A Guided Approach to Intermediate and Advanced Coding, 2e **(Lame/Young)**
Chapter 2 Documentation and Coding Review

2.1 Matching Questions

Directions: Select the word or phrase that best completes each sentence.

A) Principal procedure
B) Subjective information
C) Complication
D) Laboratory report
E) Principal diagnosis
F) Present illness
G) Administrative documentation
H) Medical necessity
I) Clinical documentation
J) Review of systems
K) Objective documentation
L) Comorbidity
M) Social and personal history
N) Utilization management
O) Standing orders
P) Chief complaint
Q) Consultation
R) Family medical history
S) Past medical history
T) Progress note

1) Information collected from the patient or other historian.

2) Procedure that was performed for the definitive treatment of the main condition or complication of the condition.

3) Established orders to direct procedures to follow for a particular diagnosis or procedure.

4) Patient-stated subjective information regarding the patient's current condition.

5) The process of ensuring medical necessity is met for patients receiving care in the appropriate healthcare setting.

6) Condition that existed at admission and is thought to increase the length of stay at least one day for approximately 75% of patients.

7) Personal identifying information documented in the healthcare record.

8) The physician's assessment of the patient's current health status.

9) A chronological record of the patient's condition during an episode of care and/or while receiving treatment from a provider.

10) Information documented in the healthcare record describing the patient's condition and course of treatment.

11) The routine examination of sample fluids and substances such as blood, urine, spinal fluid, sputum, and other substances collected from patients.

12) Formal process to ensure the appropriate level of service is performed in an efficient and cost-effective manner in the appropriate setting based on the patient's physical needs and quality of life.

13) Secondary condition that arises during hospitalization and is thought to increase the length of stay by at least 1 day in approximately 75% of patients.

14) Subjective description of immediate family members' illnesses and/or diseases.

15) The advice of another physician or physicians regarding a patient's diagnosis or therapeutic options.

16) Subjective description of other symptoms or illnesses pertaining to individual body systems.

17) Subjective description of personal health habits and social status.

18) Condition established, after study, to have been the main reason for the patient's admission for inpatient treatment.

19) Patient-provided subjective description of the events or reason why the patient sought out medical treatment.

20) Subjective description of childhood and adult illnesses and medical conditions.

Answers: 1) B 2) A 3) O 4) F 5) N 6) L 7) G 8) K 9) T 10) I 11) D 12) H 13) C 14) R 15) Q 16) J 17) M 18) E 19) P 20) S

2.2 Multiple Choice Questions

1) Which of the following is a primary source document for coders?
A) Progress note
B) Operative report
C) Physician order
D) Consultation report
Answer: B

2) Which document is the main source document for the principal diagnosis, secondary diagnoses, and principal procedure?
A) Discharge summary
B) Face sheet
C) Procedure report
D) Progress note
Answer: A

3) Which of the following data elements is part of administrative documentation?
A) Date of birth
B) Cytology report
C) Current condition
D) Past procedures
Answer: A

4) The admission form is also known as the:
A) demographic sheet.
B) face sheet.
C) financial profile.
D) consent form.
Answer: B

5) Information provided by the patient to the healthcare provider should be documented with:
A) ICD-10-CM codes.
B) physician clinical terms.
C) the patient's own words.
D) formal nomenclature.
Answer: C

6) Which of the following is a confirmatory document for coders?
A) HPI
B) Physical examination
C) Discharge summary
D) Physical therapy report
Answer: D

7) Which of the following is a comorbidity?
A) Ventilator-associated pneumonia
B) Post-operative infection
C) Hypertension
D) Fall from the hospital bed
Answer: C

8) Smoking, drinking, or drug abuse are part of the patient's _____ history.
A) family
B) medical
C) social
D) past
Answer: C

9) The _____ is a primary source document from which current signs, symptoms, previous medical history, personal history, and family history are gathered.
A) history of present illness
B) physical examination
C) discharge summary
D) diagnostic report
Answer: A

10) A physical examination of the _____ typically includes temperature, turgor, vascularity, color, edema, and lesions.
A) throat
B) vital signs
C) sinuses
D) skin
Answer: D

11) _____ orders may address specifically artificial breathing or cardiopulmonary resuscitation and extend to pain control and nutrition.
A) Restraint
B) DNR
C) Standing
D) Discharge
Answer: B

12) All information regarding diagnoses in the consultation reports should be correlated with the _____ in the acute care setting.
A) chief complaint
B) therapeutic reports
C) progress notes
D) discharge summary
Answer: D

13) What should coders do when they see an order for an antibiotic?
A) Assign a code for long-term use of antibiotics.
B) Assign a code for unknown infectious disease.
C) Review the record to identify the type of infection.
D) Query the physician regarding why the antibiotic was ordered.
Answer: C

14) Which of the following is a complication?
A) Congestive heart failure
B) Metastatic colon cancer
C) Dependence on a ventilator due to quadriplegia
D) Urinary tract infection after a Foley catheter is inserted
Answer: D

15) Diagnosis documentation on the face sheet may be utilized as the:
A) admit diagnosis.
B) principal diagnosis.
C) discharge diagnosis.
D) primary diagnosis.
Answer: A

16) A routine order to start physical therapy treatment on day two after a myocardial infarction by sitting up at bedside is an example of _____ orders.
A) passive
B) standing
C) admitting
D) discharge
Answer: B

17) Which of the following is an example of a consultation?
A) The patient seeks a second surgical opinion because he/she is unsure about the need for a coronary bypass.
B) The attending physician discusses discharge plans with a patient.
C) The primary care physician requests that a cardiologist examine a patient due to complaints of chest pain.
D) The primary care physician sees a patient for follow-up on laboratory tests.
Answer: C

18) Which form of imaging has little to no risk of complications?
A) Real-time imaging
B) Chest x-ray
C) Nuclear medicine
D) Guided surgical procedure
Answer: B

19) The statement "fibrous material of the breast tissue" would likely be found in the _____ report.
A) imaging
B) pathology
C) consultation
D) laboratory
Answer: B

20) The patient's principal diagnosis, secondary diagnoses, principal procedure, and secondary procedures and the disposition of the patient are documented in the:
A) face sheet.
B) clinical information.
C) abstract summary.
D) discharge summary.
Answer: D

21) Medication to prevent the patient from moving or doing harm to self or others is an example of a _____ order.
A) discharge
B) standing
C) seclusion
D) restraint
Answer: D

22) The patient's reason for seeking care from the physician is found under which component of a SOAP note?
A) S
B) O
C) A
D) P
Answer: A

23) Which of the following does NOT require the patient to sign a consent form?
A) Immunization
B) Medication prescription
C) Notice of privacy practices
D) Operative procedure
Answer: B

24) The first "solid" place to find physician information regarding the diagnosis or diagnoses and/or treatment planned for the patient during this episode of care is the:
A) face sheet.
B) chief complaint.
C) physical examination.
D) history of present illness.
Answer: C

25) The immunization record is typically found in what setting?
A) Acute inpatient
B) Physician office
C) Emergency department
D) Same-day surgery
Answer: B

26) A summary of all medical diagnoses and issues, along with surgical history, that are watched or managed long term by the physician is found in the:
A) patient history questionnaire.
B) HPI.
C) discharge summary.
D) problem list.
Answer: D

27) What type of report describes microscopic and macroscopic examination of a specimen or foreign body?
A) Laboratory report
B) Imaging report
C) Operative report
D) Pathology report
Answer: D

28) Which of the following data elements is typically NOT found in an operative report?
A) Description of specimens removed
B) Procedure definition
C) Physical examination findings
D) Estimated blood loss
Answer: C

29) The physician's diagnosis and impression regarding the current episode of care is found under which component of a SOAP note?
A) S
B) O
C) A
D) P
Answer: C

30) Which of the following is NOT a subjective medical history question?
A) What is your date of birth?
B) What prescription medications are you currently taking?
C) What were you doing when the problem was first experienced?
D) What over-the-counter medications are you currently taking?
Answer: A

31) Which of the following can be coded directly from report results?
A) Liver panel showing elevated liver enzymes
B) Culture showing streptococcus infection
C) MRI showing presence of a tumor
D) Chest x-ray showing pneumonia
Answer: B

32) Financial data is collected on the:
A) insurance form.
B) patient history questionnaire.
C) HPI.
D) face sheet.
Answer: D

33) Comorbidities and complications are conditions that are thought to increase the length of stay at least _____ day(s) for 75% of patients.
A) 1
B) 2
C) 5
D) 7
Answer: A

34) A physical examination of the _____ typically includes trill, rhythm, friction, and apical impulse.
A) heart
B) lungs
C) abdomen
D) neurological system
Answer: A

35) A _____ is a secondary condition that arises during hospitalization.
A) comorbidity
B) secondary diagnosis
C) complication
D) chronicity
Answer: C

36) "If it isn't _____, it wasn't done."
A) medically necessary
B) documented
C) coded
D) diagnosed
Answer: B

37) The patient's means of arrival is typically found in _____ documentation.
A) physician office
B) acute inpatient
C) emergency department
D) same-day surgery
Answer: C

38) An acute care facility may utilize _____ to look at coordination of services provided to the patient.
A) progress notes
B) a discharge summary
C) consultation reports
D) laboratory reports
Answer: A

39) COP refers to:
A) clinic outpatient.
B) conditions of participation.
C) coding by provider.
D) consultation of patient.
Answer: B

40) Documentation in same-day surgery settings resembles that of the:
A) acute inpatient hospital.
B) physician office.
C) operative report.
D) emergency department.
Answer: A