

**Chapter 02: The Health Record as the Foundation of Coding**  
**Lovaasen: ICD-10-CM/PCS Coding: Theory and Practice, 2018 Edition**

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**MULTIPLE CHOICE**

1. Which is the area of the record where the attending physicians, as well as physician consultants, give their directives to the house staff, nursing, and ancillary services?
- a. Nursing notes
  - b. Anesthesia forms
  - c. Physician orders
  - d. Progress notes

ANS: C                    DIF: D                    REF: p. 16                    OBJ: 1  
TOP: Sections of the Health Record

2. What does EKG stand for?
- a. Electrocardiogram
  - b. Electroencephalogram
  - c. Elektrokariesogram
  - d. Electromagnetic

ANS: A                    DIF: E                    REF: p. 36                    OBJ: 1  
TOP: Abbreviations

3. Sometimes \_\_\_\_ is/are used to help diagnose a patient's condition.
- a. x-rays
  - b. history and physical
  - c. documentation
  - d. a discharge disposition

ANS: A                    DIF: M                    REF: p. 36                    OBJ: 6  
TOP: Guidelines for Diagnosis

4. Which of these is NOT considered a physician?
- a. Internist
  - b. Hospitalist
  - c. Resident
  - d. Medical student

ANS: D                    DIF: E                    REF: p. 39                    OBJ: 6  
TOP: Coding from Documentation Found in the Health Record

5. If the condition of a patient is being clinically evaluated, the coder would expect to see \_\_\_\_.
- a. an admission date
  - b. letters
  - c. clinical observations
  - d. an operative report

ANS: C                    DIF: D                    REF: p. 36                    OBJ: 4  
TOP: Guidelines for Diagnosis

6. In some cases, a patient is ready to be discharged from the hospital, but at the last minute, the patient develops a condition that requires him or her to stay an additional night. An example of when a patient might have to stay an additional night is when the patient \_\_\_\_.
- is feeling better
  - has no pain
  - has no additional cough
  - develops a fever

ANS: D                    DIF: E                    REF: p. 36                    OBJ: 4  
TOP: Guidelines for Diagnosis

7. The AHIMA practice brief says that a physician query should \_\_\_\_.
- “lead” the physician
  - contain precise language
  - be written on scratch paper
  - sound presumptive

ANS: B                    DIF: M                    REF: p. 41                    OBJ: 7  
TOP: Coding from Documentation Found in the Health Record

8. Chronic conditions include all of the following EXCEPT \_\_\_\_.
- hypertension
  - congestive heart failure
  - diverticulitis
  - emphysema
  - all of the above are correct

ANS: C                    DIF: M                    REF: p. 37                    OBJ: 4  
TOP: Reasons for Assigning Other Diagnoses

9. A query should contain all of the following items EXCEPT \_\_\_\_.
- date of service
  - amount of increased reimbursement due to query
  - patient name
  - area for provider signature

ANS: B                    DIF: M                    REF: p. 42                    OBJ: 7  
TOP: Explain the Physician Query Process

## **TRUE/FALSE**

1. It is the responsibility of a coder to extract from the health record the diagnoses and procedures for which a patient is being treated.

ANS: T                    DIF: M                    REF: p. 34                    OBJ: 5  
TOP: Standards for Diagnosis and Procedures

2. Abnormal findings (lab, x-ray, pathologic, and other diagnostic results) are always coded and reported when they are found.

ANS: F                    DIF: M                    REF: p. 38                    OBJ: 5  
TOP: Guidelines for Diagnosis

3. Every facility should have the same policies and procedures with regard to the query process.

ANS: F                    DIF: M                    REF: p. 40                    OBJ: 7  
TOP: Physician Queries in the Coding Process

4. One of the most important aspects of developing an effective query form is the manner in which the form is worded.

ANS: T                    DIF: E                    REF: p. 41                    OBJ: 7  
TOP: Physician Queries in the Coding Process

5. Principal diagnosis is one of the most important concepts for coders to understand and apply.

ANS: T                    DIF: D                    REF: p. 34                    OBJ: 2  
TOP: UHDDS Reporting Standards for Diagnosis and Procedures

## COMPLETION

1. The patient history and physical need to be performed and documented within \_\_\_\_\_ hours of admission for an inpatient encounter.

ANS: 24

DIF: E                    REF: p. 16                    OBJ: 1                    TOP: Reports in Health Records

2. A \_\_\_\_\_ is usually written by the attending physician on a daily basis to describe how the patient is progressing and the plan of care.

ANS: progress note

DIF: M                    REF: p. 16                    OBJ: 1                    TOP: Reports in Health Records

3. The reason, in the patient's own words, for presenting to the hospital is the \_\_\_\_\_.

ANS: chief complaint

DIF: M                    REF: p. 12                    OBJ: 1                    TOP: Documentation

## MATCHING

Match each definition to one of the following items.

- Accredits and certifies health care organizations
- The problem in the patient's own words
- The approach the practitioner is taking to solve the patient's problem
- The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care
- Codes reported on health insurance claim forms that should be supported by documentation in the medical record

- f. Person qualified by education and legally authorized to practice medicine
  - g. Requested by the attending physician to gain an expert opinion on the treatment of a particular aspect of the patient's condition that is outside the expertise of the attending physician
  - h. People who treat patients
  - i. The physician identifies the history, physical exam, and diagnostic tests
  - j. Where the subjective and objective combine for conclusion
  - k. Words of the patient; the reason the patient has presented to a health care facility for treatment
1. Chief complaint
  2. Physician
  3. Health care providers
  4. Current Procedural Terminology (CPT) and International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
  5. The Joint Commission
  6. Subjective
  7. Objective
  8. Assessment
  9. Plan
  10. Consultations
  11. Principal diagnosis

1. ANS: K                    DIF: M                    REF: p. 12                    OBJ: 1 | 2 | 4  
TOP: Health Record, UHDDS Reporting Standards for Diagnosis and Procedures
2. ANS: F                    DIF: M                    REF: p. 39                    OBJ: 1 | 2 | 4  
TOP: Health Record, UHDDS Reporting Standards for Diagnosis and Procedures
3. ANS: H                    DIF: M                    REF: p. 11                    OBJ: 1 | 2 | 4  
TOP: Health Record, UHDDS Reporting Standards for Diagnosis and Procedures
4. ANS: E                    DIF: M                    REF: p. 12                    OBJ: 1 | 2 | 4  
TOP: Health Record, UHDDS Reporting Standards for Diagnosis and Procedures
5. ANS: A                    DIF: M                    REF: p. 12                    OBJ: 1 | 2 | 4  
TOP: Health Record, UHDDS Reporting Standards for Diagnosis and Procedures
6. ANS: B                    DIF: M                    REF: p. 16                    OBJ: 1 | 2 | 4  
TOP: Health Record, UHDDS Reporting Standards for Diagnosis and Procedures
7. ANS: I                    DIF: M                    REF: p. 16                    OBJ: 1 | 2 | 4  
TOP: Health Record, UHDDS Reporting Standards for Diagnosis and Procedures
8. ANS: J                    DIF: M                    REF: p. 16                    OBJ: 1 | 2 | 4  
TOP: Health Record, UHDDS Reporting Standards for Diagnosis and Procedures
9. ANS: C                    DIF: M                    REF: p. 16                    OBJ: 1 | 2 | 4  
TOP: Health Record, UHDDS Reporting Standards for Diagnosis and Procedures
10. ANS: G                    DIF: M                    REF: p. 22                    OBJ: 1 | 2 | 4  
TOP: Health Record, UHDDS Reporting Standards for Diagnosis and Procedures
11. ANS: D                    DIF: M                    REF: p. 34                    OBJ: 1 | 2 | 4  
TOP: Health Record, UHDDS Reporting Standards for Diagnosis and Procedures

Match each definition to one of the following items.

- a. Centers for Medicare and Medicaid Services
- b. Temperature, pulse, and respiration
- c. Uniform Hospital Discharge Data Set

d. Gastroesophageal reflux disease

- 12. CMS
- 13. GERD
- 14. TPR
- 15. UHDDS

- 12. ANS: A                      DIF: E                      REF: p. 11                      OBJ: 5  
TOP: Abbreviations
- 13. ANS: D                      DIF: E                      REF: p. 10                      OBJ: 5  
TOP: Abbreviations
- 14. ANS: B                      DIF: E                      REF: p. 16                      OBJ: 5  
TOP: Abbreviations
- 15. ANS: C                      DIF: E                      REF: p. 34                      OBJ: 5  
TOP: Abbreviations

**SHORT ANSWER**

- 1. What does AHQA stand for?

ANS:  
American Health Quality Association

DIF: E                      REF: p. 10                      OBJ: 7                      TOP: Abbreviations

- 2. What year did the Uniform Hospital Discharge Data Set (UHDDS) mandate that hospitals must report a common core of data?

ANS:  
1974

DIF: M                      REF: p. 12                      OBJ: 5  
TOP: Guidelines for Reporting Diagnoses, Procedures

- 3. How long after admission is it required by TJC that the admission history and physical be completed?

ANS:  
Within 24 hours

DIF: E                      REF: p. 16                      OBJ: 1  
TOP: Sections of the Health Record

- 4. What is the definition of subjective complaint as it applies to a patient coming to a health care facility?

ANS:  
The problem stated in the patient's own words

DIF: E                      REF: p. 16                      OBJ: 1  
TOP: Sections of the Health Record

5. What does MRI stand for?

ANS:

Magnetic resonance imaging

DIF: E

REF: p. 36

OBJ: 6

TOP: Abbreviations

6. What is the goal of the physician query process?

ANS:

To improve physician documentation and coding professionals' understanding of the unique clinical situation

DIF: M

REF: p. 40

OBJ: 7

TOP: Physician Queries in the Coding Process

7. Which report should be written or dictated immediately following a procedure?

ANS:

Operative report

DIF: M

REF: p. 22

OBJ: 1

TOP: Sections of the Health Record

8. When coding a record, where is one of the best places to begin?

ANS:

The discharge summary if available.

DIF: M

REF: p. 39

OBJ: 1

TOP: Coding from Documentation Found in the Health Record

9. What are three of the five purposes of a health record?

ANS:

The following are purposes of a health record:

Describes the patient's health history

Serves as a method for clinicians to communicate regarding the treatment plan of care for the patient

Serves as a legal document of care and services provided

Serves as a source of data

Serves as a resource for health care practitioner education

DIF: M

REF: p. 11

OBJ: 1

TOP: Health Record

10. Give three reasons why a provider should be queried.

ANS:

A provider should be queried when documentation is conflicting, incomplete, or ambiguous.

Following are six specific instances:

1. Clinical indicators of a diagnosis but no documentation of the condition

2. Clinical evidence for a higher degree of specificity or severity
3. A cause-and-effect relationship between two conditions or organisms
4. An underlying cause when the patient is admitted with symptoms
5. Only the treatment is documented (without a diagnosis)
6. Present on admission (POA) indicator status is unknown or unclear

DIF: M                      REF: p. 40                      OBJ: 7  
TOP: Explain the Physician Query Process