Chapter 006 Insurance and Coding

**Multiple Choice Questions**

1. The greater the medical insurance coverage, the more \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the plan.   
A. quality  
B. expensive  
C. inexpensive  
D. friendly

2. The Birthday Rule insures that the maximum benefit will not exceed \_\_\_\_\_\_ percent of the charge for covered services.   
A. 20  
B. 50  
C. 100  
D. 80

3. According to contract law, when a physician agrees to treat a patient who is seeking medical services, there is a(n) \_\_\_\_\_\_\_\_\_\_\_\_ contract between the two.   
A. Unwritten  
B. Written  
C. Verbal  
D. Agreed

4. The rate charged to the policy-holder for the insurance policy is the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
A. Statement  
B. Deductible  
C. Co-pay  
D. Premium

5. Select the type of insurance plan that generally includes coverage of hospitalization, lab tests, surgery, and x-rays.   
A. Limited  
B. General  
C. Basic  
D. Liability

6. \_\_\_\_\_\_\_\_ payment is made by the insurance carrier after the patient has received medical services.   
A. Fee-for-services  
B. Co-pay  
C. Deductible  
D. Capitation

7. Patient John Parks had a CBC and a PFT performed. Which type of insurance will cover the services?   
A. Major medical  
B. Surgical  
C. Basic  
D. Disability

8. Which type of payment is made in advance?   
A. Co-pay  
B. Capitation  
C. Fee-for-service  
D. Deductible

9. The oldest form of managed care is:   
A. HMO  
B. PPO  
C. PPD  
D. HPO

10. PPOs do or do not require referrals to specialists.   
A. Do  
B. Do not

11. Which is the longest private-sector payer in the US?   
A. UHC  
B. Well Point  
C. Aetna  
D. BCBS

12. A physician who joins an insurance plan is a(n) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
A. participating provider  
B. nonparticipating provider  
C. active provider  
D. attending provider

13. A physician who accepts an assignment of benefits agrees to receive payment directly from the \_\_\_\_\_\_\_\_\_\_.   
A. Benefit coordinator  
B. Patient  
C. Patient's insurance carrier  
D. Patient plan

14. Hope's insurance policy states she has a coinsurance of 90/10 of covered services. When she received her notice from the insurance carrier, it stated that the charges for her last office visit were not allowed. How much of the charges is Hope responsible for?   
A. 90%  
B. 10%  
C. 0%  
D. 100%

15. Under his insurance plan, Scott is required to have prior approval for his upcoming knee replacement. Before the surgery, the surgeon must have which approval document from the insurance carrier for the surgery?   
A. Informed consent  
B. Expressed consent  
C. Patient encounter form  
D. Preauthorization/precertification approval

16. Carol and her husband, Greg, just had a baby. Carol is laid off from her job and Greg works part-time at a gas station. They are without insurance coverage. The administrative medical assistant should supply Carol and Greg with information to contact:   
A. Medicare  
B. Medicaid  
C. TRICARE  
D. CHAMPVA

17. Dr. Rodriguez receives payment from BCBS for services rendered to patients covered by the plan. This is known as:   
A. Assignment of benefits  
B. Accepting assignment  
C. Balance billing  
D. Preauthorization of services

18. If the standard fee for a Medicare covered service is $150 and the Medicare non-PAR fee schedule for the service is $80, what is the limiting charge for the services?   
A. $120  
B. $92  
C. $30  
D. $50

19. Which type of fee is a charge for a certain procedure?   
A. Customary  
B. Usual  
C. Reasonable  
D. Service

20. Which type of fee is determined by what physicians with similar training and experience in certain geographic location typically charge for a procedure?   
A. Usual  
B. Customary  
C. Reasonable  
D. Service

21. Which type of fee is approved by the insurance carrier for a difficult or complicated service?   
A. Usual  
B. Customary  
C. Reasonable  
D. Service

22. The payment system used by Medicare is the \_\_\_\_\_\_\_\_\_\_.   
A. Relative value scale  
B. Resource-based relative value scale  
C. National relative value limit  
D. Diagnosis relative scale

 23. How many coding systems are used to keep track of the many thousands of possible diagnoses and of procedures and services by the physicians, and to simplify the process of verifying the medical necessity of each procedure?   
A. Three  
B. Six  
C. Four  
D. Two

24. Which type of code is reporting what is wrong with the patient or what brought the patient to see the physician?   
A. Diagnostic  
B. Procedural  
C. HCPCS  
D. Medical

25. Which type of code is for reporting each procedure and service that the physician has performed in treating the patient?   
A. Diagnostic  
B. Procedural  
C. HCPCS  
D. Medical

26. Codes used for the diagnosis of external causes, such as poisonings and injuries, are known as:   
A. V codes  
B. HCPCS codes  
C. Evaluation and management codes  
D. E codes

27. Michael last visited his physician, which is a single-physician office practice, in September 2006. He is at the office today for a sore throat and chest congestion. Since he was already a patient, the medical insurance coder submitted an established patient E/M code to Michael's insurance carrier for payment. The insurance carrier requested additional documentation regarding the visit. Which of the following may have been the reason?   
A. Michael's visit should have been coded from the HCPCS code selections.  
B. The medical insurance coder did not submit the claim to the insurance carrier on the actual day of Michael's visit.  
C. Michael's visit should have been coded from the new patient E/M category.  
D. There was no reason for the insurance carrier to request the additional documentation.

28. During Michael's sick visit a CBC was performed. Which type of code(s) should be used for the service?   
A. Unbundled code  
B. E codes  
C. Bundled code  
D. Medicine code

29. The Evaluation and Management section of procedure codes should fall within which range of codes?   
A. 90281-99607  
B. 70010-79999  
C. 80047-89398  
D. 99201-99499

30. The Anesthesiology section of procedure codes should fall within which range of codes?   
A. 90281-99607  
B. 100121-79999  
C. 00100-01999, 99100-99140  
D. 99201-99499

31. The Surgery section of procedure codes should fall within which range of codes?   
A. 90281-99607  
B. 100121-69990  
C. 00100-01999, 99100-99140  
D. 99201-99499

32. The Radiology section of procedure codes should fall within which range of codes?   
A. 70010-79999  
B. 100121-69990  
C. 80047-89398  
D. 99201-99499

33. The Pathology and Laboratory section of procedure codes should fall within which range of codes?   
A. 70010-79999  
B. 100121-69990  
C. 80047-89398  
D. 99201-99499

34. CPT codes are \_\_\_\_\_\_-digit numbers.   
A. Five  
B. Six  
C. Seven  
D. Eight

35. ICD-9-CM codes have been revised \_\_\_\_\_\_ times.   
A. One  
B. Nine  
C. Three  
D. Five

36. Updates of the ICD-9-CM are published \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
A. Every 3 years  
B. Every 10 years  
C. Every 5 years  
D. Every year

37. The ICD-9-CM uses \_\_\_\_\_\_\_\_-digit codes for broad categories of diseases, injuries, and symptoms.   
A. Two  
B. Three  
C. Four  
D. Five

38. Updated CPT books are published \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
A. Every three years  
B. Every 10 years  
C. Every 5 years  
D. Every year

39. The implementation date for the ICD-10 code is set for:   
A. October 1, 2013  
B. December 1, 2012  
C. January 1, 2013  
D. December 1, 2013

40. Which of the following is not an advantage of ICD-10?   
A. A higher level of specificity  
B. Expansion of and within the categories  
C. Increased number of bilateral codes  
D. Fewer and more concise categories

41. The Medicine (except Anesthesiology) section of procedure codes should fall within which range of codes?   
A. 70010-79999  
B. 100121-69990  
C. 90281-99607  
D. 99201-99499

**Fill in the Blank Questions**

42. The \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ permits the specification of a diagnosis code as exactly as possible.   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

43. A(n) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is the form used in the medical office to record the patient's diagnosis (or diagnoses) and the procedures performed during a patient's visit.   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

44. CM in ICD-9-CM stands for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

45. ICD stands for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

46. ICD-9-CM codes are assigned and updated by the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

47. Volume 1 of the ICD-9-CM book is the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

48. Volume 2 of the ICD-9-CM book is the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

49. Volume 3 of the ICD-9-CM book is the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

50. The CPT-4 book is published by the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

51. CPT-4 stands for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

52. A coding system that uses both all the codes in the CPT and additional codes that cover many supplies, such as sterile trays and durable medical equipment is known as\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

53. An analysis done in order to determine the connection between the diagnostic and procedural information is known as \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

54. \_\_\_\_\_\_\_\_ is the organization that administers Medicare and Medicaid.   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

55. A(n) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is a stated amount an insured must pay for an insurance policy.   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Multiple Choice Questions**

**Answers**

1.*(p. 223)* The greater the medical insurance coverage, the more \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the plan.   
A. quality  
**B.** expensive  
C. inexpensive  
D. friendly

The greater the medical insurance coverage, the more expensive the plan.

2.*(p. 223)* The Birthday Rule insures that the maximum benefit will not exceed \_\_\_\_\_\_ percent of the charge for covered services.   
A. 20  
B. 50  
**C.** 100  
D. 80

The Birthday Rule insures that the maximum benefit will not exceed 100 percent of the charge for covered services.

3.*(p. 222)* According to contract law, when a physician agrees to treat a patient who is seeking medical services, there is a(n) \_\_\_\_\_\_\_\_\_\_\_\_ contract between the two.   
**A.** Unwritten  
B. Written  
C. Verbal  
D. Agreed

According to contract law, when a physician agrees to treat a patient who is seeking medical service, there is an unwritten contract between the two.

4.*(p. 222)* The rate charged to the policy-holder for the insurance policy is the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
A. Statement  
B. Deductible  
C. Co-pay  
**D.** Premium

The rate charged to the policy-holder for the insurance policy is the premium.

5.*(p. 223)* Select the type of insurance plan that generally includes coverage of hospitalization, lab tests, surgery, and x-rays.   
A. Limited  
B. General  
**C.** Basic  
D. Liability

The basic insurance plan that generally includes coverage of hospitalization, lab tests, surgery, and x-rays.

6.*(p. 223)* \_\_\_\_\_\_\_\_ payment is made by the insurance carrier after the patient has received medical services.   
**A.** Fee-for-services  
B. Co-pay  
C. Deductible  
D. Capitation

Fee-for-services payment is made by the insurance carrier after the patient has received medical services.

7.*(p. 223)* Patient John Parks had a CBC and a PFT performed. Which type of insurance will cover the services?   
A. Major medical  
B. Surgical  
**C.** Basic  
D. Disability

Basic insurance will cover a CBC and a PFT.

8.*(p. 224)* Which type of payment is made in advance?   
A. Co-pay  
**B.** Capitation  
C. Fee-for-service  
D. Deductible

Capitation is a type of payment made in advance for services.

9.*(p. 225)* The oldest form of managed care is:   
**A.** HMO  
B. PPO  
C. PPD  
D. HPO

The oldest form of managed care is the HMO.

10.*(p. 227)* PPOs do or do not require referrals to specialists.   
A. Do  
**B.** Do not

PPOs do not require referrals to specialists.

11.*(p. 227)* Which is the longest private-sector payer in the US?   
A. UHC  
B. Well Point  
C. Aetna  
**D.** BCBS

BCBS is the longest private-sector payer in the US.

12.*(p. 230)* A physician who joins an insurance plan is a(n) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
**A.** participating provider  
B. nonparticipating provider  
C. active provider  
D. attending provider

A physician who joins an insurance plan is a participating provider.

13.*(p. 231)* A physician who accepts an assignment of benefits agrees to receive payment directly from the \_\_\_\_\_\_\_\_\_\_.   
A. Benefit coordinator  
B. Patient  
**C.** Patient's insurance carrier  
D. Patient plan

A physician who accepts an assignment of benefits agrees to receive payment directly from the patient's insurance carrier.

14.*(p. 225)* Hope's insurance policy states she has a coinsurance of 90/10 of covered services. When she received her notice from the insurance carrier, it stated that the charges for her last office visit were not allowed. How much of the charges is Hope responsible for?   
A. 90%  
B. 10%  
C. 0%  
**D.** 100%

When a patient has a coinsurance of 90/10, the insurance company will pay at 90% and the patient will be responsible for 10% of the charges unless it is a non-covered service.

15.*(p. 225)* Under his insurance plan, Scott is required to have prior approval for his upcoming knee replacement. Before the surgery, the surgeon must have which approval document from the insurance carrier for the surgery?   
A. Informed consent  
B. Expressed consent  
C. Patient encounter form  
**D.** Preauthorization/precertification approval

A surgeon must have a preauthorization/precertification approval document from the insurance carrier when prior approval is required.

16.*(p. 228)* Carol and her husband, Greg, just had a baby. Carol is laid off from her job and Greg works part-time at a gas station. They are without insurance coverage. The administrative medical assistant should supply Carol and Greg with information to contact:   
A. Medicare  
**B.** Medicaid  
C. TRICARE  
D. CHAMPVA

Uninsured, low-income families with children may qualify for Medicaid.

17.*(p. 231)* Dr. Rodriguez receives payment from BCBS for services rendered to patients covered by the plan. This is known as:   
**A.** Assignment of benefits  
B. Accepting assignment  
C. Balance billing  
D. Preauthorization of services

A physician who accepts an assignment of benefits agrees to receive payment directly from the patient's insurance carrier.

18.*(p. 232)* If the standard fee for a Medicare covered service is $150 and the Medicare non-PAR fee schedule for the service is $80, what is the limiting charge for the services?   
A. $120  
**B.** $92  
C. $30  
D. $50

The limiting charge is 115 percent of the fee listed in the nonPAR Medicare fee schedule.

19.*(p. 233)* Which type of fee is a charge for a certain procedure?   
A. Customary  
**B.** Usual  
C. Reasonable  
D. Service

A usual fee is a charge for a certain procedure.

20.*(p. 233)* Which type of fee is determined by what physicians with similar training and experience in certain geographic location typically charge for a procedure?   
A. Usual  
**B.** Customary  
C. Reasonable  
D. Service

A customary fee is determined by what physicians with similar training and experience in a certain geographic location typically charge for a procedure.

21.*(p. 233)* Which type of fee is approved by the insurance carrier for a difficult or complicated service?   
A. Usual  
B. Customary  
**C.** Reasonable  
D. Service

A reasonable fee is one that is approved by the insurance carrier for a difficult or complicated service.

22.*(p. 233)* The payment system used by Medicare is the \_\_\_\_\_\_\_\_\_\_.   
A. Relative value scale  
**B.** Resource-based relative value scale  
C. National relative value limit  
D. Diagnosis relative scale

The payment system used by Medicare is the resource-based relative value scale.

23.*(p. 234)* How many coding systems are used to keep track of the many thousands of possible diagnoses and of procedures and services by the physicians, and to simplify the process of verifying the medical necessity of each procedure?   
A. Three  
B. Six  
C. Four  
**D.** Two

There are two coding systems are used to keep track of the many thousands of possible diagnoses and of procedures and services by the physicians, and to simplify the process of verifying the medical necessity of each procedure.

24.*(p. 234)* Which type of code is reporting what is wrong with the patient or what brought the patient to see the physician?   
**A.** Diagnostic  
B. Procedural  
C. HCPCS  
D. Medical

Diagnostic codes are used when reporting what is wrong with the patient or why they are seeing the physician.

25.*(p. 234)* Which type of code is for reporting each procedure and service that the physician has performed in treating the patient?   
A. Diagnostic  
**B.** Procedural  
C. HCPCS  
D. Medical

Procedural codes are used when reporting each procedure and service that the physician has performed in treating a patient.

26.*(p. 237)* Codes used for the diagnosis of external causes, such as poisonings and injuries, are known as:   
A. V codes  
B. HCPCS codes  
C. Evaluation and management codes  
**D.** E codes

E codes are used for the diagnosis of external causes, such as poisonings and injuries.

27.*(p. 241)* Michael last visited his physician, which is a single-physician office practice, in September 2006. He is at the office today for a sore throat and chest congestion. Since he was already a patient, the medical insurance coder submitted an established patient E/M code to Michael's insurance carrier for payment. The insurance carrier requested additional documentation regarding the visit. Which of the following may have been the reason?   
A. Michael's visit should have been coded from the HCPCS code selections.  
B. The medical insurance coder did not submit the claim to the insurance carrier on the actual day of Michael's visit.  
**C.** Michael's visit should have been coded from the new patient E/M category.  
D. There was no reason for the insurance carrier to request the additional documentation.

A patient is considered a "new patient" if that person has not received professional services from the physician or a physician of the same specialty practicing within the same group in the past three years.

28.*(p. 243-244)* During Michael's sick visit a CBC was performed. Which type of code(s) should be used for the service?   
A. Unbundled code  
B. E codes  
**C.** Bundled code  
D. Medicine code

A bundled code is a code used for group of related procedures such as a laboratory panel or test.

29.*(p. 239)* The Evaluation and Management section of procedure codes should fall within which range of codes?   
A. 90281-99607  
B. 70010-79999  
C. 80047-89398  
**D.** 99201-99499

The Evaluation and Management codes fall in the range of codes 99201-99499.

30.*(p. 239)* The Anesthesiology section of procedure codes should fall within which range of codes?   
A. 90281-99607  
B. 100121-79999  
**C.** 00100-01999, 99100-99140  
D. 99201-99499

The Anesthesiology codes fall in the range of codes 00100-01999, 99100-99140.

31.*(p. 239)* The Surgery section of procedure codes should fall within which range of codes?   
A. 90281-99607  
**B.** 100121-69990  
C. 00100-01999, 99100-99140  
D. 99201-99499

The Surgery codes fall in the range of codes 100121-79999.

32.*(p. 239)* The Radiology section of procedure codes should fall within which range of codes?   
**A.** 70010-79999  
B. 100121-69990  
C. 80047-89398  
D. 99201-99499

The Radiology codes fall in the range of codes 70010-79999.

33.*(p. 239)* The Pathology and Laboratory section of procedure codes should fall within which range of codes?   
A. 70010-79999  
B. 100121-69990  
**C.** 80047-89398  
D. 99201-99499

The Pathology and Laboratory codes fall in the range of codes 80047-89398.

34.*(p. 239)* CPT codes are \_\_\_\_\_\_-digit numbers.   
**A.** Five  
B. Six  
C. Seven  
D. Eight

CPT codes are five digit numbers.

35.*(p. 234)* ICD-9-CM codes have been revised \_\_\_\_\_\_ times.   
A. One  
**B.** Nine  
C. Three  
D. Five

ICD-9-CM codes have been revised nine times.

36.*(p. 234)* Updates of the ICD-9-CM are published \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
A. Every 3 years  
B. Every 10 years  
C. Every 5 years  
**D.** Every year

Updates of the ICD-9-CM are published every year.

37.*(p. 234)* The ICD-9-CM uses \_\_\_\_\_\_\_\_-digit codes for broad categories of diseases, injuries, and symptoms.   
A. Two  
**B.** Three  
C. Four  
D. Five

The ICD-9-CM uses three-digit codes for broad categories of disease, injuries, and symptoms.

38.*(p. 238)* Updated CPT books are published \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
A. Every three years  
B. Every 10 years  
C. Every 5 years  
**D.** Every year

Updated CPT books are published every year.

39.*(p. 244)* The implementation date for the ICD-10 code is set for:   
**A.** October 1, 2013  
B. December 1, 2012  
C. January 1, 2013  
D. December 1, 2013

The implementation date for the ICD-10 code is set for October 1, 2013.

40.*(p. 244)* Which of the following is not an advantage of ICD-10?   
A. A higher level of specificity  
B. Expansion of and within the categories  
C. Increased number of bilateral codes  
**D.** Fewer and more concise categories

More categories and codes have been added than what are in the ICD-9-CM.

41.*(p. 239)* The Medicine (except Anesthesiology) section of procedure codes should fall within which range of codes?   
A. 70010-79999  
B. 100121-69990  
**C.** 90281-99607  
D. 99201-99499

The Medicine (except Anesthesiology) codes fall in the range of codes 90281-99607.

**Fill in the Blank Questions**

42.*(p. 234)* The \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ permits the specification of a diagnosis code as exactly as possible.   
**Sub-classification suffix**

The sub-classification suffix permits the specification of a diagnosis code as exactly as possible.

43.*(p. 234)* A(n) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is the form used in the medical office to record the patient's diagnosis (or diagnoses) and the procedures performed during a patient's visit.   
**Patient encounter form**

A patient encounter form is the form used in the medical office to record the patient's diagnosis (or diagnoses) and the procedures performed during a patient's visit.

44.*(p. 234)* CM in ICD-9-CM stands for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
**Clinical modification**

CM in the ICD-9-CM stands for clinical modification.

45.*(p. 234)* ICD stands for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
**International Classification of Diseases**

ICD stands for International Classification of Diseases.

46.*(p. 234)* ICD-9-CM codes are assigned and updated by the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
**World Health Organization of the United Nations**

ICD-9-CM codes are assigned and updated by the World Health Organization of the United Nations.

47.*(p. 235)* Volume 1 of the ICD-9-CM book is the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
**Diseases: Tabular List**

Volume 1 of the ICD-9-CM book is the Disease: Tabular List.

48.*(p. 235)* Volume 2 of the ICD-9-CM book is the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
**Diseases: Alphabetic Index**

Volume 2 of the ICD-9-CM book is the Diseases: Alphabetic Index.

49.*(p. 235)* Volume 3 of the ICD-9-CM book is the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
**Procedures: Tabular List**

Volume 3 of the ICD-9-CM book is the Procedure: Tabular List.

50.*(p. 238)* The CPT-4 book is published by the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
**American Medical Association**

The CPT-4 book is published by the American Medical Association.

51.*(p. 238)* CPT-4 stands for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
**Current Procedural Terminology, fourth edition**

CPT-4 stands for *Current Procedural Terminology, fourth edition*.

52.*(p. 242)* A coding system that uses both all the codes in the CPT and additional codes that cover many supplies, such as sterile trays and durable medical equipment is known as\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
**HCPCS**

A coding system that uses both all the codes in the CPT and additional codes that cover many supplies, such as sterile trays and durable medical equipment is known as HCPCS.

53.*(p. 243)* An analysis done in order to determine the connection between the diagnostic and procedural information is known as \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
**Code linkage**

An analysis done in order to determine the connection between the diagnostic and procedural information is known as code linkage.

54.*(p. 231)* \_\_\_\_\_\_\_\_ is the organization that administers Medicare and Medicaid.   
**CMS**

CMS is the organization that administers Medicare and Medicaid.

55.*(p. 222)* A(n) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is a stated amount an insured must pay for an insurance policy.   
**Premium**

A premium is a stated amount an insured must pay for an insurance policy.