps facilitate the efficient processing and payment of health services.

The HCPCS Level II codes are updated once a year. This annual update is crucial for accommodating new procedures, technologies, and changes in healthcare practice. The updates ensure that the coding system remains comprehensive, current, and reflective of contemporary medical practice and available healthcare services. The regular yearly update is scheduled to take effect on January 1 each year. This timing helps ensure that all stakeholders, including healthcare providers, insurance companies, and policy administrators, start the new year with the most current set of codes, thus streamlining the billing and reimbursement processes.

The update process involves the addition, revision, or deletion of codes based on changes in technology or medical practice. Stakeholders, including professional health groups, industry representatives, and the Centers for Medicare and Medicaid Services (CMS), can submit applications for modifications to the HCPCS Level II codes. These applications are reviewed by the CMS HCPCS Workgroup, which comprises representatives from various sectors of the healthcare industry.

By updating the HCPCS codes once a year, the system helps ensure that it meets current healthcare service needs, reflecting new technologies and therapeutic procedures that have emerged over the preceding year. Additionally, this annual update facilitates uniformity and standardization in the coding and billing process across the United States, which is essential for effective healthcare management and administration.

Question: 4

"West" indicator on the clinical value compass represents what?

- A. Clinical outcomes.
- B. Health status or function.
- C. Costs of care.
- D. Patient satisfaction.

Answer: A

Explanation:

The "West" indicator on the clinical value compass specifically represents "Clinical outcomes." This is part of a broader framework used in healthcare to assess various aspects of care delivery and its impact on patients. The clinical value compass is designed as a metaphorical tool to guide healthcare providers and administrators in evaluating performance and improving patient care across multiple dimensions. To understand the significance of the "West" indicator, it's essential to consider what clinical outcomes entail. Clinical outcomes refer to the measurable changes in health, function, or quality of life that result from the care or interventions provided to patients. This could include outcomes such as mortality rates, readmission rates, infection rates, recovery times, and other health indicators that reflect the effectiveness of clinical interventions.

The compass consists of four directions, each representing a critical component of healthcare evaluation: 1. ****North**** - Health status or function: This direction assesses how well the healthcare

services improve or maintain the physical and mental health of patients. 2. ****South**** - Costs of care: This focuses on the financial aspects of healthcare, analyzing how costs are managed in providing patient care. 3. ****East**** - Patient satisfaction: This measures how satisfied patients are with the care they receive, which can include aspects of communication, timeliness, and the overall experience. 4. ****West**** - Clinical outcomes: As previously mentioned, this direction focuses on the tangible results of medical care and their impact on patient health. The integration of these four indicators helps provide a holistic view of healthcare quality and efficiency, driving improvements across different sectors of the healthcare system. By focusing on clinical outcomes, health care providers can identify effective practices and areas needing improvement, thereby enhancing the overall quality of care and patient well-being.

Question: 5

Which of the following statements about Medicare Part A is accurate?
check all answers that apply

- A. Medicare Part A is inpatient hospital insurance.
- B. Medicare Part A is provided with no premiums to most beneficiaries.
- C. Most services covered under Medicare Part A do not require an annual deductible and copayment to be paid by the beneficiary.
- D. One of the services included in Medicare Part A is hospice care.

Answer: A,B,D

Explanation:

Medicare Part A is primarily known as hospital insurance and covers various types of inpatient care. This includes inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care services. Understanding the coverage specifics can help beneficiaries manage their health care planning more effectively.

One critical aspect of Medicare Part A is its coverage of hospice care. Hospice care is provided for terminally ill patients who choose palliative care (comfort care) instead of care aimed at curing their illness. This service is covered under Medicare Part A if the patient meets certain conditions set by Medicare, such as having a terminal illness with a prognosis of six months or less to live if the illness runs its normal course.

Concerning costs, Medicare Part A does require most beneficiaries to pay certain out-of-pocket costs. These include a deductible for each benefit period and copayments for extended inpatient hospital and skilled nursing facility stays. For example, for a hospital stay in 2023, the Medicare Part A deductible is \$1,600 for each benefit period. Days 1-60 in a hospital do not require a copayment, but days 61-90 require a copayment of \$400 per day, and beyond 90 days, it's \$800 per day under lifetime reserve days. Moreover, while Medicare Part A covers many services, it is crucial to note the limitations. For instance, it does not cover long-term or custodial care if that is the only care needed, nor does it cover private rooms unless medically necessary, or personal items like phone and television in a hospital or nursing home.

Eligibility for premium-free Medicare Part A largely depends on the work history of either the beneficiary or their spouse. Individuals or their spouses who have paid Medicare taxes for at least 40 quarters (10 years) typically do not have to pay premiums for Part A. Those who haven't met this requirement might have to pay a premium for coverage.

In summary, Medicare Part A provides essential coverage for inpatient care, including hospice, with certain cost-sharing measures like deductibles and copayments. It is usually premium-free for those who have adequately paid into the system through Medicare taxes. Understanding these facets helps beneficiaries navigate their health coverage more effectively and plan for potential healthcare costs.

Question: 6

What does the suffix "emesis" refer to?

- A. Vomiting.
- B. Discharge.
- C. The end of an event.
- D. The beginning of an event.

Answer: A

Explanation:

The suffix "emesis" specifically refers to the act of vomiting. It is derived from the Greek word "emein," which translates directly to "to vomit." This suffix is commonly used in medical terminology to describe conditions related to vomiting.

For example, the term "hematemesis" incorporates this suffix and is used to describe a specific type of vomiting—vomiting blood. This term breaks down into two parts: "hema" meaning blood, and "emesis" meaning vomiting, thus it literally translates to "vomiting of blood."

Understanding the suffix "emesis" can help in comprehending various medical terms related to vomiting, enhancing both medical professionals' and patients' understanding of symptoms and conditions.

Question: 7

What does IPPS stand for?

- A. Indirect Prospective Payment System.
- B. Inpatient Prospective Payment System.
- C. Inpatient Production Payment System.
- D. Ideal Patient Payment System.

Answer: B

Explanation:

IPPS stands for Inpatient Prospective Payment System. This system is used by Medicare to reimburse hospitals for inpatient stays. Under the IPPS, hospitals are paid a fixed amount for each patient's stay, and the payment rates are predetermined based on the diagnosis-related group (DRG) to which the patient's case is classified.

The DRG system categorizes patients based on their primary diagnosis, procedures, age, sex, discharge status, and the presence of complications or comorbidities. Each DRG has an associated weight that represents the relative amount of resources required to treat patients in that group compared to others.

The DRG weight, along with the hospital's base payment rate, determines the total payment the hospital will receive for a case.

The IPPS is designed to encourage efficiency in hospital resource use. By providing a predetermined payment amount, it incentivizes hospitals to manage their costs and avoid unnecessary services. However, the system also includes adjustments to account for factors such as hospital location, teaching status, and the share of low-income patients, ensuring that hospitals are fairly compensated for the challenges they face.

In summary, the Inpatient Prospective Payment System (IPPS) is a method through which Medicare reimburses hospitals for inpatient stays, using a classification system based on Diagnosis-Related Groups (DRGs) to determine payment rates. This system aims to promote cost-efficient care while adjusting for various hospital characteristics and patient demographics.

Question: 8

CPT surgical codes followed by what symbol are charged on a fee-for-service basis?

- A. *
- B. #
- C. @
- D. ^

Answer: A

Explanation:

*CPT (Current Procedural Terminology) codes are used by medical professionals to standardize billing across services and procedures. These codes ensure that there is a consistent language through which the services rendered by healthcare providers can be communicated to payers, such as insurance companies, for the purpose of billing. *

*When referring to CPT codes in a fee-for-service context, certain symbols next to these codes can indicate specific billing or procedural guidelines. The symbol "&" after a CPT code is particularly pertinent in this context as it signifies that the procedure associated with the CPT code is charged on a fee-for-service basis. *

*Under a fee-for-service model, each procedure or service provided by a healthcare professional is billed separately. This model contrasts with other payment models such as capitation or bundled payments, where services might be grouped together for billing, or the provider is paid a set fee per patient regardless of the number of services provided. *

*The use of the "&" symbol in CPT coding therefore plays a crucial role in the billing process, as it clearly identifies the procedures that are to be billed individually. This ensures transparency and accuracy in the billing process, allowing healthcare providers to be compensated specifically for the services they have rendered, rather than receiving a general payment for their time or number of patients seen. This method can often incentivize thorough and specific care, as each task performed is directly linked to a financial return.

Question: 9

Chapter 1 of ICD-9-CM provides three late effect codes for use when there is a residual condition due to previous infection or parasitic infection. Which of the following is one of these late effect codes?
check all answers that apply

- A. late effects of tuberculosis
- B. late effects of brain damage
- C. late effects of acute poliomyelitis
- D. late effects of other infectious and parasitic diseases
- E. late effects of myocardial infarction

Answer: A,C,D

Explanation:

In ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification), the concept of "late effects" refers to the residual impacts that occur after the acute phase of an illness or injury has ended. These effects can manifest much later and are directly linked to the initial condition. Chapter 1 specifically deals with infectious and parasitic diseases and includes codes that capture the late effects of these conditions.

The term "late effects" includes physical or mental damages that remain after an infection or parasitic disease has been cured or has subsided. The ICD-9-CM provides specific codes for these late effects, which are crucial for accurate medical coding and subsequent treatment. These codes help in tracking the long-term consequences of diseases and in the planning of appropriate management strategies for patients.

Among the late effect codes provided in Chapter 1 of ICD-9-CM, the following are key: 1. ****Late effects of tuberculosis**** - This code is used when a patient suffers long-term health issues related to a past tuberculosis infection. These could include lung damage or neurological sequelae. 2. ****Late effects of acute poliomyelitis**** - This code applies to residual effects that follow an episode of poliomyelitis, such as post-polio syndrome, which can result in muscle weakness and fatigue that appear years after the initial infection. 3. ****Late effects of other infectious and parasitic diseases**** - This is a broader category that includes late effects of various other infectious and parasitic diseases not specified elsewhere.

When coding for these conditions, the code for the residual effect (if identified) is typically sequenced first. This is followed by the appropriate late effect code. However, there are exceptions, which are specified in the Alphabetic Index of the ICD-9-CM manual. This hierarchical approach in coding ensures that the primary condition is highlighted while also acknowledging the consequent late effects.

Understanding and using these codes correctly is essential for effective patient management, allowing healthcare providers to offer targeted therapies and interventions that address both the immediate and delayed complications of infectious diseases. The specificity of these codes also aids in epidemiological studies, helping public health officials to monitor trends and outcomes associated with various infections and their long-term impacts on populations.

Question: 10

Diverticula may be either acquired or congenital. Which of the following statements in this regard is accurate?

check all answers that apply

- A. For certain sites, ICD-9-CM assumes that the condition is congenital unless specified otherwise.

- B. Diverticula of the esophagus are assumed to be congenital unless otherwise specified.
- C. For certain sites, ICD-9-CM assumes that the diverticula are acquired.
- D. Diverticula of the colon are assumed to be congenital unless specified as acquired.

Answer: A,B,C

Explanation:

Diverticula are small, bulging pouches that can form in the lining of the digestive system. They are found most commonly in the lower part of the large intestine (colon). Diverticula themselves may not cause any problems, but when they become inflamed or infected, it leads to a condition known as diverticulitis.

Diverticula can be either congenital or acquired. Congenital diverticula are present from birth and are usually caused by developmental defects during embryogenesis. Acquired diverticula, on the other hand, are more common and typically develop later in life due to factors such as increased pressure inside the colon or a weakening of the colon wall.

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is a system used in the United States for coding and classifying morbidity data from inpatient and outpatient records, physician offices, and most National Center for Health Statistics (NCHS) surveys. When coding diverticula in ICD-9-CM, assumptions about whether diverticula are congenital or acquired can vary depending on the anatomical site of the diverticula.

According to the ICD-9-CM guidelines: 1. Diverticula of the esophagus are generally assumed to be congenital unless specified otherwise. This assumption is based on medical understanding that esophageal diverticula, such as Zenker's diverticulum, often arise from structural or developmental anomalies present from birth. 2. Conversely, diverticula of the colon are assumed to be acquired unless specified as congenital. This is because most cases of colonic diverticula develop due to acquired factors like dietary habits, aging, and increased colonic pressure—conditions more prevalent in older adults. Therefore, when coding for diverticula, it is crucial for healthcare providers to specify whether the condition is congenital or acquired to ensure accurate ICD-9-CM coding. For instance, unspecified diverticulosis of the colon is coded as 562.10, which implies an acquired condition unless otherwise noted. Accurate coding is essential not only for appropriate patient management but also for epidemiological studies, health care planning, and reimbursement processes.

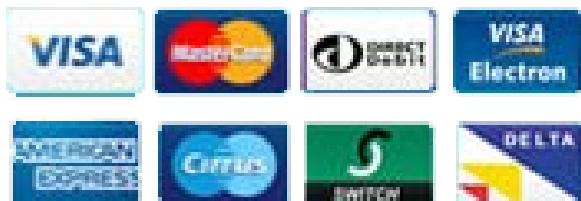
In summary, understanding whether diverticula are assumed to be congenital or acquired in the ICD-9-CM helps in correct medical coding and treatment approaches. It highlights the importance of detailed medical documentation and awareness of coding guidelines among healthcare professionals.

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