medical insurance claims chapter and coding chapters

Name_____

MULTIPLE CHOICE. Choose the one alternative that best completes the statement or answers the question.

1) The _____ insurance claim form is used for hospitalization services. 1) _____
A) CMS-1540 B) DD Form 2642 C) CMS-1450 D) CMS-5410

2) The CMS-1500 has _____ blocks of information to complete. 2) _____
A) 33 B) 22 C) 37 D) 27

3) Blocks 1 to 13 of the CMS-1500 represent information about the patient's _____ and insurance carrier. 3) _____
A) diagnosis B) total charge
C) demographics D) procedures performed

4) _____ involves the physician agreeing to forfeit the amount the insurance company does not authorize. 4) _____
A) Deduction B) Discount C) Write off D) Forfeiture

5) Patients who have health insurance coverage with more than one medical insurance plan will have one primary insurance coverage and one _____ one. 5) _____
A) secondary B) inferior C) downgraded D) backup

6) A _____ saves the medical assistant the time required for a patient to sign an insurance claim form for each office visit. 6) _____
A) signature on file B) forgery
C) computer D) signature stamp

7) Insurance claims administrators' use the _____ rule to determine which parent's benefit plans will cover a dependent minor's medical bills when that minor is covered by both parents' plans. 7) _____
A) custodial B) birthday
C) keepsake D) first come, first served

8) After medical assistants complete claim forms, he or she enters data into the insurance claim _____. 8) _____
A) file B) book C) computer D) log

9) All of the following are some of the most common reasons for claim form rejection *except* _____. 9) _____
A) incorrect or missing diagnosis code
B) incorrect or missing insurance company name
C) incorrect place of service
D) incorrect or missing patient registration information

10) To avoid claim rejection, the medical assistant must _____ every claim for accuracy before submitting it. 10) _____
A) complete B) hand write C) type D) review

11) If the _____ claim form is not used, Medicare will reject it. 11) _____
A) DD Form 2642 B) CMS-1540 C) UB-92 D) CMS-1500

12) Due to the type of documentation required for _____ claims, some service providers will not see those patients. In some states, patients must see physicians who specialize in these types of cases. 12) _____
A) workers' compensation B) Medicare
C) Social Security D) Medicaid

13) All the following are true of processing paper claim forms *except* _____. 13) _____
A) clip no items to the claim forms B) use no tape on the claim forms
C) never use punctuation D) always use decimals

14) _____ claims are submitted to insurance carriers on time. The first time these claims are submitted to insurance carriers, they are processed and payment is sent to the providers. 14) _____
A) clean B) one-time C) neat D) dirty

15) When legally married parents have the same birthday, the parent holding the primary medical insurance is the one with the _____ date of inception. 15) _____
A) equal B) earliest C) best D) latest

16) Before releasing any patient information, you must obtain a signed _____ statement. 16) _____
A) physician
B) living revocable trust
C) authorization for medical information release
D) copy of a valid identification

17) There are usually time limits for refiling rejected claims, so medical assistants must be very aware of these deadlines and resubmit claims _____ the time limits have expired. 17) _____
A) after B) when C) before D) if

18) When a claim form has one or more errors, it must be _____. 18) _____
A) thrown away B) corrected and then resubmitted
C) documented and then resubmitted D) submitted anyway

19) All medical offices were mandated to comply with electronic filing by October _____. 19) _____
A) 1978 B) 2008 C) 2003 D) 1993

20) After copying each _____, the medical assistant files it in the patient's medical record. 20) _____
A) credit card B) driver's license
C) insurance card D) Social Security card

21) _____ is prior approval for the medical service to be covered by insurance. 21) _____
A) previously insured B) postauthorization
C) post approval D) preauthorization

22) The _____ period is the period during which payments for Medicare hospital benefits are available. 22) _____
A) time B) insurance C) benefit D) open

23) When the medical assistant receives payment on a claim, the _____ must be documented in the insurance claim log. 23) _____

A) physician on duty
B) insurance company
C) date
D) patient's Social Security number

MATCHING. Choose the item in column 2 that best matches each item in column 1.

Match each term to the correct statement.

24) _____ is the failure to keep something confidential or releasing patient information without the patient's authorization. 24) _____

25) _____ cover patients eligible for both Medicare and Medicaid. 25) _____

26) _____ accept insurance companies' allowed amount for services rendered to be payment in full (less patient co-payments). 26) _____

27) A(n)_____ is one sheet that list lists the patient's name, diagnoses, and treatments with added space for filling in claim information. 27) _____

28) _____ allows physicians to be paid directly from insurance carriers. 28) _____

29) _____ bill patients, and the patients are expected to pay the charges. 29) _____

30) _____ is prior approval. 30) _____

31) A(n) _____ is a health insurance claim form that has been completed correctly with no errors or omissions. 31) _____

32) _____ is insurance set up specifically for work-related injuries. 32) _____

33) The _____ is the time during which payments for Medicare hospital benefits are available. 33) _____

A) superbill
B) nonparticipating providers
C) cross-over claims
D) preauthorization
E) breach of confidentiality
F) participating provider
G) worker's compensation
H) assignment of benefits
I) clean claim
J) benefit period

coding chapter starts here

MULTIPLE CHOICE. Choose the one alternative that best completes the statement or answers the question.

34) The CPT manual is organized numerically or alphanumerically in sections of service types (Table 17-1). The most common codes for Evaluation and Management (E/M) services (e.g., office visits, consultations, physician's components for emergency services and inpatient hospital care) are in the front of the manual. There are also codes for anesthesia, surgery, radiology, pathology and laboratory, and miscellaneous medical services. 34) _____

A) code
B) numeric diagnosis codes
C) alphanumeric diagnosis codes
D) medical terms

35) The ICD-9-CM coding manual has _____ volumes of information. 35) _____

A) one B) two C) three D) four

36) By 1988, the _____ was passed, requiring physicians to use diagnosis codes to receive Medicare reimbursement. 36) _____

A) Medicare Catastrophic Coverage Act
B) Medicare Diagnosis code
C) Medicare Diagnosis and Reimbursement Act
D) Medicare Reimbursement code

37) A _____ indicates a new code. 37) _____

A) brace B) parenthesis C) bullet D) bracket

38) _____ type is used for all exclusion notes and to identify codes that should *not* be used to describe primary diagnoses. 38) _____

A) italicized B) highlighted C) underlined D) boldface

39) Each Level II code begins with a letter with _____ number(s) after it. 39) _____

A) one B) three C) two D) four

40) Procedure and diagnosis coding is _____ for billing purposes and physician orders of extended services. 40) _____

A) required B) suggested C) optional D) unneeded

41) _____ is an intentional representation that an individual knows to be false or does not believe to be true and makes knowing that it could cause the individual or some other person some unauthorized benefit. 41) _____

A) medical coding
B) compliance planning
C) symbolism
D) fraud

42) The process of insurance billing includes accurately identifying the diagnostic, procedure, and service codes on the medical insurance _____ form. 42) _____

A) claim B) procedure C) service D) release

43) _____ require(s) the use of the CMS-1500 form for Medicare billing and, for most providers, all medical billing as well as electronic bill submission. 43) _____

A) HIPAA B) physicians C) the government D) state law

44) The procedure and service codes are in the _____ listing. 44) _____
A) Current Procedural Terminology cpt
B) Current Codes Terminology
C) Current Services Terminology
D) Current Procedure and Services Terminology

45) Elderly patients and caregivers of patients may not understand the _____ as stated on the superbill. 45) _____
A) bill B) code C) law D) diagnosis

46) Volume _____ (the Tabular List) has 17 chapters of disease and injury codes and supplementary classifications for V and E codes. 46) _____
A) I B) II C) III D) IV

47) The ICD-9-CM manual uses _____ for certain diseases and conditions. 47) _____
A) tables B) graphs C) charts D) pictures

48) Evaluation and Management is based on all the following 48) _____
A) exam complexity
B) all these options are correct
C) degree of difficulty in medical decision-making
D) patient history

49) The Evaluation and Management codes are _____ oriented and were designed to link procedures or diagnoses with the time it takes physicians to diagnosis and treat patients. 49) _____
A) production B) service C) diagnosis D) procedure

50) Only the codes that stand _____ have full descriptions. 50) _____
A) alone B) together C) straight D) long term

51) Which of the following three factors of Evaluation and Management can be the most complex? 51) _____
A) degree of difficulty in medical decision making
B) degree of difficulty in patient satisfaction
C) exam complexity
D) patient history

52) It is important to understand the difference between new and established patients, and consultations and referrals, and to be sure the proper place of service (office, hospital, skilled nursing facility, emergency department) is _____. 52) _____
A) diagnosed B) molded C) coded D) paid

53) Commonly accepted descriptions of services or procedures are presented _____ the code number. 53) _____
A) between B) in addition to C) before D) after

54) The _____ code reflects detailed information about the illness or injury converted to numeric form. 54) _____
A) patient B) information
C) diagnosis ICD-9 D) procedure

55) To code services correctly, locate the desired procedure in the index at the _____ of the CPT manual. 55) _____

A) back B) middle C) front D) top

56) A _____ code is used when the procedure code does not accurately describe the procedure. 56) _____

A) description B) procedure C) modifier D) practice

57) To code properly, begin with Volume II, the _____ Index. 57) _____

A) Alphabetic B) Numeric C) Code D) Alphanumeric

58) The Centers for Medicare and Medicaid Services Web site (http://www.cms.hhs.gov/providers/fraud/) has information to help you better understand insurance _____. 58) _____

A) reimbursement B) companies C) premiums D) fraud

59) When using multiple modifiers, always list the modifier -_____ first. 59) _____

A) 88 B) 33 C) 99 D) 66

60) The _____-digit modifier provides added information about patient services. 60) _____

A) one B) two C) three D) four

61) The most common modifier is _____, which indicates the procedure was bilateral done at the same time, such as bilateral myringtomies and tube insertions. 61) _____

A) 10 B) 55 C) 50 D) 25

62) According to a 1993 survey by the Health Insurance Association of America for private insurers' health care fraud investigations, which of the following has the highest overall health care fraud activity? 62) _____

A) fraudulent diagnosis
B) waiver of patient deductibles and co-payments
C) billing for services not rendered
D) none of the above

63) A medical office without a _____ may be at risk of liability issues. 63) _____

A) transcriber B) pharmacist
C) compliance plan D) physician's quarters

64) Although the federal government requires that certain people are eligible for Medicaid benefits and sets standards for quality of care, the _____ carry out most of the day-to-day business of Medicaid. 64) _____

A) patients B) physicians
C) states D) medical assistants

65) Coding of procedures and diagnoses MUST be supported by the _____ in the patient record. 65) _____

A) codes B) documentation C) references D) insurance

66) Which of the following would a medical assistant need to report suspected insurance fraud? 66) _____

A) date of service B) patient's insurance number
C) patient's name D) all of the above

67) There can only be up to _____ diagnosis code(s) on the insurance claim form. 67) _____
A) three B) two C) four D) one

68) Which of the following should a medical assistant not code? 68) _____
A) rule-out diagnosis B) questionable diagnosis
C) probable diagnosis D) all of the above

69) Which ICD-9-CM volume is an alphabetic index? 69) _____
A) I B) II
C) III D) none of the above

70) Which ICD-9-CM volume is a tabular list? 70) _____
A) I B) II
C) III D) none of the above

71) Which ICD-9-CM volume has V codes and E codes? 71) _____
A) I B) II
C) III D) none of the above

72) The _____ code reflects detailed information about the service provided utilizing levels of care. 72) _____
A) patient B) procedure C) diagnosis D) information

73) Often, a _____ code is given, although ranges of possible codes (joined with a hyphen) are presented and should be used when needed. 73) _____
A) single B) double C) triple D) quadruple

74) Volume _____ has an index of poisoning and adverse effects of chemicals and drugs and an index of injuries caused by external efforts, like accidents. 74) _____
A) I B) II C) III D) IV

75) _____ has gradually grown from a new office task to a career that requires extensive training and knowledge of both the medical and insurance professions. 75) _____
A) coding B) phoning C) moaning D) controlling

76) Every year, ICD-9-CM codes are updated. The newly published codes are available publicly on or before _____. 76) _____
A) June 1 B) December 1 C) September 1 D) October 1

1) C
2) A
3) C
4) C
5) A
6) A
7) B
8) D
9) B
10) D
11) D
12) A
13) D
14) A
15) B
16) C
17) C
18) B
19) C
20) C
21) D
22) C
23) C
24) E
25) C
26) F
27) A
28) H
29) B
30) D
31) I
32) G
33) J
34) D
35) C
36) A
37) C
38) A
39) D
40) A
41) D
42) A
43) A
44) A
45) D
46) A
47) A
48) B
49) B
50) A

51) A
52) C
53) D
54) C
55) A
56) C
57) A
58) D
59) C
60) B
61) C
62) A
63) C
64) C
65) B
66) D
67) C
68) D
69) B
70) A
71) A
72) B
73) A
74) B
75) A
76) D