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# AHIMA

## AHIMA-CCS

### Certified Coding Specialist (CCS)



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## Question: 1

A patient presents with a severe allergic reaction after consuming shellfish. The physician documents anaphylaxis and administers epinephrine. What is the significance of CAC in this coding scenario?

- A. It can suggest relevant diagnosis and procedure codes.
- B. It can provide alerts for potential drug interactions.
- C. It can generate patient education materials.
- D. It can track the patient's allergy history.

## Answer: A

Explanation:

CAC's significance lies in its ability to suggest relevant diagnosis and procedure codes based on the physician's documentation of anaphylaxis and the administration of epinephrine. This ensures that the coding accurately reflects the patient's acute condition.

## Question: 2

A patient is admitted with acute renal failure due to dehydration secondary to vomiting. What is the principal diagnosis for coding?

- A. N18.9
- B. N17.9
- C. E86.0
- D. R11.2

## Answer: B

Explanation:

The principal diagnosis is N17.9 (Acute kidney failure, unspecified), as it directly relates to the patient's condition leading to the admission. Dehydration can be documented as a secondary diagnosis.

## Question: 3

A healthcare provider is conducting an internal audit of its compliance with HIPAA privacy rules. Which of the following practices should be prioritized to ensure adherence to the Minimum Necessary Standard?

- A. Implementing role-based access controls
- B. Allowing all staff to access all patient records

- C. Storing all patient records in a single location
- D. Using paper records instead of electronic records

**Answer: A**

Explanation:

Implementing role-based access controls is essential for ensuring that only authorized personnel can access specific patient records based on their job responsibilities. This practice aligns with the Minimum Necessary Standard under HIPAA.

### Question: 4

A health system is evaluating its risk analysis process under the HIPAA Security Rule. Which element must be included for compliance?

- A. Conduct regular and thorough evaluations of potential threats and vulnerabilities to ePHI
- B. Assess risks to ePHI only when a breach occurs
- C. Wait for federal audits to dictate security assessments
- D. Limit the scope of assessment to physical security only

**Answer: A**

Explanation:

HIPAA mandates ongoing risk analysis to identify potential threats to electronic protected health information and evaluate vulnerabilities so that adequate security plans can be implemented proactively.

### Question: 5

A patient with a history of hypertension is seen for a routine check-up. The physician documents “hypertensive heart disease” but does not specify the stage. What is the appropriate coding action?

- A. Code hypertensive heart disease as unspecified
- B. Code only hypertension
- C. Do not code the condition
- D. Query for the stage of hypertensive heart disease

**Answer: A**

Explanation:

In the absence of specific staging information, the coder should code hypertensive heart disease as unspecified. This is compliant with coding guidelines when detailed documentation is lacking.

### Question: 6

In a case where "rule out deep vein thrombosis (DVT)" is documented in the discharge summary without confirmatory ultrasound, what is appropriate coding?

- A. Code leg swelling symptom and do not code DVT
- B. Code suspected DVT with discharge diagnosis
- C. Query physician for diagnosis confirmation
- D. Code DVT as principal diagnosis

**Answer: A**

Explanation:

Coding guidelines prohibit coding "rule out" diagnoses. Without ultrasound confirmation or definitive physician diagnosis, coders should code symptoms like leg swelling, not the suspected DVT.

### Question: 7

A patient has a laparoscopic gastric bypass surgery performed. What is the appropriate ICD-10-PCS code?

- A. 0DBD4ZZ
- B. 0DBD3ZZ
- C. 0DBD0ZZ
- D. 0DBD1ZZ

**Answer: C**

Explanation:

The correct code is 0DBD0ZZ, which indicates a laparoscopic gastric bypass. The root operation is "Bypass," and it is performed via a laparoscopic approach.

### Question: 8

Inpatient myositis: CK 5000 U/L, MRI muscle edema, EMG fibrillations. Rheum: "dermatomyositis probable." Skin rash photo missing. Ambiguous. Query for?

- A. Confirm M33.00 with skin involvement for immunosuppressant
- B. Use CK for rhabdo
- C. Await biopsy
- D. Code M62.81 muscle disorder

**Answer: A**

Explanation:

Indicators support DM; query Bohan criteria, inpatient steroid dosing, vs. outpatient's ANA titer review.

## Question: 9

A facility's quarterly report shows SOI/ROM scores lagging national medians (SOI 1.8 vs. 2.1) due to undercaptured comorbidities in oncology cases, e.g., neutropenia (ANC 800/ $\mu$ L) not linked to chemotherapy, affecting MS-DRG 847-849. How does targeted CDI impact CMI?

- A. Decreases CMI due to higher scrutiny on query rates.
- B. No significant change, as oncology DRGs are fixed-weight.
- C. Increases CMI by elevating base DRG weight through CC addition for neutropenia.
- D. Only affects ROM, not SOI or CMI.

## Answer: C

Explanation:

Neutropenia as CC (D70.3) in chemo patients elevates SOI/ROM per 3M APR-DRG logic and MS-DRG 847 (chemo w/o acute leukemia w CC), increasing relative weight from 1.2 to 1.8, thus CMI. (uplift per HFMA 2024 study) and OCM risk adjustment. Fixed-weight myth ignores CC impact.

## Question: 10

Under the Hospital-Acquired Condition Reduction Program, how is penalty status determined?

- A. Hospitals in the worst performing quartile based on HAC measures receive payment reductions
- B. Penalties are assessed only on procedures with documented infections
- C. HAC reductions are voluntary and have no financial impact
- D. Hospitals are penalized only if HAC rates exceed national average by 50%

## Answer: A

Explanation:

The program cuts payments for the lowest performing hospitals (bottom 25%) on HAC measures. The penalty is not solely based on fixed thresholds or specific procedures but overall performance. Penalties are mandatory, not voluntary.

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