Registered Health Information Administrator (RHIA)

1. In preparation for an HER, you are conducting a total facility inventory of all forms currently used. You must name each form for bar coding and indexing into a document management system. The unnamed document in front of you includes a microscopic description of tissue excised during surgery. The document type you are most likely to give to this form is

A. recovery room record.

B. pathology report.

C. operative report.

D. discharge summary.

Answer(s): B

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2. Patient data collection requirements vary according to health care setting. A data element you would expect to be collected in the MDS, but not in the UHDDS would be

A. personal identification.

B. cognitive patterns.

C. procedures and dates.

D. principal diagnosis.

Answer(s): B

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3. A good first step toward protecting the security of data contained in a health information computer system would be to

A. establish a good record tracking system.

B. define levels of security for different types of information, depending on sensitivity.

C. provide remote terminals for improved access to the record.

D. provide internet access to facility records.

Answer(s): B

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4. In the number "99-0001" listed in a tumor registry accession register, what does the prefix "99" represent?

A. the number of primary cancers reported for that patient

B. the year the case was entered into the database of the registry

C. the sequence number of the case

D. the stage of the tumor based upon the TNM system of staging

Answer(s): B

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5. A risk manager needs to locate a full report of a patient's fall from his bed, including witness reports and probable reasons for the fall. She would most likely find this information in the

A. doctors' progress notes.

B. integrated progress notes.

C. incident report.

D. nurses' notes.

Answer(s): C

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6. For continuity of care, ambulatory care providers are more likely than providers of acute care services to rely on the documentation found in the

A. interdisciplinary patient care plan.

B. discharge summary.

C. transfer record.

D. problem list.

Answer(s): D

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7. Joint Commission does not approve of auto authentication of entries in a health record. The primary objection to this practice is that

A. it is too easy to delegate use of computer passwords.

B. evidence cannot be provided that the physician actually reviewed and approved each report.

C. electronic signatures are not acceptable in every state.

D. tampering too often occurs with this method of authentication.

Answer(s): B

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8. As part of quality improvement study you have been asked to provide information on the menstrual history, number of pregnancies, and number of living children on each OB patient from a stack of old obstetrical records the best place in the record to locate this information is the

A. prenatal record.

B. labor and delivery record.

C. postpartum record.

D. discharge summary.

Answer(s): A

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9. As a concurrent record reviewer for an acute care facility, you have asked Dr. Crossman to provide an updated history and physical for one of her recent admissions. Dr. Crossman pages through the medical record to a copy of an H&P performed in her office a week before admission. You tell Dr. Crossman.

A. a new H&P is required for every inpatient admissions.

B. that you apologize for not noticing the H&P she provided.

C. the H&P copy is acceptable as long as she documents any interval changes.

D. Joint Commission standards do not allow copies of any kind in the original record.

Answer(s): C

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10. As a new CTR, you are interested in identifying every reportable case of cancer from the previous year. A key resource will be the facility's

A. disease index.

B. number control index.

C. physicians' index.

D. patient index.

Answer(s): A

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11. Joint Comission requires the attending physician to countersign health record documentation that is entered by

A. interns or medical students.

B. midwives.

C. consulting physicians.

D. physician partners.

Answer(s): A

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12. The minimum length of time for retaining original medical records is primarily governed by

A. Joint Commission.

B. medical staff.

C. state law.

D. readmission rates.

Answer(s): C

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13. The use of personal signature stamps for authentication of entries in a paper-based record requires special measures to guard against delegated use of the stamp. In a completely computerized patient record system, similar rmeasures might be utilized to govern the use of

A. fingerprint signatures.

B. voice recognition systems.

C. expert systems.

D. electronic signatures.

Answer(s): D

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14. Discharge summary documentation must include

A. a detailed history of the patient.

B. a note from social services or discharge planning.

C. significant findings during hospitalization.

D. correct codes for significant procedures

Answer(s): C

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15. The performance of ongoing record reviews is an important tool is ensuring data quality through accurate health records. These reviews evaluate

A. quality of care through the use of pre-established criteria.

B. adverse effects and contraindications of drugs utilized during hospitalization.

C. potentially compensable events.

D. completeness, adequacy, and quality of documentation.

Answer(s): D

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16. Ultimate responsibility for the quality and completion of entries in patient health records belongs to the

A. chief of staff.

B. attending physician.

C. HIM director.

D. risk manager.

Answer(s): B

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17. Quantitative and qualitative reviews performed on patient records by medical record personnel in either a skilled nursing facility or inpatient psychiatiry facility are generally in the form

of

A. retrospective deficiency analysis.

B. special study audits.

C. concurrent chart review.

D. occurrence screening.

Answer(s): C

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18. The foundation for communicating all patient care goals in long-term care settings is the

A. legal assessment.

B. labor and delivery record.

C. interdisciplinary patient care plan.

D. Uniform Hospital Discharge Data Set.

Answer(s): C

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19. Which interdisciplinary committee is most likely to be charged with the responsibility for monitoring trends in delinquent health record percentages?

A. Health Record Committee.

B. Utilization Review Committee.

C. Risk Management Committee.

D. Joint Conference Committee.

Answer(s): A

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20. A health record analyst needs to quickly compare all lab values during one hospitalization. The paper-based health record format best suited for this purpose is

A. problem-oriented.

B. source-oriented.

C. reverse chronological.

D. integrated.

Answer(s): B
