AAPC

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Question: 1

it depends on doc

A. To deine the Medicare coverage and payment policy for a service or procedure, which of the following resources will indicate if a service is payable, noncovered, or bundled into another service?
B. Healthcare workers must be provided specific training including the use of Standard Precautions if they might come into contact with _____.
C. A 68-year-old Medicare patient presented for an annual examination and had no complaints. Her claim, billed as 99387, was denied. Was this billed correctly? If not, how is this encounter correctly billed?
D. Services that are performed for treatment or diagnosis of an injury, illness, or disease in accordance with generally accepted standards of medical practice defines:

Answer: C

Question: 2

quarterly

A. person bringing civil action for FCA violation for themselves
B. NCCI edits are updated by CMS and released
C. Blue Cross/Blue Shield identifies the individual or employer who pays for healthcare insurance coverage as the:
D. Most medical debt is discharged, the provider will write-off amounts owed.

Answer: B

Question: 3

TILA

A. Medicare states that reporting bundled codes in addition to the major procedural code is considered to be unbundling, and if repeated with frequency it is considered to be:
B. In addition to the standardization of the codes (ICD-10, CPT, HCPCS, and NDC) used to request payment for medical services, what must be used on all transactions for employers and providers?
C. A practice allows patients to pay large balances over a six month time period with a finance charge applied. The patient receives a statement every month that only shows the unpaid balance. What does this violate?

D. An initial denial is received in the office from Aetna. The denial is investigated and the office considers that the payment was not according to their contract. According to Aetna's policy, what must the biller do?

Answer: C

Question: 4

inadequate med recd

A. The ub-04 claim form is Also Called:
B. Ms-drgs:
C. All the following are considered Fraud, EXCEPT:
D. Npi:

Answer: C

Question: 5

covered entity

A. Health plan, clearinghouses, and any entity transmitting health information is considered by the Privacy Rule to be a:
B. The for a supplemental policy for Medicare is:
C. TRICARE Prime as his health plan. Who will be responsible for coordinating his health care, maintaining his medical records and referrals to specialists when needed
D. Indicates specific CPT code pairs that can be reported on the same day for the same beneficiary by the same provider.

Answer: A

Question: 6

CHAMPVA

A. A practice allows patients to pay large balances over a six month time period with a finance charge applied. The patient receives a statement every month that only shows the unpaid balance. What does this violate?
B. Barbara's late husband, Joe, was a lieutenant in the Navy. He served for 30 years, retiring 10 years prior to his death that was related to service connected disability. Barbara will still have healthcare coverage as Joe's widow under which of the following healthcare programs?

C. A savings account that allows individuals to save pre-tax dollars to reimburse for healthcare expenses is known as a(n):
D. Medicare states that reporting bundled codes in addition to the major procedural code is considered to be unbundling, and if repeated with frequency it is considered to be:

Answer: B

Question: 7

POS, PPO

A. When charges are entered and all required components are verified by the claims editing system, what would this be considered as?
B. Which of the following situations allows release of PHI without authorization from the patient?
C. Which type of managed care insurance allows patients to self-refer to out-of-network providers and pay a higher co-insurance/copay amount?
D. Medicare provides a list of questions to ask beneficiaries that helps deine if Medicare is primary or secondary. Where can this information be found?

Answer: C

Question: 8

FSA

A. The part of National Correct Coding Initiative (NCCI) that places frequency limitations on codes that can be billed on a single date of service by a single provider is called:
B. misusing any information on the claim, charging excessively for services or supplies, billing for services not medically necessary, failure to maintain adequate medical or financial records, improper billing practices, or billing Medicare patients at a higher fee scale that non-Medicare patients.
C. An employee has signed up for a program through her employer. It allows her to put pre-tax money away from her paycheck in order to pay for out-of-pocket healthcare expenses. She may contribute up to $2650 (2018) per year. If she does not use all of the money during the current year, she forfeits it. What is this?
D. A practice allows patients to pay large balances over a six month time period with a finance charge applied. The patient receives a statement every month that only shows the unpaid balance. What does this violate?

Answer: C

Question: 9

capitation

A. Managed Care Organizations (MCOs) place the physician at financial risk for the care of the patient and are reimbursed by
B. sent by payers to identify the status of a claim and indicate if that claim has been accepted, adjudicated, and/or received by the payer.
C. Medicare provides a list of questions to ask beneficiaries that helps deine if Medicare is primary or secondary. Where can this information be found?
D. When the Cigna appeals process has been exhausted, what happens if the provider still disagrees with the decision?

Answer: A

Question: 10

oral, rectal

A. "with contrast" does not include ___ contrast (for CT Scan)
B. Which of the following modifiers are not used to bypass NCCI edits?
C. When should patient invoices (statements) be sent to the patient?
D. Which of the three TRICARE options are not available to active duty service members?

Answer: A

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