Chapter 2 Hospital-Based Care

MULTIPLE CHOICE

1. The physician sends the patient to the hospital for a radiological examination. The patient returns to the physician's office for follow-up of test results. From the point of view of the hospital, what type of hospital patient is this?
   a. inpatient
   b. emergency outpatient
   c. clinic outpatient
   d. referred outpatient

   ANS: D PTS: 1

2. What is a program for the performance of elective surgical procedures on patients who are classified as outpatients and typically are released from the surgery center on the day of surgery, thus avoiding an overnight stay in the health care facility?
   a. ambulatory surgery
   b. partial hospitalization
   c. adult day care
   d. surgery clinic

   ANS: A PTS: 1

3. Regional databases used to validate claims and track utilization throughout the United States contain information on each Medicare beneficiary in _____ that include data from both hospital and physician claims.
   a. common working files
   b. ambulatory patient groups
   c. uniform ambulatory care data sets
   d. charge description masters

   ANS: A PTS: 1

4. In the hospital setting, the term "resident" is primarily applied to _____.
   a. a licensed physician participating in an approved graduate medical education program
   b. an outpatient evaluated and treated in the observation area of the hospital
   c. a computer program that resides in RAM, used to diagnose emergency patients quickly
   d. patients enrolled in the hospital's long-term ambulatory care program

   ANS: A PTS: 1

5. Select the TRUE statement below with regard to Medicare hospital outpatient reimbursement.
   a. The hospital may be paid for only one RBRVS per day per patient
   b. The hospital may be paid for only one APC per day per patient
   c. The hospital may be paid for only one APC per patient per 72 hours
   d. The hospital may be paid for more than one APC per patient visit

   ANS: D PTS: 1

6. Under EMTALA, hospitals that offer emergency services _____.
   a. are free to refuse emergency services to patients who do not show proof of insurance
   b. can refuse emergency services to patients as long as another hospital agrees to accept the patient as a transfer
   c. must screen and stabilize, if necessary, any patient who arrives in the emergency department
   d. must provide emergency services free of charge to a certain number of individual to meet the EMTALA charity obligations

   ANS: C PTS: 1

7. Partial hospitalization services are paid for under APCs when _____.
   a. received by unstable dialysis patients in a part of the hospital where patients generally do not stay overnight
   b. psychiatric or behavioral health patients receive certain services and spend part of the day or the night in the hospital
   c. an observation patient has been in the hospital for over 48 hours and the patient's condition still does not permit discharge to home
   d. an inpatient length of stay is too short for a regular DRG payment

   ANS: B PTS: 1

8. Which of the following statements is FALSE?
   a. Documentation of telephone calls is an important element in good risk management for ambulatory care.
   b. A hospital compliance officer may be concerned with avoiding fraudulent coding and billing as well as with monitoring compliance with federal regulations such as HIPAA.
   c. Because of their knowledge of coding, health information managers can help review, revise, and maintain the hospital's chargemaster.
   d. Hospitals receive Medicare reimbursement for ambulatory care through an outpatient prospective payment system (OPPS) based on diagnosis related groups (DRGs).

   ANS: D PTS: 1

9. Medicare payments to long-term acute care hospitals (LTACHs) are based on _____.
   a. LTC-DRGs
   b. PIP-DCGs
   c. DRGs
   d. RUGs

   ANS: A PTS: 1

10. Which of the following statements is TRUE?
    a. Hospitals must be accredited by the Joint Commission.
    b. Hospitals must be licensed by the state in which they are located.
    c. Hospitals must have a hospitalist on staff to qualify for CMS certification.
    d. Hospitals do not have to be licensed to admit patients.

    ANS: B PTS: 1

11. Without documented information on the diagnoses or symptoms that prompted a physician to order a test, the hospital lacks the information needed to demonstrate that the test was _____.
    a. performed in a timely manner
    b. professionally administered
    c. medically necessary
    d. critically assessed

    ANS: C PTS: 1

12. The Joint Commission requires that the medical record contain a summary list for each patient that should include all of the following EXCEPT _____,
    a. significant medical diagnoses and conditions
    b. significant operative and invasive procedures
    c. adverse and allergic drug reactions
    d. past insurance and billing accounts with significant balances

    ANS: D PTS: 1

13. Which of the following statements is FALSE in relation to documentation requirements specific to patients receiving urgent or immediate care?
    a. When emergency, urgent, or immediate care is provided, the time and means of arrival are also documented in the medical record.
    b. The medical record notes how long a patient receiving emergency, urgent, or immediate care had to wait for treatment.
    c. The medical record of a patient receiving emergency, urgent, or immediate care notes the conclusions at termination of treatment including final disposition, condition at discharge, and instructions for follow-up care.
    d. The medical record contains a copy of the information made available to practitioners or organizations providing follow-up care.

    ANS: B PTS: 1

14. Which audit initiative resulted in many teaching hospitals having to repay millions of dollars to the Medicare program because they lacked documentation to substantiate Medicare payments to faculty physicians who supervised residents?
    a. PATH
    b. EMTALA
    c. MAC
    d. HOPPS

    ANS: A PTS: 1

15. As required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, CMS has replaced past claims processing contractors known as fiscal intermediaries and Medicare carriers with _____.
    a. Medicare Payment Processors (MPPs)
    b. Medicare Evaluation Boards (MEBs)
    c. Medicare Administrative Contractors (MACs)
    d. Medicare Revenue Exchanges (MREs)

    ANS: C PTS: 1

16. MS-DRGs differ from DRGs in that MS-DRGs take into account _____.
    a. patient demographic data such as address, insurance type, etc.
    b. various levels of patient illness using secondary diagnoses.
    c. whether the hospital is a “teaching” hospital or “non-teaching” hospital
    d. whether the patient has had any previous hospitalizations

    ANS: B PTS: 1

17. When a hospital provides services to a Medicare patient as an outpatient within 72 hours before a related inpatient admission, charges for those outpatient services _____.
    a. must be billed separately from the inpatient bill.
    b. must not be billed separately from the inpatient bill.
    c. must be written off as “uncollectable” expenses.
    d. must be billed prior to the inpatient admission.

    ANS: B PTS: 1

18. Which of the following statements is FALSE in relation to APC status indicators?
    a. “S” represents a significant service that is not discounted when more than one APC is present on a claim.
    b. “T” represents a significant procedure that is discounted when other procedures are performed with it.
    c. “P” represents a partial hospitalization service.

d. "V" represents those services which are not billable under the OPPS.

ANS: D PTS: 1

19. For certain categories of encounter-based hospital outpatient services, "Composite APCs" result in _____.
    a. only a single payment for certain common combination services provided on the same day of service
    b. individual payments for each service provided during the outpatient visit
    c. additional payments for hospital supplies and technical assistance
    d. zero payments due to the fact that these services are not covered by Medicare

    ANS: A PTS: 1

20. Which of the following is NOT one of the payment mechanisms created by Medicare to discourage the transfer of patients between the LTCH and other facilities for financial rather than clinical reasons?
    a. The "Interrupted Stay" Rule
    b. The "5 Percent" Rule
    c. The "10 Day" Rule
    d. The "25 Percent" Rule

    ANS: C PTS: 1

21. The standard form for submitting information to third-party payers when filing claims for hospital services is the _____.
    a. UB-04
    b. CMS 1500
    c. DRG 919
    d. APC 8000

    ANS: A PTS: 1

22. HCPCS "Level II" or national codes refer to _____.
    a. CPT codes
    b. ICD-9-CM codes
    c. APC codes
    d. codes that CMS developed

    ANS: D PTS: 1

23. In most hospitals, the patient record starts with the _____.
    a. registration process
    b. initial evaluation by nursing staff
    c. first physician visit
    d. discharge process

    ANS: A PTS: 1

24. The legislative act which provides incentives to healthcare providers who utilize EHRs to enhance the quality of care provided their patients is the _____.
    a. Emergency Medical Treatment and Active Labor Act (EMTALA)
    b. American Recovery and Reinvestment Act (ARRA)
    c. Health Insurance Portability and Accountability Act (HIPAA)
    d. Electronic Health Record Adoption Act (EHRAA)

    ANS: B PTS: 1

25. Which of the following is a criterion for demonstrating "meaningful use" of electronic health records by hospitals?
    a. Use of CPOE (computerized provider order entry) for orders directly entered by authorizing provider
    b. Record smoking status for patients 13 years old or older
    c. Check insurance eligibility electronically from public and private payers
    d. None of the above is a criterion

e. All of the above are criteria

ANS: E PTS: 1

26. Risk management departments protect health care organizations from financial loss that could occur as a result of _____.
    a. meaningful use activities
    b. potentially compensable events
    c. disagreements between staff members
    d. ICU patients who are transferred to LTACHs

    ANS: B PTS: 1

27. Mr. Smith goes to the emergency room at Northpark Hospital complaining of chest pain. He states that he does not have health insurance and does not have the money to immediately pay for treatment. According to EMTALA, the hospital must _____.
    a. refuse to treat Mr. Smith if the ER physician is not willing to admit him to the hospital for full treatment
    b. explain all billing practices including collection agency policies before Mr. Smith can be treated
    c. screen and stabilize Mr. Smith before attempting to transfer him to another facility
    d. contact CMS to verify that Mr. Smith qualifies for public assistance

    ANS: C PTS: 1

28. All of the following are potential roles for HIM professionals within a hospital setting EXCEPT _____.
    a. Performance Improvement Analyst
    b. Coding Supervisor
    c. Cancer Registrar
    d. Respiratory Therapist
    e. EHR Implementation Specialist

    ANS: D PTS: 1

29. Amy Williams is the HIPAA Compliance Officer for Wayne County Hospital. In her role she will be expected to _____.
    a. Audit records against codes submitted
    b. Purchase supplies for the operating room suite
    c. Ensure insurance information is obtained upon patient admission
    d. Track patient disposition after discharge

    ANS: A PTS: 1

30. The _____ involves all of the activities from pricing to selling of health care services and then collecting what is owed from the purchaser for those services.
    a. APC System
    b. Revenue Cycle
    c. HIPAA Program
    d. Utilization Review Plan

    ANS: B PTS: 1

31. A computer file that contains a list of the Healthcare Common Procedural Coding System (HCPCS) codes and associated charges for the services provided to hospital patients is referred to as a _____.
    a. fiscal intermediary
    b. revenue code
    c. chargemaster
    d. status indicator

ANS: C PTS: 1

32. Dr. Moore admits Mary Knight to Tanner Hospital for observation. If he feels that Mary meets the criteria for admission as an inpatient, Dr. Moore must generally make that decision within a _____ time frame.
    a. 12-hour
    b. 24-hour
    c. 48-hour
    d. 72-hour

    ANS: B PTS: 1

33. Under an Inpatient Prospective Payment System (IPPS) that pays a hospital according to the diagnosis related group (DRG) assigned to each patient's stay, what would the payment be for a DRG with a relative weight of 1.75 if the hospital's PPS rate is $8,225?
    a. $4,700.00
    b. $14,393.75
    c. $21,276.60
    d. Not enough information to calculate

    ANS: B PTS: 1

34. The Hospital Outpatient Prospective Payment System (OPPS) allows for additional payments to be made to cover the costs of innovative medical devices, drugs, and biologicals. These payments are referred to as _____.
    a. Disproportionate Share Hospital Payments
    b. Experimental Incentives
    c. Research and Development Incentives
    d. Pass-Through Payments

    ANS: D PTS: 1

35. The _____ specifies definitions and rules for selecting the principal diagnosis, other diagnoses, principal procedure, and several other elements that are critical in DRG assignment and payment for hospital based care.
    a. UHDDS
    b. UACDS
    c. DEEDS
    d. NCVHS

    ANS: A PTS: 1

TRUE/FALSE

1. A partial hospitalization program is considered to be a type of outpatient psychiatric program.

   ANS: T PTS: 1

2. Hospital clinics are often organized by medical specialty to facilitate medical education.

   ANS: T PTS: 1

3. Hospital observation services may be billed to all payers as outpatient services for observation stays up to 72 hours.

   ANS: F PTS: 1

4. For referred outpatients, the hospital provides diagnostic or therapeutic services, but it does not take responsibility for evaluating or managing the patient's care.

ANS: T PTS: 1

5. A hospitalist is a physician who provides comprehensive care to hospitalized patients, but who does not ordinarily see patients outside of the hospital setting.

   ANS: T PTS: 1

6. Hospitals that meet the standards of the Joint Commission, HFAP, or DNV are deemed to meet the Conditions of Participation.

   ANS: T PTS: 1

7. According to the Joint Commission, the records of patients receiving continuing ambulatory care services must contain a summary list of known significant diagnoses, conditions, procedures, drug allergies, and medications.

   ANS: T PTS: 1

8. When a resident, as part of his or her graduate medical education, participates with a teaching physician in providing a service, the teaching physician cannot receive reimbursement for the service from Medicare under any circumstances.

   ANS: F PTS: 1

9. The PATH audits demonstrated that teaching physician documentation almost always supported the level of service billed to Medicare; therefore, these audits did not result in significant reimbursement of funds to Medicare.

   ANS: F PTS: 1

10. A hospital would likely be reimbursed for more than one APC for an emergency department patient whose visit includes evaluation and management, X-rays, and a procedure.

    ANS: T PTS: 1

11. Charges for ancillary services, such as laboratory and radiology charges, are usually captured through the hospital chargemaster.

    ANS: T PTS: 1

12. With regard to Medicare, hospitals should bill separately any charges for ancillary services provided on an outpatient basis within 72 hours prior to an inpatient admission.

    ANS: F PTS: 1

13. A revenue code appropriate to the HCPCS code listed with it must be included on the bill for outpatient services or the claim may be rejected.

    ANS: T PTS: 1

14. Voice recognition systems are becoming more common in hospital emergency departments.

    ANS: T PTS: 1

15. Potentially compensable events (PCEs) are occurrences that may result in litigation against the health care provider or that may require the health care provider to compensate an injured party.

ANS: T PTS: 1