

AHIMA Certified Coding Specialist - Physician-based (CCS-P) Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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SAMPLE

Questions

SAMPLE

- 1. What does it mean when a claim is “denied”?**
 - A. The insurance company refuses to pay for the services billed**
 - B. The claim has been delayed for further investigation**
 - C. The claim has been approved but with adjustments**
 - D. The claim is pending review by a supervisor**
- 2. What is the practice of clustering in medical coding?**
 - A. Coding a wide range of services**
 - B. Coding only for low-level services**
 - C. Coding one or two middle levels of service for all encounters**
 - D. Coding exclusively for high-level services**
- 3. When can radiology reports be utilized for coding purposes?**
 - A. For clarifying billing disputes**
 - B. When used to clarify an outpatient diagnosis**
 - C. For establishing patient treatment plans**
 - D. Only during emergency situations**
- 4. What must practices ensure when establishing fee schedules?**
 - A. Charge less than competitor rates**
 - B. Align with government requirements**
 - C. Avoid billing below payer rates**
 - D. Include additional service fees**
- 5. What is the primary purpose of a fee schedule in a medical practice?**
 - A. Determining staff salaries**
 - B. Managing reimbursements for services**
 - C. Calculating annual expenses**
 - D. Hiring additional service providers**

- 6. What does the abbreviation “CMS” stand for in healthcare?**
- A. Central Medical Services**
 - B. Centers for Medicare and Medicaid Services**
 - C. Comprehensive Medical Solutions**
 - D. Clinical Management System**
- 7. What action should an office manager take if unbundling practices are discovered?**
- A. Initiate training for coding staff**
 - B. Refund overpayments from a third-party payer**
 - C. Document unbundled services**
 - D. File complaints with the OIG**
- 8. What section of a POMR serves as a “Table of Contents”?**
- A. Progress Notes**
 - B. Problem List**
 - C. Medical History**
 - D. Initial Plan**
- 9. What essential aspect should healthcare providers focus on to ensure coding compliance?**
- A. Using the most advanced technology**
 - B. Regular training on coding guidelines**
 - C. Increasing patient volume**
 - D. Reducing operational costs**
- 10. What does the term "limiting charge" refer to in relation to Medicare providers?**
- A. Maximum charges allowed for any service**
 - B. A cap on total annual billing**
 - C. The excess amount a NON PAR provider can collect over the approved amount**
 - D. Fees for expedited claims processing**

Answers

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1. A
2. C
3. B
4. C
5. B
6. B
7. B
8. B
9. B
10. C

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Explanations

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1. What does it mean when a claim is “denied”?

- A. The insurance company refuses to pay for the services billed**
- B. The claim has been delayed for further investigation**
- C. The claim has been approved but with adjustments**
- D. The claim is pending review by a supervisor**

When a claim is described as “denied,” it indicates that the insurance company has determined that it will not provide payment for the services that have been billed. This situation can arise for various reasons, such as the service not being covered under the patient’s policy, lack of medical necessity, incorrect coding, or a failure to meet the insurance company’s guidelines or requirements. Understanding what a denial means is crucial for healthcare providers and coding specialists, as it emphasizes the need to review and potentially appeal the denial based on the specific reasons provided by the insurer. Other scenarios, such as claims being delayed for further investigation, approved but with adjustments, or pending review by a supervisor, do not reflect a denial but rather indicate different stages of the claims process. Each of these situations can involve communication and possible action required from the healthcare provider or coding staff, but they do not represent a refusal to pay the claim outright.

2. What is the practice of clustering in medical coding?

- A. Coding a wide range of services**
- B. Coding only for low-level services**
- C. Coding one or two middle levels of service for all encounters**
- D. Coding exclusively for high-level services**

Clustering in medical coding refers specifically to the practice of coding one or two middle levels of service for all encounters. This approach is utilized to maintain a consistent coding strategy across similar patient encounters, regardless of the actual complexity or level of service provided during those encounters. By coding at a predetermined level rather than adjusting based on the specific details of each service, this practice can streamline the coding process, but it may also lead to potential inaccuracies in representing the services rendered. It is important for coders to be aware of the implications of clustering, as it may not reflect the true level of care provided, ultimately impacting both reimbursement and compliance with regulations. In professional coding environments, such practices must be carefully monitored to ensure that they do not lead to documentation and coding issues. This context helps coders understand why using middle levels for all encounters can be problematic while emphasizing the importance of accurate and compliant coding practices.

3. When can radiology reports be utilized for coding purposes?

- A. For clarifying billing disputes**
- B. When used to clarify an outpatient diagnosis**
- C. For establishing patient treatment plans**
- D. Only during emergency situations**

Utilizing radiology reports for coding purposes is essential when these reports serve to clarify an outpatient diagnosis. Radiology reports contain specific details about the examinations performed, findings, and conclusions drawn by the radiologist. These elements are critical for accurate coding, as they provide the necessary documentation to support the diagnosis and any subsequent billing for procedures. When a radiology report indicates a diagnosis or provides details that enable coders to select the most appropriate code, it directly influences the accuracy of coding and billing for outpatient services. This underscores the importance of these documents in ensuring that the coded data reflect the patient's condition correctly. While radiology reports could theoretically be referenced in various contexts such as billing disputes, establishing treatment plans, or in emergency situations, their primary role in coding is to clarify and validate outpatient diagnoses. Thus, the use of these reports is fundamentally linked to the clarity and verification of the diagnosis for coding purposes, making this choice the correct one.

4. What must practices ensure when establishing fee schedules?

- A. Charge less than competitor rates**
- B. Align with government requirements**
- C. Avoid billing below payer rates**
- D. Include additional service fees**

When establishing fee schedules, practices must ensure that they avoid billing below payer rates because billing below what payers are willing to reimburse can result in significant financial losses for the practice, as well as potential compliance issues. It is critical for practices to set their fees such that they align with the reimbursement amounts that they receive from insurance companies and Medicare or Medicaid, which often dictate minimum allowable charges for specific services. Pricing services below these rates could lead to denials of claims, as many payers will only reimburse up to their predetermined rates. This means that if a practice charges a fee lower than the payer's rate, it can create confusion and lead to disputes or payment delays, harming the revenue cycle and overall financial health of the practice. While other considerations such as competition, government regulations, and additional service fees are important factors in establishing a fee schedule, ensuring that fees do not fall below payer rates is directly related to maintaining revenue integrity and securing timely payments for services rendered.

5. What is the primary purpose of a fee schedule in a medical practice?

- A. Determining staff salaries**
- B. Managing reimbursements for services**
- C. Calculating annual expenses**
- D. Hiring additional service providers**

The primary purpose of a fee schedule in a medical practice is to manage reimbursements for services. A fee schedule is a comprehensive list that outlines the payment rates for various medical services or procedures provided by the practice. It plays a crucial role in ensuring that the practice is compensated fairly for the services rendered to patients, particularly in dealings with insurance companies and government payers. By establishing clear and consistent fees for each service, practices can streamline the billing process and create expectations regarding compensation. This not only aids in maintaining financial stability but also helps in negotiating contracts with insurers, ensuring that reimbursements align with the established rates. Additionally, a well-structured fee schedule allows practices to monitor the overall financial performance and adjust fees based on market changes or service costs. While determining staff salaries, calculating annual expenses, and hiring additional service providers are important elements of managing a medical practice, they do not directly relate to the primary function of a fee schedule. The fee schedule specifically serves to address compensation for services rendered, making it an essential tool for managing a practice's revenue cycle effectively.

6. What does the abbreviation "CMS" stand for in healthcare?

- A. Central Medical Services**
- B. Centers for Medicare and Medicaid Services**
- C. Comprehensive Medical Solutions**
- D. Clinical Management System**

The abbreviation "CMS" stands for "Centers for Medicare and Medicaid Services." This federal agency within the United States Department of Health and Human Services administers the nation's major healthcare programs, including Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). It plays a crucial role in regulating and overseeing the healthcare system, establishing guidelines, and ensuring that beneficiaries receive quality care. Understanding the role of CMS is vital for coding professionals because it impacts reimbursement processes, regulatory compliance, and guidelines related to healthcare services. The focus on Medicare and Medicaid makes it essential for those in the coding field to stay informed about changes and updates from this agency, as they can directly affect coding practices and the accuracy of claims submissions. Other options do not reflect the official name of the agency or its functions, which is why they are less relevant in a healthcare context. "Central Medical Services," "Comprehensive Medical Solutions," and "Clinical Management System" do not represent well-known entities within the U.S. healthcare system nor do they align with the responsibilities of CMS.

7. What action should an office manager take if unbundling practices are discovered?

- A. Initiate training for coding staff**
- B. Refund overpayments from a third-party payer**
- C. Document unbundled services**
- D. File complaints with the OIG**

Refunding overpayments from a third-party payer is the appropriate action to take when unbundling practices are discovered. Unbundling refers to the inappropriate separation of services that should be billed as a bundled package. This practice can lead to overbilling, which can result in the healthcare provider receiving payments that exceed what is allowable under payer guidelines. When unbundling is identified, it signifies that the practice may have inadvertently charged payers more than what the bundled services would have cost. By initiating a refund to the affected payer, the office demonstrates compliance with payer contracts and regulatory requirements, and addresses the potential financial harm caused by the unbundling practices. This proactive step helps mitigate legal or financial repercussions, reinforces ethical billing practices, and can restore trust with payers. Additionally, addressing unbundling through refunds is a part of maintaining compliance and reporting accuracy, aligning with the ethics of coding and billing. Taking this action can also set the stage for further corrective measures, such as training coding staff to prevent future occurrences, which would strengthen the processes in place.

8. What section of a POMR serves as a "Table of Contents"?

- A. Progress Notes**
- B. Problem List**
- C. Medical History**
- D. Initial Plan**

The Problem List serves as a "Table of Contents" for the Problem-Oriented Medical Record (POMR) because it provides a concise summary of all active and inactive conditions a patient is experiencing or has experienced during their care. Each entry in the Problem List is typically linked to specific progress notes and treatment plans, allowing healthcare providers to quickly identify the issues at hand and navigate through the details of an individual patient's medical record. This organization not only enhances efficiency in clinical practice by making it easy to locate relevant information quickly but also facilitates continuity of care, as different members of the healthcare team can easily understand the patient's health context and history. The other sections, such as Progress Notes, Medical History, and Initial Plan, provide important clinical information but do not serve the role of organizing the record in the overarching manner that the Problem List does. Instead, those sections delve deeper into each problem or condition but do not function as the summary or navigational tool that the Problem List represents.

9. What essential aspect should healthcare providers focus on to ensure coding compliance?

- A. Using the most advanced technology**
- B. Regular training on coding guidelines**
- C. Increasing patient volume**
- D. Reducing operational costs**

Healthcare providers should focus on regular training on coding guidelines to ensure coding compliance because coding is a constantly evolving field, influenced by changes in regulations, standards, and practices. Regular training ensures that coding professionals remain up to date with the latest coding systems, such as ICD-10, CPT, and HCPCS, as well as any changes in the Medicare and Medicaid guidelines. It also helps staff to understand the importance of correct coding, which directly impacts revenue cycle management, billing accuracy, and compliance with federal and state regulations. In addition, ongoing education helps coders to recognize potential areas of risk, such as upcoding or downcoding, and supports ethical practices within healthcare organizations. This training ultimately leads to better patient care through accurate documentation and billing practices, thereby reducing the risk of audits and penalties due to non-compliance. Regularly updating knowledge and skills is fundamental in maintaining coding accuracy and compliance in the dynamic landscape of healthcare regulations.

10. What does the term "limiting charge" refer to in relation to Medicare providers?

- A. Maximum charges allowed for any service**
- B. A cap on total annual billing**
- C. The excess amount a NON PAR provider can collect over the approved amount**
- D. Fees for expedited claims processing**

The term "limiting charge" specifically relates to the amount a non-participating Medicare provider can bill a patient above the approved Medicare reimbursement rate for a given service. When a non-par provider accepts Medicare patients but chooses not to participate in the Medicare program, they can charge above the Medicare-approved amount, but there is a limit to how much excess they can impose. This limitation is set to protect patients from excessive out-of-pocket costs while ensuring that providers do not charge arbitrary fees. In this context, the other options do not accurately describe what a limiting charge entails. For example, maximum charges for services or caps on total annual billing are broader concepts not specific to the limitations placed on non-participating providers. Likewise, expedited claims processing fees do not factor into the concept of limiting charges at all. Thus, the option correctly defining the limiting charge is that it is the excess amount a non-par provider can collect over the approved amount.