***Medical Insurance, 8e* (Valerius)**

**Chapter 1 Introduction to the Revenue Cycle**

1) The employment forecast for well-trained medical insurance and coding specialists is/are

A) decreasing opportunities.

B) staying the same as today.

C) increasing opportunities.

D) remaining stagnant.

Answer: C

Explanation: Knowledgeable medical office employees are in demand.

Difficulty: 1 Easy

Topic: Working in the Medical Insurance Field

Learning Objective: 01.01

Bloom's: Remember

ABHES: 1.a Graduates will be able to: Describe the current employment outlook for the medical assistant

CAHIIM: VI.E.2 Explain return on investment for employee training/development

2) Medical insurance specialists ensure financial success of the medical practice by

A) using health information technology.

B) setting their own rules and regulations.

C) failing to communicate effectively.

D) recording only cash payments.

Answer: A

Explanation: Providers must compete in a complex environment of various health plans, managed care contracts, and federal and state regulations.

Difficulty: 2 Medium

Topic: Working in the Medical Insurance Field

Learning Objective: 01.01

Bloom's: Understand

ABHES: 7.b Graduates will be able to: Navigate electronic health records systems and practice management software

CAHIIM: III.A.1 Utilize software in the completion of HIM processes

3) According to the textbook, pick the rising occupation in the health care industry that requires the employee to have the highest level of proficiency in dealing with the public professionally and pleasantly.

A) health information technician

B) medical assistant

C) lab technician

D) radiology technician

Answer: B

Explanation: Medical assistants who are expected to excel are those best fit to deal with the public through a courteous, pleasant manner and a professional demeanor.

Difficulty: 2 Medium

Topic: Working in the Medical Insurance Field

Learning Objective: 01.01

Bloom's: Understand

ABHES: 1.a Graduates will be able to: Describe the current employment outlook for the medical assistant; 1.b Graduates will be able to: Compare and contrast the allied health professions and understand their relation to medical assisting

CAHIIM: VI.E.2 Explain return on investment for employee training/development

4) A computerized lifelong health care record for an individual that incorporates data from all sources is known as a(n)

A) electronic health record (EHR).

B) practice management program (PMP).

C) computerized health record (CHR).

D) lifelong health care record (LHR).

Answer: A

Explanation: Electronic health record (EHR) is a computerized lifelong health care record for an individual that incorporates data from all sources.

Difficulty: 1 Easy

Topic: Working in the Medical Insurance Field

Learning Objective: 01.01

Bloom's: Remember

ABHES: 4.b.2 Institute federal and state guidelines when: Entering orders in and utilizing electronic health records; 7.b Graduates will be able to: Navigate electronic health records systems and practice management software

CAHIIM: III.A.1 Utilize software in the completion of HIM processes

5) In a medical practice, cash flow is required to

A) pay for office expenses.

B) pay for hospital supplies.

C) pay for nursing home employees.

D) pay for the staff of an insurance company.

Answer: A

Explanation: Cash flow, the movement of monies into and out of the practice, is needed in order to pay for office expenses such as salaries and overhead.

Difficulty: 1 Easy

Topic: Working in the Medical Insurance Field

Learning Objective: 01.01

Bloom's: Remember

ABHES: 7.c Graduates will be able to: Perform billing and collection procedures

CAHIIM: IV.A.2 Evaluate the revenue cycle management processes; IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

6) What is the definition of revenue cycle?

A) clinical care provided for patients, from appointment to discharge

B) all administrative and clinical functions which ensure that sufficient monies flow into the practice to pay bills

C) all coding and billing steps involved in preparing correct claims

D) complete documentation that is submitted to third-party payers

Answer: B

Explanation: The revenue cycle includes all administrative and clinical functions that ensure sufficient monies flow into the practice to pay bills.

Difficulty: 1 Easy

Topic: The Revenue Cycle

Learning Objective: 01.08

Bloom's: Remember

ABHES: 7.c Graduates will be able to: Perform billing and collection procedures

CAHIIM: IV.A.2 Evaluate the revenue cycle management processes; IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

7) Medical insurance specialists use practice management programs to

A) schedule patients.

B) collect data on patients' diagnoses and services.

C) record payments from insurance companies.

D) All of these are correct.

Answer: D

Explanation: Expertise in the use of practice management programs is an important skill in the medical practice. Medical insurance specialists use them to

    • Schedule patients.

    • Organize patient and insurance information.

    • Collect data on patients' diagnoses and services.

    • Generate, transmit, and report on the status of health care claims.

    • Record payments from insurance companies.

    • Generate patients' statements, post payments, and update accounts.

    • Create financial and productivity reports.

Difficulty: 1 Easy

Topic: Working in the Medical Insurance Field

Learning Objective: 01.01

Bloom's: Remember

ABHES: 7.b Graduates will be able to: Navigate electronic health records systems and practice management software

CAHIIM: III.A.1 Utilize software in the completion of HIM processes

8) Examine the list of services in the answer choices below and determine which one would most likely be considered a noncovered service at a primary care medical office.

A) emergency medical care

B) employment-related injuries

C) surgical procedures

D) annual physical examinations

Answer: B

Explanation: Most medical insurance policies do not cover employment-related injuries; emergency care and surgical procedures are generally covered services, while annual physical examinations are often covered as preventive medical services.

Difficulty: 1 Easy

Topic: Medical Insurance Basics

Learning Objective: 01.02

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

9) What kind of medical services are annual physical examinations and routine screening procedures?

A) covered

B) preventive

C) noncovered

D) surgical

Answer: B

Explanation: Annual physicals and screening procedures are examples of preventive medical services, because they help keep patients healthy and prevent illness.

Difficulty: 1 Easy

Topic: Medical Insurance Basics

Learning Objective: 01.02

Bloom's: Remember

ABHES: 7.a Graduates will be able to: Gather and process documents

CAHIIM: IV.A.2 Evaluate the revenue cycle management processes; IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

10) Under an insurance contract, the patient is the first party and the physician is the second party. Who is the third party?

A) provider

B) PCP

C) insurance plan

D) federal government

Answer: C

Explanation: The payer, or insurance plan, is the third party under an insurance contract.

Difficulty: 2 Medium

Topic: Medical Insurance Basics

Learning Objective: 01.02

Bloom's: Understand

ABHES: 7.a Graduates will be able to: Gather and process documents

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

11) In what ways can insurance policies be written?

A) an individual or group

B) only group

C) only individual

D) only workers

Answer: A

Explanation: A group or individual can be insured.

Difficulty: 2 Medium

Topic: Medical Insurance Basics

Learning Objective: 01.02

Bloom's: Understand

ABHES: 7.a Graduates will be able to: Gather and process documents

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

12) Medical insurance is a(n) \_\_\_\_\_\_\_\_ between a policyholder and a health plan.

A) verbal agreement

B) written agreement

C) informal agreement

D) exchange of money

Answer: B

Explanation: Medical insurance is a written policy that states the terms of an agreement between a policyholder (an individual) and a health plan (an insurance).

Difficulty: 1 Easy

Topic: Medical Insurance Basics

Learning Objective: 01.02

Bloom's: Remember

ABHES: 7.a Graduates will be able to: Gather and process documents

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

13) Determine which of the following entities is not considered a provider.

A) nurse practitioners

B) long-term care facilities

C) insurance companies

D) medical supply companies

Answer: C

Explanation: Providers include physicians, nurse-practitioners, physician assistants, therapists, hospitals, laboratories, long-term care facilities, and suppliers such as pharmacies and medical supply companies.

Difficulty: 2 Medium

Topic: Medical Insurance Basics

Learning Objective: 01.02

Bloom's: Understand

ABHES: 7.a Graduates will be able to: Gather and process documents

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

14) Dependents of a policyholder may include his/her

A) spouse and children.

B) only spouse.

C) only children.

D) physician.

Answer: A

Explanation: A policyholder's dependents, customarily the spouse and children, may also be covered for an additional cost.

Difficulty: 1 Easy

Topic: Medical Insurance Basics

Learning Objective: 01.02

Bloom's: Remember

ABHES: 7.a Graduates will be able to: Gather and process documents

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

15) Identify the type of service that is not considered to be a preventive medical service.

A) pediatric and adolescent immunizations

B) prenatal care

C) outpatient surgery

D) routine screening procedures

Answer: C

Explanation: Many health plans cover preventive medical services, such as annual physical examinations, pediatric and adolescent immunizations, prenatal care, and routine screening procedures; primary care is generally a covered service.

Difficulty: 2 Medium

Topic: Medical Insurance Basics

Learning Objective: 01.02

Bloom's: Understand

ABHES: 7.a Graduates will be able to: Gather and process documents

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

16) The key to receiving coverage and payment from a payer is the payer's definition of

A) provider.

B) medical necessity.

C) policyholder.

D) medical insurance.

Answer: B

Explanation: A payer's definition of medical necessity is the key to coverage and payment.

Difficulty: 1 Easy

Topic: Medical Insurance Basics

Learning Objective: 01.02

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims; 7.a Graduates will be able to: Gather and process documents

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

17) Determine which of the following types of services a health plan will not pay for.

A) noncovered services

B) covered services

C) preventive medical services

D) hospitalization

Answer: A

Explanation: Medical insurance policies describe noncovered services, those for which they do not pay.

Difficulty: 2 Medium

Topic: Medical Insurance Basics

Learning Objective: 01.02

Bloom's: Understand

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

18) Where do medical insurance companies summarize the payments they may make for medically necessary medical services?

A) medical necessity document

B) workers' compensation document

C) schedule of benefits document

D) encounter form

Answer: C

Explanation: Medical insurance policies contain a schedule of benefits that summarizes the payments that may be made for medically necessary medical services that policyholders receive.

Difficulty: 1 Easy

Topic: Medical Insurance Basics

Learning Objective: 01.02

Bloom's: Remember

ABHES: 7.a Graduates will be able to: Gather and process documents

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

19) In general, how do the cost of policies written for groups compare to those written for individuals?

A) Policies written for groups are cheaper.

B) Policies written for individuals are cheaper.

C) Policies written for individuals and groups cost the same.

D) Policies written for groups are more expensive.

Answer: A

Explanation: In general, policies that are written for groups costs policyholders less than those written for individuals.

Difficulty: 1 Easy

Topic: Medical Insurance Basics

Learning Objective: 01.02

Bloom's: Remember

ABHES: 4.a Graduates will be able to follow documentation guidelines

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

20) Review the choices below and select the most appropriate definition for health plan benefits, as defined by American's Health Insurance Plans (AHIP).

A) advantages offered to policyholders

B) provider services

C) payments for covered medical services

D) list of network providers

Answer: C

Explanation: Health plans provide benefits, which are defined by AHIP as payments for covered medical services.

Difficulty: 2 Medium

Topic: Medical Insurance Basics

Learning Objective: 01.02

Bloom's: Understand

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

21) Compare the choices below to determine which type of provider service would most likely NOT be covered by a health plan.

A) a medical procedure that is not included in a plan's benefits

B) an illness that started after the insurance coverage began

C) a surgery performed on an outpatient basis

D) all elective procedures performed in the hospital

Answer: A

Explanation: Medical insurance policies describe noncovered services that they do not cover, which include excluded services.

Difficulty: 3 Hard

Topic: Medical Insurance Basics

Learning Objective: 01.02

Bloom's: Analyze

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

22) What type of insurance reimburses income lost because of a person's inability to work?

A) disability insurance

B) standard medical insurance

C) medical necessity coverage

D) self-insured coverage

Answer: A

Explanation: Patients may have disability insurance that provides reimbursement for income lost because of a person's inability to work.

Difficulty: 1 Easy

Topic: Medical Insurance Basics

Learning Objective: 01.02

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

23) Under a written insurance contract, the policyholder pays a premium, and the insurance company provides

A) payments for covered medical services.

B) preventive medical services.

C) surgery.

D) copayments.

Answer: A

Explanation: A written insurance contract requires the policyholder to pay a premium, in exchange for which the insurance company provides payments for covered medical services.

Difficulty: 3 Hard

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Analyze

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

24) Out-of-pocket expenses must be paid by

A) the provider.

B) the insured.

C) the health plan.

D) the insurance company.

Answer: B

Explanation: Insured individuals pay out-of-pocket expenses before receiving benefits.

Difficulty: 1 Easy

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Remember

ABHES: 7.c Graduates will be able to: Perform billing and collection procedures

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

25) Which of the following conditions must be met before payment is made under an indemnity plan?

A) payment of premium, deductible, and coinsurance

B) payment of the copayment

C) payment of the premium and coinsurance

D) payment of the deductible

Answer: A

Explanation: Before a payment is made to an insured person under an indemnity plan, payments of the premium, deductible, and coinsurance must be up to date.

Difficulty: 1 Easy

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

26) Under an indemnity plan, typically a patient may use the services of

A) only HMO network providers.

B) any affiliated provider.

C) any provider.

D) only out-of-network providers.

Answer: C

Explanation: Under indemnity plans, patients are free to choose their providers.

Difficulty: 2 Medium

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Understand

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

27) Under a fee-for-service plan, the third-party payer makes a payment

A) before medical services are provided.

B) after medical services are provided.

C) at the time of the visit.

D) once a month under a PMPM.

Answer: B

Explanation: Fee-for-service plans pay retroactively.

Difficulty: 1 Easy

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

28) Calculate the amount of money a patient would owe for a covered service costing $1,200 if their indemnity policy has a coinsurance rate of 75-25, and they have already met their deductible.

A) $0

B) $300

C) $900

D) $1,200

Answer: B

Explanation: The patient must pay an out-of-pocket expense of $300 ($1,200 x 0.25 = $300) for this service.

Difficulty: 3 Hard

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Analyze

ABHES: 7.c Graduates will be able to: Perform billing and collection procedures

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

29) Calculate the amount of money a patient would owe for a noncovered service costing $900 if their indemnity policy has a coinsurance rate of 80-20, and they have already met their deductible.

A) $0

B) $180

C) $720

D) $900

Answer: D

Explanation: The patient would owe the entire cost of $900, as insurance policies do not pay for noncovered services.

Difficulty: 3 Hard

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Analyze

ABHES: 7.c Graduates will be able to: Perform billing and collection procedures

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

30) Calculate the amount of money a patient would owe for a covered service costing $1,800 if their indemnity policy has a $400 deductible (which has not been met) and their coinsurance rate is 80-20.

A) $280

B) $680

C) $1,400

D) $1,800

Answer: B

Explanation: The patient must pay an out-of-pocket expense of $680 ($1,800 - $400 = $1,400; $1,400 x 0.20 = $280; $280 + $400 deductible = $680) for this service.

Difficulty: 3 Hard

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Analyze

ABHES: 7.c Graduates will be able to: Perform billing and collection procedures

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

31) When is a deductible paid?

A) before benefits begin

B) at the end of the year

C) after benefits begin

D) never

Answer: A

Explanation: A deductible is an amount of money that the insured pays on covered services before benefits begin.

Difficulty: 1 Easy

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Remember

ABHES: 7.c Graduates will be able to: Perform billing and collection procedures

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

32) How is coinsurance defined?

A) the periodic payment the insured is required to make to keep a policy in effect

B) the amount that the insured pays on covered services before benefits begin

C) the percentage of each claim that the insured pays

D) a prepayment covering provider's services for a plan member for a specified period

Answer: C

Explanation: Coinsurance is the portion of charges an insured person must pay for health care services after the deductible.

Difficulty: 1 Easy

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

33) What is a premium?

A) the periodic payment the insured is required to make to keep a policy in effect

B) the amount that the insured pays on covered services before benefits begin

C) the percentage of each claim that the insured pays

D) a prepayment covering provider's services for a plan member for a specified period

Answer: A

Explanation: A premium is money the insured pays to a health plan for a policy.

Difficulty: 1 Easy

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

34) Calculate the amount of money the insurance company would owe on a covered service costing $850 if there is a $500 deductible (which has not yet been met) and no coinsurance.

A) $0

B) $150

C) $350

D) $500

Answer: C

Explanation: The health plan would owe $350 ($850 - $500 = $350).

Difficulty: 3 Hard

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Analyze

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

35) In how many managed care plans may a physician participate?

A) zero

B) one

C) two

D) many

Answer: D

Explanation: A physician may choose to participate in many managed care plans.

Difficulty: 1 Easy

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

36) Identify the advantages offered to patients in managed care plans, as compared to indemnity insurance.

A) lower premiums and charges

B) higher premiums

C) higher deductibles

D) lower premiums, charges, and deductibles

Answer: D

Explanation: Managed care offers a more restricted choice of (and access to) providers and treatments in exchange for lower premiums, deductibles, and other charges than traditional indemnity insurance.

Difficulty: 1 Easy

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

37) Choose the entity(ies) that may form agreements with an MCO.

A) the patient and provider

B) the provider

C) the health plan

D) the provider and health plan

Answer: A

Explanation: Instead of only the patient having a policy with the health plan, both the patient and the provider have agreements with the MCO.

Difficulty: 2 Medium

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Understand

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

38) Name a benefit a provider usually gets from participation with a health plan.

A) an increased number of patients

B) a decreased number of patients

C) more contractual duties

D) no contractual duties

Answer: A

Explanation: Participation brings providers benefits, such as more patients, as well as contractual duties, and usually, reduced fees.

Difficulty: 1 Easy

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

39) Health care claims report data to payers about \_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_.

A) the patient; the physician's income taxes

B) the patient; the services provided by the physician

C) the physician; the services provided by the physician

D) the service; the deductible

Answer: B

Explanation: Health care claims report data about the patient and the services provided by the physician.

Difficulty: 1 Easy

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

40) An indemnity policy states that the coinsurance rate is 80-20. Which of the following is the payer's portion?

A) 20

B) 60

C) 80

D) 100

Answer: C

Explanation: The first number in the coinsurance rate is the payer's portion; the second is the insured's. In this case, the payer's portion is 80% and the insured's portion is 20%.

Difficulty: 1 Easy

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

41) In what format are health care claims sent?

A) only electronic

B) only hard copy

C) electronic or hard copy

D) claims do not need to be sent

Answer: C

Explanation: Health care claims are sent to payers in either electronic or hard copy format.

Difficulty: 1 Easy

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

42) What is the formula for calculating an insurance company payment in an indemnity plan?

A) charge − deductible

B) deductible − coinsurance

C) deductible + coinsurance

D) charge − deductible − coinsurance

Answer: D

Explanation: The formula for calculating an indemnity insurance payment is charge minus deductible minus coinsurance.

Difficulty: 2 Medium

Topic: Healthcare Plans

Learning Objective: 01.03

Bloom's: Understand

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

43) A capitated payment amount is called a

A) copayment.

B) coinsurance payment.

C) retroactive payment.

D) prospective payment.

Answer: D

Explanation: Capitated payments are paid prospectively, or in advance of services.

Difficulty: 1 Easy

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

44) Identify the type of HMO cost-containment method that limits members to receiving services from the HMO's physician network.

A) cost-sharing

B) restricting patients' choice of providers

C) requiring preauthorization for services

D) controlling drug costs

Answer: B

Explanation: In order to restrict patients' choice of providers, HMOs require members to receive services from their network of physicians, hospitals, and other providers.

Difficulty: 2 Medium

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Understand

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

45) Identify the type of HMO cost-containment method that requires providers to use a formulary.

A) cost-sharing

B) restricting patients' choice of providers

C) requiring preauthorization for services

D) controlling drug costs

Answer: D

Explanation: In controlling drug costs, HMOs require providers to prescribe drugs for patients only from the HMO's formulary.

Difficulty: 2 Medium

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Understand

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

46) Identify the type of HMO cost-containment method that requires the patient to pay a copayment.

A) cost-sharing

B) restricting patients' choice of providers

C) requiring preauthorization for services

D) controlling drug costs

Answer: A

Explanation: In the cost-sharing method of cost-containment, HMOs require patients to pay a specified charge called a copayment when they see a provider.

Difficulty: 2 Medium

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Understand

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

47) Identify the type of HMO cost-containment method that requires patients to obtain approval for services before they receive the treatment.

A) cost-sharing

B) restricting patients' choice of providers

C) requiring preauthorization for services

D) controlling drug costs

Answer: C

Explanation: Requiring patients to obtain preauthorization before they receive many types of services is an HMO cost-containment method.

Difficulty: 2 Medium

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Understand

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

48) If a POS HMO member elects to receive medical services from out-of-network providers they usually

A) pay an additional cost.

B) need only pay the standard copayment.

C) will receive inferior treatment.

D) pay less than in-network benefits.

Answer: A

Explanation: POS members who receive medical services from out-of-network providers that they choose usually pay an additional cost.

Difficulty: 2 Medium

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Understand

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

49) Which term best describes medical services that meet professional medical standards?

A) medical etiquette.

B) medical networks.

C) medical necessity.

D) medical ethics.

Answer: C

Explanation: For more information, the definition of medical necessity can be located in the Medicare.gov glossary. It is a payment concept--payers do not pay for medically unnecessary procedures and treatments.

Difficulty: 1 Easy

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

50) Which of the following is required when an HMO patient is admitted to the hospital for nonemergency treatment?

A) referral

B) coinsurance

C) preauthorization

D) utilization

Answer: C

Explanation: Patients must secure preauthorization for nonemergency hospitalizations.

Difficulty: 2 Medium

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Understand

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

51) One of the advantages of an HMO for patients who face difficult treatments is Disease/Case Management by assigning a

A) referral.

B) PCP.

C) copayment.

D) case manager.

Answer: D

Explanation: HMOs often assign case managers to work with patients who face difficult treatments.

Difficulty: 2 Medium

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Understand

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

52) Under a capitated rate for each plan member, which of the following does a provider share with the third-party payer?

A) payments

B) risk

C) services

D) the premium

Answer: B

Explanation: In a capitated plan, providers and payers share the risk of increased demand for medical services.

Difficulty: 2 Medium

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Understand

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

53) The capitated rate per member per month covers

A) all medical services.

B) services listed on the schedule of benefits.

C) the episode of care.

D) all members' premiums.

Answer: B

Explanation: The capitated rate of prepayment covers only services listed on the schedule of benefits.

Difficulty: 2 Medium

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Understand

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

54) To be fully covered, patients who enroll in an HMO may use the services of

A) only HMO network providers.

B) any provider within 50 miles.

C) only out-of-network providers.

D) any provider.

Answer: A

Explanation: HMOs require their members to see only network providers in order to be fully covered.

Difficulty: 1 Easy

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

55) For a patient insured by an HMO, the phrase "out-of-network" means providers who are

A) not under contract with the payer.

B) only acting as a specialist.

C) whose offices are more than 50 miles from the patient.

D) licensed by the state.

Answer: A

Explanation: Out-of-network providers do not have any agreement with the patient's health plan.

Difficulty: 1 Easy

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

56) Patients who enroll in a point-of-service type of HMO may use the services of

A) only HMO network providers.

B) any affiliated provider.

C) only out-of-network providers.

D) HMO network or out-of-network providers.

Answer: D

Explanation: POS plans expand patients' options to include out-of-network providers.

Difficulty: 1 Easy

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

57) When a POS option is elected under a health maintenance organization, the patient may

A) choose providers only from the HMO's network.

B) choose providers who are not in the HMO's network.

C) choose any provider without additional expense.

D) choose providers only from the IPA's network.

Answer: B

Explanation: POS plans provide patients with the option of using non-network providers.

Difficulty: 2 Medium

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Understand

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

58) Identify another name for a point-of-service (POS) plan.

A) closed HMO

B) open HMO

C) free HMO

D) restricted HMO

Answer: B

Explanation: A point-of-service (POS) plan is also called an open HMO.

Difficulty: 1 Easy

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

59) Calculate the monthly capitation payment a provider should receive from a health plan if they have 80 contracted patients and a capitated payment of $40 per month.

A) $1,200

B) $2,400

C) $3,200

D) $4,000

Answer: C

Explanation: The monthly capitation payment would total $3,200 (80 x $40 = $3,200).

Difficulty: 3 Hard

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Analyze

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

60) A physician has a contract to receive a $2,000 monthly capitation fee, based on a fee of $50 for 40 patients who are in the plan. If only 10 patients visited the practice in the last month, the capitation payment will be

A) $500.

B) $1,000.

C) $2,000.

D) $4,000.

Answer: C

Explanation: The monthly capitation fee is $2,000, regardless of the number of patients who visit the physician.

Difficulty: 2 Medium

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Understand

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

61) Describe the role of a primary care physician (PCP) in an HMO.

A) coordinating patients' overall care

B) ensuring that some services are necessary

C) providing health care services for the patient

D) admitting the patient to the hospital regardless of the condition

Answer: A

Explanation: A PCP coordinates patient's overall care to ensure that all services are, in the PCP's judgment, necessary.

Difficulty: 2 Medium

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Understand

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

62) Another term used for a primary care physician (PCP) is

A) controller.

B) practitioner.

C) gatekeeper.

D) specialist.

Answer: C

Explanation: A primary care physician (PCP) may also be called a gatekeeper.

Difficulty: 1 Easy

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

63) On what is the PMPM rate usually based?

A) health-related characteristics of the enrollees

B) a restricted choice of providers

C) the health plan's formulary

D) fee for service

Answer: A

Explanation: The capitated rate, called PMPM, is usually based on the health-related characteristics of the enrollees, such as age and gender.

Difficulty: 1 Easy

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

64) Higher copayments may be charged for patient visits to/for

A) preventive services.

B) the office of a specialist.

C) their primary care physician.

D) medical necessary services.

Answer: B

Explanation: A higher copayment may be required for a visit to the office of a specialist or for the use of emergency department services.

Difficulty: 1 Easy

Topic: Health Maintenance Organizations

Learning Objective: 01.04

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

65) In a preferred provider organization (PPO) plan, referrals to specialists are

A) required.

B) not required.

C) more expensive.

D) less expensive.

Answer: B

Explanation: PPOs do not usually demand a referral for a specialist visit.

Difficulty: 1 Easy

Topic: Preferred Provider Organizations

Learning Objective: 01.05

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

66) What do providers participating in a PPO generally receive in exchange for accepting lower fees?

A) more patient visits

B) capitation payments

C) less patient visits

D) increased hospitalization rates

Answer: A

Explanation: In exchange for accepting lower fees, providers generally see more patients.

Difficulty: 1 Easy

Topic: Preferred Provider Organizations

Learning Objective: 01.05

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

67) PPO members who use out-of-network providers may be subjected to

A) higher copayments.

B) lower copayments.

C) lower insurance rates.

D) decreased deductibles.

Answer: A

Explanation: PPO members may use out-of-network providers, usually for higher copayments, increased deductibles, or both.

Difficulty: 1 Easy

Topic: Preferred Provider Organizations

Learning Objective: 01.05

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

68) Imagine you are a patient who wants to regulate your health care expenses on your own; what type of insurance plan would you use?

A) health maintenance organization

B) preferred provider organization

C) consumer-driven health plan

D) point-of-service plan

Answer: C

Explanation: Cost containment in consumer-driven health plans begins with consumerism, which is the idea that patients who themselves pay for health care services become more careful consumers.

Difficulty: 3 Hard

Topic: Consumer-Driven Health Plans

Learning Objective: 01.06

Bloom's: Apply

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

69) Consumer-driven health plans combine a health plan with a special "savings account" that is used to pay what before the deductible is met?

A) coinsurance

B) medical bills

C) excluded services

D) non-medically necessary services

Answer: B

Explanation: Consumer-driven health plans combine a health plan with a special "savings account" that is used to pay medical bills before the deductible is met.

Difficulty: 1 Easy

Topic: Consumer-Driven Health Plans

Learning Objective: 01.06

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

70) Name the two components of a consumer-driven health plan (CDHP).

A) a health plan and a gatekeeper

B) a health plan and a special "savings account"

C) a gatekeeper and a special "savings account"

D) a gatekeeper and a formulary

Answer: B

Explanation: Consumer-driven health plans (CDHPs) combine a health plan, usually a PPO with a high deductible and low premiums, with a special "savings account" used to pay medical bills before the deductible has been met.

Difficulty: 1 Easy

Topic: Consumer-Driven Health Plans

Learning Objective: 01.06

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

71) Employers that offer health plans to employees without using an insurance carrier are

A) third-party payers.

B) third-party administrators.

C) independent contractors.

D) self-funded (insured) health plans.

Answer: D

Explanation: Self-funded (insured) health plans offer health plans directly to employees.

Difficulty: 1 Easy

Topic: Medical Insurance Payers

Learning Objective: 01.07

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

72) Determine which method a self-funded health plan most often uses in setting up its provider network.

A) hire a PCP to provide a network

B) set up their own provider network

C) buy the use of existing networks from managed care organizations

D) are not required to set up a network

Answer: C

Explanation: Self-funded health plans most often buy the use of existing networks from managed care organizations.

Difficulty: 1 Easy

Topic: Medical Insurance Payers

Learning Objective: 01.07

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

73) Which of the following is an example of a private-sector payer?

A) Medicare

B) Medicaid

C) workers' compensation insurance

D) insurance company

Answer: D

Explanation: An insurance company is considered a private-sector payer, as opposed to government programs such as Medicare.

Difficulty: 1 Easy

Topic: Medical Insurance Payers

Learning Objective: 01.07

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

74) Which of the following covers patients who are age 65 and over?

A) Medicare

B) Medicaid

C) TRICARE

D) CHAMPUS

Answer: A

Explanation: Medicare covers the age 65 and over population.

Difficulty: 1 Easy

Topic: Medical Insurance Payers

Learning Objective: 01.07

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

75) Which of the following programs covers people who cannot otherwise afford medical care?

A) Medicare

B) Medicaid

C) TRICARE

D) CHAMPUS

Answer: B

Explanation: Medicaid covers people who otherwise could not afford medical care.

Difficulty: 1 Easy

Topic: Medical Insurance Payers

Learning Objective: 01.07

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

76) Scheduling appointments is part of which revenue cycle step?

A) Step 1, preregister patients.

B) Step 10, follow up on patient payments.

C) Step 8, monitor patient adjudication.

D) Step 5, review coding compliance.

Answer: A

Explanation: Scheduling appointments is the first step in the revenue cycle.

Difficulty: 1 Easy

Topic: The Revenue Cycle

Learning Objective: 01.08

Bloom's: Remember

ABHES: 7.e Graduates will be able to: Apply scheduling principles

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

77) Collecting copayments is part of which revenue cycle step?

A) Step 3, check in patients.

B) Step 10, follow up payments and collections

C) Step 8, monitor patient adjudication.

D) Step 5, review billing compliance

Answer: A

Explanation: Collecting copayments is done during patient check-in.

Difficulty: 1 Easy

Topic: The Revenue Cycle

Learning Objective: 01.08

Bloom's: Remember

ABHES: 7.c Graduates will be able to: Perform billing and collection procedures

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

78) When medical insurance specialists work with patient billing programs, they need

A) computer skills.

B) communication skills.

C) knowledge of anatomy.

D) flexibility.

Answer: A

Explanation: Most medical practices use computers to handle billing and process claims.

Difficulty: 2 Medium

Topic: The Revenue Cycle

Learning Objective: 01.08

Bloom's: Understand

ABHES: 7.b Graduates will be able to: Navigate electronic health records systems and practice management software

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

79) A patient ledger records

A) the patient's illnesses.

B) the patient's financial transactions.

C) the patient's relatives.

D) the day's appointments and payments.

Answer: B

Explanation: A patient ledger is a record of a particular patient's financial transactions with the practice.

Difficulty: 1 Easy

Topic: The Revenue Cycle

Learning Objective: 01.08

Bloom's: Remember

ABHES: 7.c Graduates will be able to: Perform billing and collection procedures

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

80) Imagine you are a medical insurance specialist; identify the impact your ability to prepare accurate, timely claims can have on the practice.

A) Preparing accurate and timely claims generally leads to full and timely reimbursement from the health plan.

B) Preparing accurate and timely claims generally leads to a higher capitation payment.

C) Preparing accurate and timely claims generally leads to a higher coinsurance rate.

D) Preparing accurate and timely claims generally leads to more patients.

Answer: A

Explanation: When medical insurance specialists prepare accurate, timely claims, the practice is most likely to receive full and timely reimbursement from the health plan.

Difficulty: 3 Hard

Topic: The Revenue Cycle

Learning Objective: 01.08

Bloom's: Apply

ABHES: 7.c Graduates will be able to: Perform billing and collection procedures

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

81) What step is used when patient payments are later than permitted under the financial policy?

A) Step 3, check in patients.

B) Step 10, follow up patient payments and collections.

C) Step 2, establish financial responsibility for the visit.

D) Step 4, review coding compliance.

Answer: B

Explanation: A collection process is often started when patient payments are later than permitted under the practice's financial policy.

Difficulty: 1 Easy

Topic: The Revenue Cycle

Learning Objective: 01.08

Bloom's: Remember

ABHES: 7.c Graduates will be able to: Perform billing and collection procedures

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

82) Verifying insurance is part of which revenue cycle step?

A) Step 3, check in patients.

B) Step 10, follow up patient payments.

C) Step 2, establish financial responsibility for the visit.

D) Step 4, review coding compliance.

Answer: C

Explanation: Verifying insurance is part of establishing financial responsibility for a visit.

Difficulty: 1 Easy

Topic: The Revenue Cycle

Learning Objective: 01.08

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

83) Describe the process of adjudication.

A) the practice's monitoring of the money that is needed to run the practice

B) the payer's process of putting a claim through a series of steps designed to judge whether it should be paid

C) the process of appealing a rejected claim

D) the practice's comparison of each payment sent with a claim

Answer: B

Explanation: A health plan's process of examining claims and determining benefits is adjudication.

Difficulty: 2 Medium

Topic: The Revenue Cycle

Learning Objective: 01.08

Bloom's: Understand

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

84) In what step does the medical insurance specialist verify that charges are in compliance with insurance guidelines?

A) Step 3, check in patients.

B) Step 10, follow up patient payments.

C) Step 2, establish financial responsibility for the visit.

D) Step 5, review billing compliance.

Answer: D

Explanation: Medical insurance specialists apply their knowledge of payer guidelines to analyze what can be billed on health care claims.

Difficulty: 1 Easy

Topic: The Revenue Cycle

Learning Objective: 01.08

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

85) What term is used to describe the action of satisfying official requirements?

A) adjudication

B) compliance

C) accounts receivable (A/R)

D) accounts payable (A/P)

Answer: B

Explanation: Compliance means actions that satisfy official requirements, such as the proper assigning of codes.

Difficulty: 1 Easy

Topic: The Revenue Cycle

Learning Objective: 01.08

Bloom's: Remember

ABHES: 7.d Graduates will be able to: Process insurance claims

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

86) What adds up to form a practice's accounts receivable?

A) money due from health plans

B) money due from patients

C) money due from both health plans and patients

D) money owed to patients

Answer: C

Explanation: The money due from plans, as well as payments due from patients, add up to form the practice's accounts receivable (A/R).

Difficulty: 1 Easy

Topic: The Revenue Cycle

Learning Objective: 01.08

Bloom's: Remember

ABHES: 7.c Graduates will be able to: Perform billing and collection procedures

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

87) Practice management programs may be used for

A) scheduling appointments and financial record keeping.

B) financial record keeping and billing.

C) billing only.

D) scheduling appointments, financial record keeping, and billing.

Answer: D

Explanation: PMPs are used for scheduling appointments, billing, and financial record keeping.

Difficulty: 1 Easy

Topic: The Revenue Cycle

Learning Objective: 01.08

Bloom's: Remember

ABHES: 7.b Graduates will be able to: Navigate electronic health records systems and practice management software

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

88) Which of the following characteristics should medical insurance specialists use when working with patients' records and handling finances?

A) able to work as a team member

B) honesty and integrity

C) knowledge of medical terms

D) communication skills

Answer: B

Explanation: Handling financial matters requires honesty and integrity.

Difficulty: 3 Hard

Topic: Achieving Success

Learning Objective: 01.09

Bloom's: Apply

ABHES: 4.a Graduates will be able to follow documentation guidelines; 4.g Graduates will be able to display compliance with the Code of Ethics of the profession

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

89) The statement that "coding professionals should not change codes. . .to increase billings" is an example of

A) professional ethics.

B) professional services.

C) professional etiquette.

D) personal ethics.

Answer: A

Explanation: Each professional organization has a code of ethics that is to be followed by its membership.

Difficulty: 3 Hard

Topic: Achieving Success

Learning Objective: 01.09

Bloom's: Apply

ABHES: 4.a Graduates will be able to follow documentation guidelines; 4.g Graduates will be able to display compliance with the Code of Ethics of the profession

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

90) Courteous treatment of patients who visit the medical practice is an example of medical

A) ethics.

B) etiquette.

C) coding.

D) insurance.

Answer: B

Explanation: Medical etiquette requires courteous treatment of patients.

Difficulty: 1 Easy

Topic: Achieving Success

Learning Objective: 01.09

Bloom's: Remember

ABHES: 5.c Graduates will be able to: Assist the patient in navigating issues and concerns that may arise (i.e., insurance policy information, medical bills, and physician/ provider orders)

CAHIIM: IV.A.1 Apply policies and procedures for the use of data required in healthcare reimbursement

91) In large medical practices, a medical insurance specialist is more likely to

A) need to use professionalism.

B) handle a variety of billing and collections tasks.

C) have more specialized duties.

D) have less specialized duties.

Answer: C

Explanation: In large medical practices, the duties of medical insurance specialists may be more specialized.

Difficulty: 1 Easy

Topic: Achieving Success

Learning Objective: 01.09

Bloom's: Remember

ABHES: 1.b Graduates will be able to: Compare and contrast the allied health professions and understand their relation to medical assisting

CAHIIM: VI.E.2 Explain return on investment for employee training/development

92) The most important characteristic for a medical insurance specialist to possess is

A) professionalism.

B) punctuality.

C) friendliness.

D) quickness.

Answer: A

Explanation: The most important characteristic that medical insurance specialists should evidence is professionalism.

Difficulty: 1 Easy

Topic: Achieving Success

Learning Objective: 01.09

Bloom's: Remember

ABHES: 4.g Graduates will be able to display compliance with the Code of Ethics of the profession

CAHIIM: II.B.1 Apply confidentiality, privacy and security measures and policies and procedures for internal and external use and exchange to protect electronic health information

93) What skills and attributes are required for successful mastery of the tasks of a medical insurance specialist?

A) professional appearance and attention to detail

B) courtesy and good attendance

C) initiative and communication skills

D) attention to detail and ability to work as a team member

Answer: D

Explanation: A number of skills and attributes are required for successful mastery of the tasks of a medical insurance specialist, including knowledge of medical terminology, anatomy, physiology, and medical coding; communication skills; attention to detail; flexibility; health information technology skills; honesty and integrity; and ability to work as a team member.

Difficulty: 1 Easy

Topic: Achieving Success

Learning Objective: 01.09

Bloom's: Remember

ABHES: 4.g Graduates will be able to display compliance with the Code of Ethics of the profession

CAHIIM: II.B.1 Apply confidentiality, privacy and security measures and policies and procedures for internal and external use and exchange to protect electronic health information

94) Professional organizations generally have a(n) \_\_\_\_\_\_\_\_ that its members should follow/possess.

A) employee policy and procedure manual

B) list of attributes

C) code of ethics

D) financial policy

Answer: C

Explanation: Each professional organization has a code of ethics that is to be followed by its membership.

Difficulty: 1 Easy

Topic: Achieving Success

Learning Objective: 01.09

Bloom's: Remember

ABHES: 4.g Graduates will be able to display compliance with the Code of Ethics of the profession

CAHIIM: II.B.1 Apply confidentiality, privacy and security measures and policies and procedures for internal and external use and exchange to protect electronic health information

95) The designation of Registered Medical Assistant (RMA) is awarded by

A) AAMA.

B) AAPC.

C) AMT.

D) AHIMA.

Answer: C

Explanation: The RMA is awarded by the AMT.

Difficulty: 1 Easy

Topic: Moving Ahead

Learning Objective: 01.10

Bloom's: Remember

ABHES: 1.c Graduates will be able to: Describe and comprehend medical assistant credentialing requirements, the process to obtain the credential and the importance of credentialing

CAHIIM: VI.E.2 Explain return on investment for employee training/development

96) Certification as a Certified Professional Coder (CPC) is awarded by

A) AAMA.

B) AAPC.

C) AMT.

D) AHIMA.

Answer: B

Explanation: The American Academy of Professional Coders grants the Certified Professional Coder.

Difficulty: 1 Easy

Topic: Moving Ahead

Learning Objective: 01.10

Bloom's: Remember

ABHES: 1.c Graduates will be able to: Describe and comprehend medical assistant credentialing requirements, the process to obtain the credential and the importance of credentialing

CAHIIM: VI.E.2 Explain return on investment for employee training/development

97) The titles of Certified Coding Specialist (CCS) and Certified Coding Specialist–Physician-based (CCS-P) are awarded by

A) AMA.

B) CNN.

C) ABC.

D) AHIMA.

Answer: D

Explanation: The CCS and CCS-P certifications are awarded by AHIMA.

Difficulty: 1 Easy

Topic: Moving Ahead

Learning Objective: 01.10

Bloom's: Remember

ABHES: 1.c Graduates will be able to: Describe and comprehend medical assistant credentialing requirements, the process to obtain the credential and the importance of credentialing

CAHIIM: VI.E.2 Explain return on investment for employee training/development

98) Pick the most accurate definition of certification.

A) recognition of professionalism

B) recognition of a superior level of skill by an official organization

C) recognition of a successful career

D) recognition of higher level of degree of schooling

Answer: B

Explanation: Certification is recognition of a superior level of skill by an official organization.

Difficulty: 2 Medium

Topic: Moving Ahead

Learning Objective: 01.10

Bloom's: Understand

ABHES: 1.c Graduates will be able to: Describe and comprehend medical assistant credentialing requirements, the process to obtain the credential and the importance of credentialing

CAHIIM: VI.E.2 Explain return on investment for employee training/development

99) What is typically required of professional organizations?

A) good attendance

B) continuing education sessions

C) membership in more than one organization

D) there are no requirements

Answer: B

Explanation: Most professional organizations require certified members to keep up-to-date by taking annual training courses

Difficulty: 1 Easy

Topic: Moving Ahead

Learning Objective: 01.10

Bloom's: Remember

ABHES: 1.c Graduates will be able to: Describe and comprehend medical assistant credentialing requirements, the process to obtain the credential and the importance of credentialing

CAHIIM: VI.E.2 Explain return on investment for employee training/development