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## **NHA-CBCS**

**NHA Certified Billing and Coding Specialist (CBCS)**



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## Question: 1

What is APC code 8010 associated with?

- A. Mental Health Services Composite.
- B. Ancillary Outpatient Services When Patient Expires.
- C. Critical Care.
- D. Clinic Visits and Related Services

## Answer: A

Explanation:

APC code 8010 is associated with Mental Health Services Composite. APC stands for Ambulatory Payment Classification, which is a system used in the United States to classify outpatient services and procedures for the purpose of payment. The APC system is designed to categorize services that are similar in terms of clinical characteristics and resource usage, thereby standardizing payment to hospitals and clinics for outpatient services.

Specifically, APC code 8010 encompasses a range of mental health services provided in an outpatient setting. These services can include counseling, psychiatric consultations, and therapy sessions, among others. The classification under a composite code like 8010 typically means that the services grouped under this code share similarities in resource requirements and clinical complexity, which simplifies the billing and reimbursement process for healthcare providers.

The use of APC codes, including 8010 for Mental Health Services, plays a crucial role in the management of healthcare costs and resource allocation. It ensures that facilities are reimbursed fairly while also providing a structured way to monitor the types of services delivered in outpatient settings. This is particularly important in the field of mental health, where the type and frequency of services can vary widely from one patient to another.

In addition to APC 8010, there are other codes within the APC system that categorize different types of outpatient services. For example, APC 5881 relates to Ancillary Outpatient Services When Patient Expires, APC 5041 covers Critical Care, and APC 5012 includes Clinic Visits and Related Services. Each code has specific criteria and associated services, highlighting the comprehensive nature of the APC system in covering various aspects of outpatient care.

## Question: 2

HIPAA training for healthcare staff is typically divided into three levels. Level three involves management training, which would cover which of the following topics?

- A. Records used in marketing.
- B. Record audits.
- C. Facility privacy policies and procedures.
- D. Proper forms of record management.

## Answer: B

### Explanation:

HIPAA (Health Insurance Portability and Accountability Act) training for healthcare staff is crucial in ensuring the confidentiality, integrity, and availability of protected health information (PHI). This training is typically structured into three levels to cater to the different roles and responsibilities within a healthcare organization. Level three, which is targeted at management and administrative personnel, includes advanced topics that are integral to overseeing and ensuring compliance with HIPAA regulations across an organization.

One of the primary topics covered in level three training is record audits. This involves teaching management how to conduct and manage audits of health records to ensure they comply with HIPAA standards. Record audits are critical as they help identify and rectify any potential security or privacy issues, thus protecting the organization against breaches and ensuring patient trust.

Another important area covered in level three training is facility privacy policies and procedures. Managers learn how to develop, implement, and maintain privacy policies that are compliant with HIPAA. This includes understanding the nuances of patient rights and how they translate into day-to-day operations. Managers are also taught how to handle privacy breaches and the necessary steps to mitigate any damage, including proper reporting and notification procedures.

Proper forms of record management are also a key focus of level three HIPAA training. This section deals with the correct handling, storing, and disposing of PHI. Managers learn about the technological and physical safeguards that should be in place to protect health records. Additionally, they are taught about the legal requirements for retaining records and how to ensure that staff adhere to these standards. Overall, level three of HIPAA training equips management with the knowledge and tools needed to oversee comprehensive compliance programs within healthcare facilities. It ensures that senior staff members are well-prepared to handle the complexities associated with managing PHI and can guide their teams in maintaining the highest standards of privacy and security.

## Question: 3

A bypass procedure is performed. Which character would explain where the bypass is from?

- A. Fourth character.
- B. Second character.
- C. Seventh character.
- D. Sixth character.

## Answer: A

### Explanation:

The correct answer to the question "A bypass procedure is performed. Which character would explain where the bypass is from?" is the fourth character.

To understand why this is the case, it's important to recognize how medical coding, particularly with procedures like a bypass, works in systems such as the ICD-10-PCS (International Classification of Diseases, Tenth Revision, Procedure Coding System). In this coding system, each character has a specific meaning that contributes to a comprehensive description of the medical procedure performed.

In the context of a bypass procedure, the characters of the code describe various aspects of the procedure: 1. The first character denotes the section of the medical procedure. 2. The second character specifies the body system or general physiological system or anatomical region involved. 3. The third character indicates the root operation, or the objective of the procedure. 4. The fourth character is crucial for your question as it specifies the body part or the specific anatomical site from which the bypass originates. This is essential for understanding the source area of the bypass.

For example, if the bypass procedure involves rerouting blood from one part of the heart to another, the fourth character will indicate the part of the heart from which the blood is being redirected.

Thus, when coding or decoding the specifics of a bypass procedure, the fourth character is what you would refer to for details on where exactly the bypass is originating from. This character helps in identifying the source area which is critical for correct medical documentation and treatment planning.

In contrast, other characters like the sixth or seventh might describe other aspects such as the approach or the device used, and the qualifier (seventh character) often provides additional information about the procedure, such as the destination of the bypass.

## Question: 4

Brian is reviewing a chart of a patient who is having a mammogram after a recent mastectomy. Before Brian can code the procedure, he must clarify what information with the physician?

- A. If the patient has any breast implants.
- B. The patient's age.
- C. If this is the patient's first mammogram.
- D. The patient's pathology results from the surgery.

## Answer: A

Explanation:

The correct information Brian needs to clarify with the physician is whether the patient has any breast implants. This detail is crucial because the presence of breast implants can influence the specific mammogram procedure and the corresponding coding.

In the context of medical coding, accuracy is paramount, and various factors must be considered to ensure the right codes are used. For patients who have undergone mastectomy, which is the surgical removal of one or both breasts, partially or completely, the scenario changes notably if they have had breast reconstruction. Breast reconstruction often involves the use of implants to restore the breast's appearance post-mastectomy.

Therefore, knowing whether the patient has implants will help Brian determine the correct mammogram code. Different codes exist for mammograms performed on natural breasts compared to those performed on reconstructed breasts with implants. The coding differences are important because they might need to capture additional complexities associated with imaging breasts that contain implants. Mammograms in breasts with implants may require additional views or special techniques, influencing how the procedure is coded.

Should Brian find that the patient has had reconstruction with implants, he will need to select a code that appropriately reflects this, ensuring that the procedure is billed correctly and that the patient's medical records are accurate and comprehensive. This ensures not only correct billing but also proper follow-up care and appropriate medical interventions in the future.

## Question: 5

Which of the following prefixes means half?

- A. mono-
- B. supra-
- C. para-
- D. semi-

**Answer: D**

Explanation:

The correct answer to the question of which prefix means "half" is "semi-." The prefix "semi-" is derived from the Latin word "semis," which means half. It is commonly used in English to denote that something is partially or not completely the attribute described by the root word to which it is attached.

For example, "semicircle" refers to half of a circle, and "semiannual" means occurring twice a year or every half year. Similarly, "semiformal" refers to attire that is not entirely formal but is more formal than casual wear.

In contrast, the other prefixes listed have different meanings: - "Mono-" comes from Greek "monos" meaning single or alone. It is used in words like "monochrome" (one color) and "monologue" (a speech by one person). - "Supra-" comes from Latin meaning above or over. It appears in terms such as "supranational" (beyond or above national levels) and "suprarenal" (situated above the kidneys). - "Para-" also from Greek, meaning beside or alongside. It is seen in words like "parallel" (lines or planes that are side by side and have the same distance continuously between them) and "paralegal" (a person trained in subsidiary legal matters but not fully qualified as a lawyer).

Therefore, among the options provided, "semi-" is the only prefix that accurately conveys the meaning of half.

## Question: 6

In which of the following sections of the electronic health record system would medication orders/MARs be located?

- A. Signal Tracing Data.
- B. Diagnostic Image Data.
- C. Discrete, Structured, ASCII Data.
- D. Document Image Data.

**Answer: C**

Explanation:

The correct section of the electronic health record (EHR) system where medication orders/MARs (Medication Administration Records) are located is the Discrete, Structured, ASCII Data section. This section of the EHR is specifically designed to handle various forms of structured data that can be easily entered, stored, and retrieved digitally.

In the context of an EHR, different types of data are stored in specialized sections to facilitate easy access, better organization, and efficient management. The Discrete, Structured, ASCII Data section is ideal for storing text-based, structured information such as laboratory orders/results, medication orders/MARs, online charting and documentation, and detailed charges. This type of data is typically formatted in a way that allows for easy querying and analysis, which is essential for efficient healthcare management.

Other sections of the EHR, such as the Signal Tracing Data section and the Diagnostic Image Data section, serve different purposes. The Signal Tracing Data section is used for storing continuous monitoring data such as EKG, EEG, and fetal monitoring signals. These types of data are waveform-based and require different storage and retrieval technologies. The Diagnostic Image Data section is used for storing medical imaging data such as pathology images and images from nuclear medicine. This section handles large file sizes and specialized formats that are typical of imaging data.

Finally, the Document Image Data section is reserved for storing scanned images of physical documents. This includes handwritten notes, drawings, and signed patient consent forms. These items are typically non-structured and are stored as images to preserve the original format and details, which might be necessary for legal and verification purposes.

Therefore, for finding medication orders/MARs in an EHR system, one would look into the Discrete, Structured, ASCII Data section where such structured and text-based data is appropriately organized and stored. This facilitates not only the easy retrieval of information but also ensures that the data can be integrated and analyzed with other relevant patient information to provide comprehensive and effective patient care.

## Question: 7

CPT modifiers are how many characters?

- A. 1.
- B. 2.
- C. 3.
- D. 4.

**Answer: B**

**Explanation:**

CPT modifiers are used in conjunction with CPT codes, which are standardized codes used by healthcare providers to document and report medical, surgical, and diagnostic services and procedures. CPT codes themselves are 5 characters in length and can be comprised of both numbers and letters. These codes are categorized into three distinct groups: Category I, Category II, and Category III, with Category I being further subdivided into six sections, including evaluation and management, anesthesiology, surgery, radiology, pathology and laboratory, and medicine.

CPT modifiers, on the other hand, are specifically designed to provide additional information about the healthcare services provided, and they play a critical role in addressing circumstances that may affect the performed service without changing the definition of the code itself. These modifiers are essential for conveying that a service or procedure has been altered in some way, according to specific circumstances, but not changed in its definition or code.

The length of CPT modifiers is standardized at 2 characters. These characters can be either numeric or alphanumeric, depending on the specific modifier used. This concise format allows modifiers to be

directly appended to the associated CPT code, thereby efficiently providing additional details or clarifications about the service rendered. This system of coding and modification ensures a high level of specificity and accuracy in medical billing and coding, facilitating effective communication among providers, coders, and payers.

## Question: 8

Which of the following is included in HIM?

- A. Medical facility training.
- B. Auditing.
- C. Chart coding.
- D. Law making.

**Answer: C**

Explanation:

Healthcare Information Management (HIM) systems play a crucial role in managing the data related to a patient's healthcare journey. These systems encompass various processes and services designed to handle the vast amount of data and records generated in the healthcare environment.

One significant component of HIM is chart coding. Chart coding refers to the process of assigning standardized codes to various medical services, procedures, diagnoses, and treatments documented in patient charts. This coding is essential for billing and insurance purposes, ensuring that healthcare providers are reimbursed for their services. Additionally, accurate chart coding is critical for maintaining the integrity of medical records and for facilitating efficient healthcare data management.

Other aspects of HIM include the release of information, which governs how patient information is shared within and outside the healthcare facility while complying with privacy laws such as HIPAA.

Transcription, another component of HIM, involves converting voice-recorded reports as dictated by physicians or other healthcare providers into text format.

HIM impacts multiple areas including patient care, patient satisfaction, compliance with health information privacy laws (HIPAA), and the overall revenue cycle of healthcare facilities. Thus, while HIM indeed includes chart coding, it also extends to a broader range of activities that support both clinical and administrative functions within healthcare organizations.

## Question: 9

ICD-10-CM codes H60-H95 fall under what general category?

- A. Mental, behavioral, and neurodevelopmental disorders.
- B. Diseases of the nervous system.
- C. Diseases of the ear and mastoid process.
- D. Diseases of the circulatory system.

**Answer: C**

Explanation:

ICD-10-CM codes are diagnosis codes. Codes A00-B99 are related to certain infectious and parasitic diseases, C00-D49 are neoplasms, D50-D89 are diseases of the blood and blood forming organs and certain disorders involving the immune mechanism, E00-E89 is endocrine, nutritional and metabolic diseases, F01-F99 is mental, behavioral, and neurodevelopmental disorders, G00-G99 is diseases of the nervous system, H60-H95 is diseases of the ear and mastoid process, I00-I99 is diseases of the circulatory system, J00-J99 is diseases of the respiratory system, K00-K95 is diseases of the digestive system, L00-L99 is diseases of the skin and subcutaneous tissue, M00-M99 is diseases of the musculoskeletal system and connective tissue, N00-N99 is diseases of the genitourinary system, O00-O99 is pregnancy, childbirth and the puerperium, P00-P96 is certain conditions originating in the prenatal period, Q00-Q99 is congenital malformations, deformation and chromosomal abnormalities, R00-R99 is symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified, S00-T88 is injury, poisoning and certain other consequences of external causes, V00-Y99 is external causes of morbidity, and Z00-Z99 is factors influencing health status and contact with health services.

## Question: 10

A CMAA tells the patient's family that she is a nurse. This would be considered which of the following?

- A. invasion of privacy
- B. fraud
- C. slander
- D. none of the above

## Answer: B

Explanation:

Fraud involves a deliberate deception made for personal gain or to damage another individual. This definition encompasses a range of actions, from lying about one's qualifications to misrepresenting facts to secure financial or other benefits. In the scenario provided, if a Certified Medical Administrative Assistant (CMAA) claims to be a nurse to the patient's family, she is misrepresenting her qualifications and position. This act of fraud can lead to various negative outcomes, including potential harm to the patient due to the family's misplaced trust in the CMAA's medical knowledge and skills, which are different from those of a licensed nurse.

In the medical field, accuracy in one's professional identity is crucial as it directly impacts patient care and trust. By presenting herself as a nurse, the CMAA could be trusted by the family to make medical decisions or perform clinical tasks for which she is not qualified or legally authorized. This not only endangers the patient but also undermines the trust in healthcare professionals, as family members might assume that all staff members are equally qualified to discuss and manage health conditions. Furthermore, such fraudulent behavior can have legal implications. Misrepresenting oneself as a nurse is punishable by law in many jurisdictions because it involves practicing medicine without a license, which can lead to fines and legal charges against the individual.

Therefore, in this scenario, identifying the CMAA's claim as fraud is essential not only to correct any misunderstandings but also to uphold ethical standards and legal requirements in healthcare settings. It ensures that all medical personnel are accurately representing their qualifications and capabilities, thereby safeguarding patient care and trust in medical institutions.

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