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RHIA

Registered Health Information Administrator Exam

TYPE: **DEMO**

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Question: 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: B

Question: 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: B

Question: 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: B

Question: 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: B

Question: 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: C

Question: 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: D

Question: 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: B

Question: 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: A

Question: 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: C

Question: 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: A

Question: 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: A

Question: 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: C

Question: 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: D

Question: 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: C

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