Comparative Health Information Management 4th edition Peden Test Bank

SKU: 9781285871714-TEST-BANK

Chapter 02 Hospital Based Care

MULTICHOICE

1. The physician sends the patient to the hospital for a radiological examination. The patient returns to the physician's office for follow-up of test results. From the point of view of the hospital, what type of hospital patient is this?

(A) inpatient

(B) emergency outpatient

(C) clinic outpatient

(D) referred outpatient

Answer : (D)

2. What is a program for the performance of elective surgical procedures on patients who are classified as outpatients and typically are released from the surgery center on the day of surgery, thus avoiding an overnight stay in the health care facility?

(A) ambulatory surgery

(B) partial hospitalization

(C) adult day care

(D) surgery clinic

Answer : (A)

3. Medicare Part A and Part B beneficiary information is maintained in _____, allowing real-time eligibility requests for coverage using a secure closed private network to communicate with a CMS data center or via the CMS Extranet.

(A) the HIPAA Eligibility Transaction System

(B) ambulatory patient groups

(C) uniform ambulatory care data sets

(D) charge description masters

Answer : (A)

4. In the hospital setting, the term "resident" is primarily applied to _ .

(A) a licensed physician participating in an approved graduate medical education program

Comparative Health Information Management 4th edition Peden Test Bank

(B) an outpatient evaluated and treated in the observation area of the hospital

(C) a computer program that resides in RAM, used to diagnose emergency patients quickly

(D) patients enrolled in the hospital's longterm ambulatory care program

Answer : (A)

5. Select the TRUE statement below with regard to Medicare hospital outpatient reimbursement.

(A) The hospital may be paid for only one RBRVS per day per patient

(B) The hospital may be paid for only one APC per day per patient

(C) The hospital may be paid for only one APC per patient per 72 hours

(D) The hospital may be paid for more than one APC per patient visit

Answer : (D)

6. Under EMTALA, hospitals that offer emergency services _____.

(A) are free to refuse emergency services to patients who do not show proof of insurance

(B) can refuse emergency services to patients as long as another hospital agrees to accept the patient as a transfer

(C) must screen and stabilize, if necessary, any patient who arrives in the emergency department

(D) must provide emergency services free of charge to a certain number of individual to meet the EMTALA charity obligations

Answer : (C)

7. Partial hospitalization services are paid for under Ambulatory Payment Classifications (APCs) when _____.

(A) received by unstable dialysis patients in a part of the hospital where patients generally do not stay overnight

(B) psychiatric or behavioral health patients receive certain services and spend part of the day or the night in the hospital

(C) an observation patient has been in the hospital for over 48 hours and the patient's condition still does not permit discharge to home

(D) an inpatient length of stay is too short for a regular diagnosis related group (DRG) payment

Answer : (B)

8. Which of the following statements is FALSE?

(A) Documentation of telephone calls is an important element in good risk management for ambulatory care.

(B) A hospital compliance officer may be concerned with avoiding fraudulent coding and billing as well as with monitoring compliance with federal regulations such as HIPAA.

(C) Because of their knowledge of coding, health information managers can help review, revise, and maintain the hospital's chargemaster.

(D) Hospitals receive Medicare reimbursement for ambulatory care through an outpatient prospective payment system (OPPS) based on DRGs.

Answer : (D)

9. Medicare payments to long-term acute-care hospitals (LTACHs) are based on _____.

(A) LTC-DRGs

(B) PIP-DCGs

(C) DRGs

(D) RUGs

Answer : (A)

10. Which of the following statements is TRUE?

(A) Hospitals must be accredited by The Joint Commission.

(B) Hospitals must be licensed by the state in which they are located.

(C) Hospitals must have a hospitalist on staff to qualify for CMS certification.

(D) Hospitals do not have to be licensed to admit patients.

Answer : (B)

11. Without documented information on the diagnoses or symptoms that prompted a physician to order a test, the hospital lacks the information needed to demonstrate that the test was _____.

(A) performed in a timely manner

(B) professionally administered

(C) medically necessary

(D) critically assessed

Answer : (C)

12. The Joint Commission requires that the medical record contain a summary list for each patient that should include all of the following EXCEPT _____.

(A) significant medical diagnoses and conditions

(B) significant operative and invasive procedures

(C) adverse and allergic drug reactions

(D) past insurance and billing accounts with significant balances

Answer : (D)

13. Which of the following statements is FALSE in relation to documentation requirements specific to patients receiving urgent or immediate care?

(A) When emergency, urgent, or immediate care is provided, the time and means of arrival are also documented in the medical record.

(B) The medical record notes how long a patient receiving emergency, urgent, or immediate care had to wait for treatment.

(C) The medical record of a patient receiving emergency, urgent, or immediate care notes the conclusions at termination of treatment including final disposition, condition at discharge, and instructions for follow -up care.

(D) The medical record contains a copy of the information made available to practitioners or organizations providing follow-up care.

Answer : (B)

14. Which audit initiative resulted in many teaching hospitals having to repay millions of dollars to the Medicare program because they lacked documentation to substantiate Medicare payments to faculty physicians who supervised residents?

(A) PATH

(B) EMTALA

(C) MAC

(D) HOPPS

Answer : (A)

15. As required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, CMS has replaced past claims processing contractors known as fiscal intermediaries and Medicare carriers with _____.

(A) Medicare Payment Processors (MPPs)

(B) Medicare Evaluation Boards (MEBs)

(C) Medicare Administrative Contractors (MACs)

(D) Medicare Revenue Exchanges (MREs)

Answer : (C)

16. MS-DRGs differ from DRGs in that MS-DRGs take into account _____.

(A) patient demographic data such as address, insurance type, etc.

(B) various levels of patient illness using secondary diagnoses.

(C) whether the hospital is a "teaching" hospital or "nonteaching" hospital

(D) whether the patient has had any previous hospitalizations

Answer : (B)

17. When a hospital provides services to a Medicare patient as an outpatient within 72 hours before a related inpatient admission, charges for those outpatient services _____.

(A) must be billed separately from the inpatient bill

(B) must not be billed separately from the inpatient bill

(C) must be written off as "uncollectable" expenses

(D) must be billed prior to the inpatient admission

Answer : (B)

18. Which of the following statements is FALSE in relation to APC status indicators?

(A) "S" represents a significant service that is not discounted when more than one APC is present on a claim.

(B) "T" represents a significant procedure that is discounted when other procedures are performed with it.

(C) "P" represents a partial hospitalization service.

(D) "V" represents those services which are not billable under the OPPS.

Answer : (D)

19. For certain categories of encounterbased hospital outpatient services, "Composite APCs" result

in _____.

(A) only a single payment for certain common combination services provided on the same day of service

(B) individual payments for each service provided during the outpatient visit

(C) additional payments for hospital supplies and technical assistance

(D) zero payments due to the fact that these services are not covered by Medicare

Answer : (A)

20. Which of the following is NOT one of the payment mechanisms created by Medicare to discourage the transfer of patients between the LTCH and other facilities for financial rather than clinical reasons?

(A) The "Interrupted Stay" Rule

(B) The "5 Percent" Rule

(C) The "10 Day" Rule

(D) The "25 Percent" Rule

Answer : (C)

21. The standard form for submitting information to third-party payers when filing claims for hospital services is the _____.

(A) UB-04

(B) CMS 1500

(C) DRG 919

(D) APC 8000

Answer : (A)

22. HCPCS "Level II" or national codes refer to _.

(A) CPT codes

(B) ICD-9-CM codes

(C) APC codes

(D) codes that CMS developed

Answer : (D)

23. In most hospitals, the patient record starts with the _____.

(A) registration process

(B) initial evaluation by nursing staff

(C) first physician visit

(D) discharge process

Answer : (A)

24. The legislative act that provides incentives to health care providers who utilize EHRs to enhance the quality of care provided their patients is the _____.

(A) Emergency Medical Treatment and Active Labor Act (EMTALA)

(B) American Recovery and Reinvestment Act (ARRA)

(C) Health Insurance Portability and Accountability Act (HIPAA)

(D) Electronic Health Record Adoption Act (EHRAA)

Answer : (B)

25. Which of the following uses of electronic systems can enhance patient safety?

(A) Use of computerized provider order entry (CPOE) for orders directly entered by authorizing provider

(B) Record smoking status for patients 13 years old or older

(C) Check insurance eligibility electronically from public and private payers

(D) Use of voice recognition systems in radiology

Answer : (A)

26. Risk management departments protect health care organizations from financial loss that could occur as a result of _____.

(A) meaningful use activities

(B) potentially compensable events

(C) disagreements between staff members

(D) ICU patients who are transferred to LTACHs

Answer : (B)

27. Mr. Smith goes to the emergency room at Northpark Hospital complaining of chest pain. He states that he does not have health insurance and does not have the money to immediately pay for treatment. According to EMTALA, the hospital must _____.

(A) refuse to treat Mr. Smith if the ER physician is not willing to admit him to the hospital for full treatment

(B) explain all billing practices including collection agency policies before Mr. Smith can be treated

(C) screen and stabilize Mr. Smith before attempting to transfer him to another facility

(D) contact CMS to verify that Mr. Smith qualifies for public assistance

Answer : (C)

28. All of the following are potential roles for HIM professionals within a hospital setting EXCEPT _____.

(A) Performance Improvement Analyst

(B) Coding Supervisor

(C) Cancer Registrar

(D) Chief Medical Officer

(E) EHR Implementation Specialist

Answer : (D)

29. Amy Williams is the HIPAA Compliance Officer for Wayne County Hospital. In her role she will be expected to _____.

(A) audit records against codes submitted

(B) purchase supplies for the operating room suite

(C) ensure insurance information is obtained upon patient admission

(D) track patient disposition after discharge

Answer : (A)

30. The _____ involves all of the activities from pricing to selling of health care services and then collecting what is owed from the purchaser for those services.

(A) APC System

(B) Revenue Cycle

(C) HIPAA Program

(D) Utilization Review Plan

Answer : (B)

31. A computer file that contains a list of the Healthcare Common Procedural Coding System (HCPCS) codes and associated charges for the services provided to hospital patients is referred to as a _____.

(A) fiscal intermediary

(B) revenue code

(C) chargemaster

(D) status indicator

Answer : (C)

32. Dr. Moore admits Mary Knight to Tanner Hospital for observation. If he feels that Mary meets the criteria for admission as an inpatient, Dr. Moore must generally make that decision within a _____ timeframe.

(A) 12-hour

(B) 24-hour

(C) 48-hour

(D) 72-hour

Answer : (B)

33. Under an inpatient prospective payment system (IPPS) that pays a hospital according to the diagnosis related group (DRG) assigned to each patient's stay, what would the payment be for a DRG with a relative weight of 1.75 if the hospital's PPS rate is $8,225?

(A) $4,700.00

(B) $14,393.75

(C) $21,276.60

(D) Not enough information to calculate

Answer : (B)

34. The hospital outpatient prospective payment system (OPPS) allows for additional payments to be made to cover the costs of innovative medical devices, drugs, and biologicals. These payments are referred to as _____.

(A) disproportionate share hospital payments

(B) experimental incentives

(C) research and development incentives

(D) pass-through payments

Answer : (D)

35. The _____ specifies definitions and rules for selecting the principal diagnosis, other diagnoses, principal procedure, and several other elements that are critical in DRG assignment and payment for hospital-based care.

(A) UHDDS

(B) UACDS

(C) DEED

(D) NCVHS

Answer : (A)

TRUEFALSE

36. A partial hospitalization program is considered to be a type of outpatient psychiatric program.

(A) True

(B) False

Answer : (A)

37. Hospital clinics are often organized by medical specialty to facilitate medical education.

(A) True

(B) False

Answer : (A)

38. Hospital observation services may be billed to all payers as outpatient services for observation stays up to 72 hours.

(A) True

(B) False

Answer : (B)

39. For referred outpatients, the hospital provides diagnostic or therapeutic services, but it does not take responsibility for evaluating or managing the patient's care.

(A) True

(B) False

Answer : (A)

40. A hospitalist is a physician who provides comprehensive care to hospitalized patients, but who does not ordinarily see patients outside of the hospital setting.

(A) True

(B) False

Answer : (A)

41. Hospitals that meet the standards of The Joint Commission, HFAP, or DNV are deemed to meet the Conditions of Participation.

(A) True

(B) False

Answer : (A)

42. According to The Joint Commission, the records of patients receiving continuing ambulatory care services must contain a summary list of known significant diagnoses, conditions, procedures, drug allergies, and medications.

(A) True

(B) False

Answer : (A)

43. When a resident, as part of his or her graduate medical education, participates with a teaching physician in providing a service, the teaching physician cannot receive reimbursement for the service from Medicare under any circumstances.

(A) True

(B) False

Answer : (B)

44. The PATH audits demonstrated that teaching physician documentation almost always supported the level of service billed to Medicare; therefore, these audits did not result in significant reimbursement of funds to Medicare.

(A) True

(B) False

Answer : (B)

45. A hospital would likely be reimbursed for more than one APC for an emergency department patient whose visit includes evaluation and management, X-rays, and a procedure.

(A) True

(B) False

Answer : (A)

46. Charges for ancillary services, such as laboratory and radiology charges, are usually captured through the hospital chargemaster.

(A) True

(B) False

Answer : (A)

47. With regard to Medicare, hospitals should bill separately any charges for ancillary services provided on an outpatient basis within 72 hours prior to an inpatient admission.

(A) True

(B) False

Answer : (B)

48. A revenue code appropriate to the HCPCS code listed with it must be included on the bill for outpatient services or the claim may be rejected.

(A) True

(B) False

Answer : (A)

49. Voice recognition systems are becoming more common in hospital emergency departments.

(A) True

(B) False

Answer : (A)

50. Potentially compensable events (PCEs) are occurrences that may result in litigation against the health care provider or that may require the health care provider to compensate an injured party.

(A) True

(B) False

Answer : (A)

51. The hospitalist is a specialist dealing with conditions that require hospitalization and is therefore not distracted by the duties of seeing patients in the clinic setting.

(A) True

(B) False

Answer : (A)

52. Medical visits in a hospital clinic or emergency department (ED) are classified and paid according to level of service based on evaluation and management (E&M) codes assigned according to each individual hospital's own criteria.

(A) True

(B) False

Answer : (A)

53. The Healthcare Common Procedural Coding System (HCPCS) is the system required by CMS for coding hospital outpatient services provided to Medicare patients.

(A) True

(B) False

Answer : (A)

ESSAY

54. Describe the difference between licensure and accreditation?

Graders Info :

Licensure: Hospitals must be licensed by the state in which they are located. Licensure requirements vary from state to state. In some states, meeting federal standards or the standards of a voluntary accrediting agency largely fulfills licensing requirements. To obtain the licensure requirements for hospitals in a given state, a health information manager would contact the agency in that state responsible for licensure of hospitals. Often, licensure requirements are available at the state agency's website.
Accreditation: Hospitals voluntarily seek accreditation to demonstrate to their patients, to their communities, to insurers, to managed care organizations, and to others that their organizations are providing quality care. As previously mentioned, The Joint Commission, the AOA's Healthcare Facilities Accreditation Program (HFAP), and DNV Healthcare's NIAHO program offer voluntary accrediting programs whose standards and survey processes are "deemed" to be in compliance with the federal Conditions of Participation. The majority of U.S. hospitals are accredited by The Joint Commission. Of the three accrediting programs with deeming authority (TJC, HFAP, and NIAHO), the most recent addition is the NIAHO, a program of DNV Healthcare, Inc., an international organization originating in Norway. CMS granted DNV deeming authority in 2008 (DNV, 2010). The DNV approach is based on a combination of the ISO 9001 quality management protocols and the Conditions of Participation for Hospitals (Dowling, 2008). Both The Joint Commission and HFAP perform on-site surveys every three years, whereas DNV per-forms an annual on-site survey.

55. Give three examples of benefits of electronic health records in hospitals.

Graders Info :

Any three of the following:

- Use of CPOE (computerized provider order entry) for orders (any type) directly entered by authorizing provider can enhance patient safety by linking to decision support systems that warn of possible drug interactions or wrong dosages and by alerting prescribing clinicians to patient allergies.
- An EHR can generate reminders of services that a patient needs
- An EHR can alert clinicians to critical lab values or other new information that falls outside established safe values
- Big data or deep machine learning can be used for predictive analytics for patient risk factors

56. Describe three data elements for DEEDS.

Graders Info :

Any three of the following:

- Patient identification data
- Facility and practitioner identification data
- ED payment data
- ED arrival and first assessment data
- ED history and physical examination data

Comparative Health Information Management 4th edition Peden Test Bank

- ED procedure and result data
- ED medication data
- ED disposition and diagnosis data

57. Describe two roles where an HIM professional can utilize his or her skills in a hospital setting.

Graders Info :

Management, coding, release of information, utilization management, medical staff services

58. Describe the difference between the following types of patients: clinic outpatient, referred hospital outpatient, emergency outpatient

Graders Info :

a. Clinic outpatient: an outpatient treated in an organized clinic of the hospital in which hospital staff evaluate the patient and manage the patient's care
b. Referred hospital outpatient: an outpatient who is referred to the hospital for specific services, such as laboratory or radiology examinations. The hospital is responsible only for providing the diagnostic or therapeutic services requested, while the referring physician is responsible for evaluating and managing the patient's care. A related term is reference laboratory services, which is used to describe laboratory services performed for other providers. (Note that the term *referral* carries a different meaning when one physician "refers" a patient to another physician. In a physician-to-physician referral, responsibility for evaluating and managing the patient's care is often transferred from the referring to the receiving physician.)
c. Emergency outpatient: an outpatient evaluated and treated in the emergency department of the hospital

59. Describe what utilization management is and how it helps health care facilities.

Graders Info :

Utilization management focuses on the appropriateness, efficiency, and cost-effectiveness of health care. In the current climate of managed care and with prospective payment systems for Medicare in place, it is more important than ever for hospitals to be sure they are rendering services efficiently. In the past, hospitals were reimbursed based either on their costs or their charges. Now both Medicare and private payers limit the charges and costs they will pay. To operate efficiently in such an environment requires a team effort from physicians, hospital staff, and administration. In many hospitals, the staff members most directly responsible for monitoring utilization management are known as case managers. In earlier days, case managers often focused on working as liaisons between the medical staff and the patient and patient's family to make sure that necessary arrangements were made for a timely discharge. However, in recent years, the case management team's responsibilities have expanded to include working with the managed care contracting

office, decision support personnel, and health information services, in addition to their traditional role with clinicians, patients, and patients' families. In some instances, the case management team may work with health information services in clinical documentation improvement programs to help ensure that all of the documentation necessary for correct coding is present. In some hospitals, health information management professionals have administrative authority over case management services. Many hospitals maintain both utilization review and case management teams allowing staff to focus on the use of resources and the coordination of care between families and facilities as separate functions. Regardless of reporting relationships, the case management team can be an important ally to health information services.

60. Describe how a compliance officer benefits a health care facility.

Graders Info :

Having a compliance officer in place allows the facility to take a big picture look at their organization. The person in this position will review each department throughout the year and give recommendations and also assist on accreditation surveys. It is imperative that the compliance officer has full support from administration to ensure all needed changes are implemented when issues arise. This individual will work with the risk management/legal department at the facility to help avoid fines and lawsuits. Most hospitals appoint full-time compliance officers who manage the compliance program. A health information manager possesses skills ideally suited for this position. In a large hospital or academic medical center, there are many activities for which compliance may be monitored, and a number of health information professionals may serve on the compliance staff. In many hospitals, the compliance program has developed into a distinct department. Health information managers may lead the compliance department and/or work in specialized compliance areas within the department. For example, some members of the compliance staff may focus on coding and billing issues, which would require expert knowledge of documentation and coding guidelines. HIPAA compliance is another area in which a health information manager can provide expertise. To meet HIPAA requirements, hospitals should have a privacy officer and a security officer. In some hospitals, these positions are combined, and in others they are separate. In some hospitals, these responsibilities may fall under the compliance department, and in others these duties are delegated to a member of the information systems or health information services staff. A HIPAA compliance officer and his or her staff can provide HIPAA training; develop policies, procedures, and forms; or monitor the hospital's ongoing compliance with the HIPAA privacy, security, and/or EDI regulations. Auditing is also an important activity of the compliance program, whether auditing records against codes submitted, auditing release of information for appropriate authorization, or auditing the appropriateness of employee access to electronic health information, to name a few areas that may be addressed in the compliance plan. Whenever an audit identifies a problem area, plans for corrective action are developed in conjunction with the hospital service involved. Because developing an effective compliance program is a team effort involving many departments and health care professionals, good leadership skills are vital.