Pearson's Comprehensive Medical Coding, 2nd Ed. **(Papazian-Boyce)**
Chapter 2 Coding and Reimbursement

2.1 Multiple Choice Theory

1) Third-party payers are entities other than the physician or patient who pay for healthcare services. What percentage of healthcare services in the United States is paid by third-party payers?
A) 83%
B) 79%
C) 87%
D) 90%
Answer: C

2) What portion of healthcare services is paid for by health benefit plans funded by federal and state governments?
A) 60%
B) 33%
C) 30%
D) 57%
Answer: A

3) The Patient Protection and Affordable Care Act was passed in 2010. The PPACA placed the greatest burden on which healthcare providers?
A) Larger healthcare providers that had already established a voluntary compliance program
B) Smaller healthcare providers that had not established a voluntary compliance program
C) Smaller healthcare providers that had already established a voluntary compliance program
D) Larger healthcare providers that had not established a voluntary compliance program
Answer: B

4) The FCA was passed during the Civil War for what reason?
A) The cost of the Civil War was incredibly high, so the federal government scrutinized every claim for mistakes.
B) It was initially seen as a way to penalize the states that fought on the side of the South.
C) It was intended to combat widespread fraud when contractors sold the government faulty rifles, ammunition, rotten food, and sick horses.
D) The timing had nothing to do with the Civil War itself; the Act had been in the works for several years before the war, and it was finally signed after the war started.
Answer: C

5) The Qui Tam provision of the False Claims Act:
A) allows the government to prosecute without proving intent to defraud.
B) requires the government to prove intent to commit fraud.
C) mandates the Act be periodically updated.
D) includes financial rewards to whistleblowers who turn in violators.
Answer: D

6) The Office of the Inspector General (OIG) is a division of the:
A) Department of Health, Education, and Welfare.
B) Department of Healthcare Fraud and Abuse Control.
C) Department of Health and Human Services.
D) Centers of Medicare and Medicaid Services.
Answer: C

7) Once Medicare publishes a final rule:
A) their stance is that providers should know about it and follow it.
B) they believe it is best to ease the rule into effect.
C) they do not repeal or amend any of the provisions.
D) they review each rule on an annual basis and amend/update as needed.
Answer: A

8) OIG sample compliance programs include which of the following characteristics?
A) Education and training for employees
B) Process for reporting exceptions
C) Audit and monitoring system
D) All of the above
E) None of the above
Answer: D

9) When a payment for service is denied by the insurance company, an accounts receivable specialist:
A) calls the insurance company for further information.
B) needs to investigate the situation.
C) obtains additional information from the patient.
D) makes sure someone reviews the chart documentation.
E) should do nothing because some claims are overpaid, some are underpaid, and it all balances out in the end.
Answer: B

10) Typically, which of the following is NOT a reason claims for payment may be suspended?
A) The claim is for a very high dollar amount.
B) The claims manager has a hunch that something is inaccurate.
C) The claims have illogical information, such as gender or patient age that does not match the codes.
D) The claim needs to undergo medical necessity review.
Answer: B

11) The lifecycle of an insurance claim begins when the patient:
A) is discharged from the emergency department.
B) is diagnosed at the hospital.
C) contacts the physician to make an appointment.
D) all of the above.
Answer: C

12) Which of the following is NOT true about the surgical history?
A) It is unimportant to the patient's current condition in most instances.
B) It records the dates and types of past operations.
C) It is a narrative that describes the technique used during the procedure.
D) The operative report indicates the postoperative diagnosis.
Answer: A

13) Documentation of current and past medications, along with any medication allergies, is important to the patient's care. What should coders do with this information?
A) Nothing; the names of the medications will show up on the bill.
B) Assign the National Drug Code for each medication.
C) Assign CPT codes for each medication that was actually administered.
D) Code the long-term use of specific medications.
Answer: D

14) When processing claims, excellent documentation in a patient's paper or electronic health record can do all of the following EXCEPT:
A) reduce the amount of time needed to code the claim.
B) ensure the patient will not file a medical malpractice suit.
C) result in a more accurate and complete claim.
D) minimize problems associated with claims processing.
Answer: B

15) The social history is an integral part of a patient's health record and can provide information that could potentially be coded. Which of the following information should be coded?
A) Religious affiliation
B) Sexual orientation
C) Lifestyle habits
D) Education
Answer: C

16) The chief complaint is defined as:
A) an evaluation of the patient's vital signs.
B) the cause of the patient's current symptoms.
C) a list of symptoms as stated by the patient.
D) the reason/problem for which the patient sought treatment.
Answer: D

17) Payers are allowed to do which of the following in order to process a claim for payment?
A) Request additional information to verify whether or not the service is covered.
B) Call the patient directly.
C) Reassign the ICD-10-CM/PCS codes on the claim form.
D) Take as long as they need to process the claim.
Answer: A

18) When a healthcare provider is overpaid by Medicare, what should they do?
A) Return the overpayment.
B) Report the overpayment to Medicare.
C) Keep it.
D) Both A and B.
Answer: D

19) Which of the following is an example of a "least-restrictive setting" in regards to medical necessity criteria?
A) Inpatient colonoscopy without a valid medical reason
B) Outpatient colonoscopy
C) Inpatient colonoscopy with a valid medical reason
D) Both B and C
Answer: D

20) A medical record:
A) reports past and present illnesses.
B) is a comprehensive collection of all information about a patient at a particular facility.
C) provides a chronological record of the patient's care.
D) all of the above.
Answer: D

21) Which of the following is TRUE about managed care plans?
A) Each managed care company uses the same "model" for care.
B) Managed care plans seek to achieve better outcomes while controlling the cost of healthcare.
C) Managed care plans are a separate type of insurance.
D) There are no Medicare managed care programs.
Answer: B

22) Workers' compensation programs are:
A) not subject to HIPAA regulations.
B) subject to HIPAA regulations.
C) sometimes subject to HIPAA regulations.
D) None of the above.
Answer: A

23) The three major sources of private health insurance are:
A) self-insured plans, group plans, and Medigap plans.
B) individual plans, Medigap plans, and Medpay plans.
C) group health plans, self-insured plans, and individual plans.
D) employer group plans, third-party administrator plans, and self-insured plans.
Answer: C

24) Which of the following is NOT true about Medicare Part B?
A) It covers a specific list of physician services.
B) It covers home healthcare.
C) It covers inpatient stays at a skilled nursing facility.
D) It is optional. Medicare recipients/beneficiaries are not required to enroll.
Answer: C

25) Which of the following is TRUE about Medicare Part D?
A) It is also known as "prescription drug coverage."
B) It is offered exclusively by CMS.
C) There is only one plan from which to choose.
D) This coverage is provided free of charge for Medicare beneficiaries who enroll in "original" Medicare.
Answer: A

26) Which service would NOT be medically necessary?
A) It is mainly for the convenience of the physician.
B) It is the only way to diagnose a condition.
C) It meets the standards of good medical practice in the local area.
D) It improves the functioning of a malformed body member.
Answer: A

27) A denied claim was:
A) rejected for ineligibility prior to processing.
B) rejected prior to processing because of coding errors.
C) processed and found to be ineligible for payment.
D) processed and found to be unethical and fraudulent.
Answer: C

28) A claim is clean if it:
A) has no missing or invalid information.
B) is based on an encounter form.
C) bills for medically necessary services.
D) goes to a clearinghouse.
Answer: A

29) A coding problem that could cause a rejected or denied claim is:
A) the patient age or gender matches the diagnosis or procedure.
B) the diagnosis matches the procedure.
C) additional codes are not required.
D) the code has too many or too few characters.
Answer: D