Business Side

Multiple Choice
Identify the choice that best completes the statement or answers the question.

____ 1. Many coding professionals go on to find work as:
a. Accountants
b. Consultants
c. Medical Assistants
d. Financial Planners

____ 2. Which type of information is NOT maintained in a medical record?
a. Observations
b. Medical or surgical interventions
c. Treatment outcomes
d. Financial records

____ 3. Professionals who specialize in coding are called:
a. Coding specialists
b. Information technologists
c. Medical Assistants
d. Scribes

____ 4. EHR stands for:
a. Extended health record
b. Electronic health response
c. Electronic health record
d. Established health record

____ 5. What type of provider goes through approximately 26 ½ months of education and is licensed to practice medicine with the oversight of a physician?
a. Nurse Practitioner (NP)
b. Physician Assistant (PA)
c. Physical Therapist
d. Intern

____ 6. The Medicare program is made up of several parts. Which part covers provider fees without the use of a private insurer?
a. Part A
b. Part B
c. Part C
d. Part D

____ 7. The Medicare program is made up of several parts. Which part is affected by the Centers for Medicare & Medicaid Services - Hierarchical Condition Categories (CMS-HCC)?
a. Part A
b. Part B
c. Part C
d. Part D

____ 8. What does CMS-HCC stand for?
a. County Mandated Services – Heightened Control Center
b. Country Mandated Services – Hospital Correct Coding Initiative
c. Centers for Medicare & Medicaid Services – Hierarchal Condition Category
d. Centers for Medicare & Medicaid Services – Hospital Correct Coding Initiative

____ 9. When coding an operative report, what action would NOT be recommended?
a. Starting with the procedure listed.
b. Reading the body of the report.
c. Coding from the header without reading the body of the report.
d. Highlighting unfamiliar words.

____ 10. Which coding manuals do outpatient coders focus on learning?
a. CPT®, HCPCS Level II, ICD-10-CM, ICD-10-PCS
b. ICD-10-CM and ICD-10-PCS
c. CPT®, HCPCS Level II and ICD-10-CM

d. CPT® and ICD-10-CM

____ 11. If an NCD does not exist for a particular service/procedure performed on a Medicare patient, who determines coverage?
a. Current Procedural Terminology (CPT®) guidelines
b. Centers for Medicare & Medicaid Services (CMS)
c. Medicare Administrative Contractor (MAC)
d. The physician providing the service

____ 12. The ____describes whether specific medical items, services, treatment procedures or technologies are considered medically necessary under Medicare.
a. National Coverage Determinations Manual
b. Medicare Physician Fee Schedule
c. Medicare Severity-Diagnosis Related Groups (MS-DRG)
d. Internet Only Manual

____ 13. What is the purpose of National Coverage Determinations?
a. To notify beneficiaries of non-covered services.
b. To provide payment options to physicians.
c. To explain CMS policies on when Medicare will pay for items or services.
d. To set standards for all payers on coverage items.

____ 14. What does MAC stands for?
a. Medicaid Alert Contractor
b. Medicare Administrative Contractor
c. Medicare Advisory Contractor
d. Medicaid Administrative Contractor

____ 15. Local Coverage Determinations are administered by whom?
a. Each regional MAC
b. NCDs
c. LMRPs
d. State Law

____ 16. LCDs only have jurisdiction in their ____.
a. Locality
b. State
c. Region
d. District

____ 17. ABN stands for _____.
a. Advance Beneficiary Notice
b. Admitting Beneficiary Notice
c. Advisory Beneficial Notice
d. Advanced Benefits Notification

____ 18. When are providers responsible for obtaining an ABN for a service NOT considered medically necessary?
a. After providing a service or item to a beneficiary.
b. Prior to providing a service or item to a beneficiary.
c. During a procedure or service.
d. After a denial has been received from Medicare.

____ 19. HIPAA stands for
a. Health Insurance Provider Assistance Action
b. Health Insurance Portability and Accountant Advice
c. Health Insurance Portability and Accountability Act
d. Health Information Privacy Access Act

____ 20. In what year did HIPAA become law?

a. 1992
b. 1995
c. 1997
d. 1996

____ 21. A covered entity does NOT include
a. Healthcare providers
b. Patients
c. Clearinghouses
d. Health plans

____ 22. What is the definition of medical coding?
a. Deciphering explanation of benefits provided by an insurance carrier.
b. Translating documentation into numerical/alphanumerical codes used to obtain reimbursement.
c. Translating the services a provider performs into documentation.
d. Translating documentation into software compatible notes.

____ 23. Who is responsible for enforcing the HIPAA security rule?
a. OIG
b. HHS
c. OCR
d. CMS

____ 24. Healthcare providers are responsible for developing _____ and policies and procedures regarding privacy in their practices.
a. Patient hotlines
b. Work around procedures
c. Fees
d. Notices of Privacy Practices

____ 25. A covered entity may obtain consent from an individual to use or disclose protected health information to carry out all of the following EXCEPT what?
a. Research
b. Treatment
c. Payment
d. Healthcare operations

____ 26. The minimum necessary rule is based on sound current practice that protected health information should NOT be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function. What does this mean?
a. Staff members are allowed to access any medical record without restriction.
b. Providers should develop safeguards to prevent unauthorized access to protected health information.
c. Practices should only provide minimum necessary information to patients.
d. All of the above.

____ 27. The minimum necessary rule applies to
a. Disclosures to or requests by a health care provider for treatment purposes.
b. Disclosures to the individual who is the subject of the information.
c. Uses or disclosures that are required by other law.
d. Covered entities taking reasonable steps to limit use or disclosure of PHI

____ 28. HITECH provides a ____ day window during which any violation not due to willful neglect may be corrected without penalty.
a. 40
b. 30
c. 45
d. 60

____ 29. In what year was HITECH enacted as part of the American Recovery and Reinvestment Act?
a. 2007
b. 2010
c. 2009
d. 2000

____ 30. Which of the following choices is NOT a benefit of an active compliance plan?

a. Faster, more accurate payment of claims.
b. Eliminates risk of an audit.
c. Fewer billing mistakes.
d. Increases accuracy of provider documentation.

____ 31. What will the scope of a compliance program depend on?
a. The number of insurance carriers the provider is contracted with.
b. How many patients are seen in the office on a daily basis.
c. The size and resources of the provider's practice.
d. The specific guidelines set forth in the OIG compliance plan.

____ 32. Evaluation and management services are often provided in a standard format such as SOAP notes. What does the acronym SOAP stand for?
a. Standard, Objective, Activity, Period
b. Scope, Observation, Action, Plan
c. Subjective, Objective, Assessment, Plan
d. Source, Opinion, Advice, Provider

____ 33. According to the OIG, internal monitoring and auditing should be performed by what means?
a. Periodic audits.
b. Focused audits on problems brought to the attention of the compliance officer.
c. Audits on all denied claims.
d. Baseline audits.

____ 34. Voluntary compliance programs also provide benefits by not only helping to prevent erroneous or ____, but also by showing that the provider practice is making additional good faith efforts to submit claims appropriately.
a. Duplicative claims
b. Fraudulent claims
c. Mistaken principals
d. Over utilized codes

____ 35. How many components are included in an effective compliance plan?
a. 3
b. 4
c. 7
d. 9

____ 36. According to AAPC's Code of Ethics, an AAPC member shall use only ____and ____ means in all professional dealings.
a. private and professional
b. efficient and inexpensive
c. legal and profitable
d. legal and ethical

____ 37. What type of insurance is Medicare Part D?
a. A Medicare Advantage program managed by private insurers.
b. Hospital coverage available to all Medicare beneficiaries.
c. Prescription drug coverage available to all Medicare beneficiaries.
d. Provider coverage requiring monthly premiums.

____ 38. What type of health insurance provides coverage for low-income families?
a. Medicaid
b. Medicare
c. Commercial PPO
d. Commercial HMO

____ 39. What is PHI?
a. Provider healthcare interchange
b. Protected health information
c. Private health insurance
d. Provider healthcare incident-to

____ 40. What form is used to submit a provider's charge to the insurance carrier?
a. UB-04
b. CMS-1500
c. ABN
d. Provider reimbursement form

____ 41. Which option below is NOT a covered entity under HIPAA?
a. Medicare
b. Medicaid
c. BCBS
d. Workers' Compensation

____ 42. Which of the following is a BENEFIT of electronic transactions?
a. Payment of claims
b. Security of claims
c. Timely submission of claims
d. None of the above

____ 43. What is the value of a remittance advice?
a. It states when to schedule the patient's next appointment.
b. It states what will be paid and why any changes to charges were made.
c. It confirms the provider is part of the plan in question.
d. It catalogs the patient's coverage benefits.

____ 44. The OIG recommends that provider practices enforce disciplinary actions through well publicized compliance guidelines to ensure actions that are _____.
a. Frequent
b. Swift and enforceable
c. Consistent and appropriate
d. Permanent

____ 45. Each October the OIG releases a ____ outlining its priorities for the fiscal year ahead.
a. Compliance Plan
b. Self-referral law
c. Work Plan
d. CIA yearly review

____ 46. Which provider is NOT a mid-level provider?
a. Physician Assistant
b. Nurse Practitioner
c. Anesthesiologist
d. All choices are mid-level providers

____ 47. In what year was the AAPC founded?
a. 1956
b. 1965
c. 1980
d. 1988

____ 48. According to the AAPC Code of Ethics, which term is NOT listed as an ethical principle of professional conduct?
a. Integrity
b. Responsibility
c. Efficiency
d. Commitment

____ 49. AAPC credentialed coders have proven mastery of what information?
a. Code sets
b. Evaluation and management principles
c. Documentation guidelines
d. All of the above

____ 50. The AAPC offers over 500 local chapters across the country for the purpose of
a. Continuing education and networking
b. Financial management
c. Membership dues
d. Regulations and bylaws

Business Side
Answer Section

MULTIPLE CHOICE

1. ANS: B
   Rationale: The coding profession has evolved significantly over the past several decades into a career path with unlimited possibilities. Many professionals who have learned coding have also gone on to roles as consultants, educators or medical auditors. There are endless possibilities in an ever changing field.

   PTS: 1 DIF: Moderate
2. ANS: D
   Rationale: Every time a patient receives health care, a record is maintained of the observations, medical or surgical interventions and treatment outcomes. Administrative data, such as financial records, should not be included in the medical record or provided in response to a subpoena or request for health records.

   PTS: 1 DIF: Moderate
3. ANS: A
   Rationale: Professionals who specialize in coding are called *medical coders* or *coding specialists*.

   PTS: 1 DIF: Moderate
4. ANS: C
   Rationale: EHR stands for electronic health record

   PTS: 1 DIF: Moderate
5. ANS: B
   Rationale: Physician Assistants are licensed to practice medicine with physician supervision. A PA program takes approximately 26 ½ months to complete.

   PTS: 1 DIF: Moderate
6. ANS: B
   Rationale: Medicare Part B helps to cover medically necessary provider services, outpatient care and other medical services (including some preventive services) not covered under Medicare Part A. Medicare Part B is an optional benefit for which the patient pays a monthly premium, an annual deductible, and generally has a 20% co-insurance except for preventive services covered under the healthcare law.

   PTS: 1 DIF: Moderate
7. ANS: C
   Rationale: Accurate and thorough diagnosis coding is important for Medicare Advantage (Part C) claims because reimbursement is impacted by the patient's health status. The Centers for Medicare & Medicaid Services-hierarchical condition category (CMS-HCC) risk adjustment model provides adjusted payments based on a patient's diseases and demographic factors. If a coder does not include all pertinent diagnoses and comorbidities, there may be loss of additional reimbursement to which the provider is entitled.

   PTS: 1 DIF: Moderate
8. ANS: C
   Rationale: Centers for Medicare & Medicaid Services – Hierarchal Condition Category

   PTS: 1 DIF: Moderate

9. ANS: C
   Rationale: Operative report coding tips include reviewing the documentation in the detail of the procedure to further clarify or define both procedures and diagnoses.

   PTS: 1 DIF: Moderate
10. ANS: C
    Rationale: Outpatient coding focuses on provider services. Outpatient coders will focus on learning CPT®, HCPCS Level II and ICD-10-CM.

    PTS: 1 DIF: Moderate
11. ANS: C
    Rationale: If an NCD does not exist for a particular item, it is up to the MAC to determine coverage. According to CMS guidelines (www.cms.gov/transmittals/downloads/R2NCD1.pdf), "Where coverage of an item or service is provided for specified indications or circumstances but is not explicitly excluded for others, or where the item or service is not mentioned at all in the CMS Manual System, the Medicare contractor is to make the coverage decision, in consultation with its medical staff, and with CMS when appropriate, based on the law, regulations, rulings and general program instructions."

    PTS: 1 DIF: Moderate
12. ANS: A
    Rationale: The National Coverage Determinations Manual describes whether specific medical items, services, treatment procedures or technologies are considered medically necessary under Medicare.

    PTS: 1 DIF: Moderate
13. ANS: C
    Rationale: National Coverage Determinations (NCD) explain CMS policies on when Medicare will pay for items or services.

    PTS: 1 DIF: Moderate
14. ANS: B
    Rationale: Medicare Administrative Contractor (MAC)

    PTS: 1 DIF: Moderate
15. ANS: A
    Rationale: Each Medicare Administrative Contractor (MAC) is responsible for interpreting national policies into regional policies.

    PTS: 1 DIF: Moderate
16. ANS: C
    Rationale: LCDs only have jurisdiction within their region.

    PTS: 1 DIF: Moderate
17. ANS: A
    Rationale: ABN stands for Advance Beneficiary Notice

    PTS: 1 DIF: Moderate
18. ANS: B
    Rationale: Providers are responsible for obtaining an ABN prior to providing the service or item to a beneficiary.

PTS: 1 DIF: Moderate

19. ANS: C
Rationale: Health Insurance Portability and Accountability Act (HIPAA)

PTS: 1 DIF: Moderate

20. ANS: D
Rationale: HIPAA was adopted into law in 1996.

PTS: 1 DIF: Moderate

21. ANS: B
Rationale:

A Covered Entity is one of the following:

A Health Care Provider	A Health Plan	A Health Care Clearinghouse
This includes providers such as: • Doctors • Clinics • Psychologists • Dentists • Chiropractors • Nursing Homes • Pharmacies ...but only if they transmit any information in an electronic form in connection with a transaction for which HHS has adopted a standard.	This includes: • Health insurance companies • HMOs • Company health plans • Government programs that pay for health care, such as Medicare, Medicaid, and the military and veterans health care programs	This includes entities that process nonstandard health information they receive from another entity into a standard (i.e., standard electronic format or data content), or vice versa.

PTS: 1 DIF: Moderate

22. ANS: B
Rationale: Medical coding is the process of translating a healthcare provider's documentation of a patient encounter into a series of numeric or alphanumeric codes.

PTS: 1 DIF: Moderate

23. ANS: C
Rationale: The Office for Civil Rights (OCR) enforces the HIPAA Privacy Rule.

PTS: 1 DIF: Moderate

24. ANS: D
Rationale: Healthcare providers are responsible for developing Notices of Privacy Practices and policies and procedures regarding privacy in their practices.

PTS: 1 DIF: Moderate

25. ANS: A
Rationale: A covered entity may obtain consent of the individual to use or disclose protected health information to carry out treatment, payment or healthcare operations.

PTS: 1 DIF: Moderate

26. ANS: B

Rationale: The minimum necessary standard requires covered entities to evaluate their practices and enhance safeguards as needed to limit unnecessary or inappropriate access to and disclosure of protected health information. Only those individuals whose job requires it may have access to PHI. Only the minimum protected information required to do the job should be shared.

PTS: 1 DIF: Moderate

27. ANS: D
Rationale: The Privacy Rule generally requires covered entities to take reasonable steps to limit the use or disclosure of, and requests for, protected health information to the minimum necessary to accomplish the intended purpose. The minimum necessary standard does not apply to the following:
- Disclosures to or requests by a health care provider for treatment purposes.
- Disclosures to the individual who is the subject of the information.
- Uses or disclosures made pursuant to an individual's authorization.
- Uses or disclosures required for compliance with the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Rules.
- Disclosures to the Department of Health & Human Services (HHS) when disclosure of information is required under the Privacy Rule for enforcement purposes.
- Uses or disclosures that are required by other law.

PTS: 1 DIF: Moderate

28. ANS: B
Rationale: HITECH also lowers the bar for what constitutes a violation, but provides a 30-day window during which any violation not due to willful neglect may be corrected without penalty.

PTS: 1 DIF: Moderate

29. ANS: C
Rationale: The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology.

PTS: 1 DIF: Moderate

30. ANS: B
Rationale: Although voluntary, a compliance plan may offer several benefits, among them:
• Faster, more accurate payment of claims.
• Fewer billing mistakes.
• Diminished chances of a payer audit.
• Less chance of violating self-referral and anti-kickback statutes.
Additionally, the increased accuracy of provider documentation that may result from a compliance program actually may assist in enhancing patient care.

PTS: 1 DIF: Moderate

31. ANS: C
Rationale: The scope of a compliance program will depend on the size and resources of the provider practice.

PTS: 1 DIF: Moderate

32. ANS: C
Rationale: S-Subjective, O-Objective, A-Assessment, P-Plan

PTS: 1 DIF: Moderate

33. ANS: A

Rationale: A key component of an effective compliance program includes internal monitoring and auditing through the performance of periodic audits. This ongoing evaluation includes not only whether the provider practice's standards and procedures are in fact current and accurate, but also whether the compliance program is working, *(for example*, whether individuals are properly carrying out their responsibilities and claims are submitted appropriately).

PTS: 1 DIF: Moderate

34. ANS: B
Rationale: Voluntary compliance programs also provide benefits by not only helping to prevent erroneous or fraudulent claims, but also by showing that the provider practice is making additional good faith efforts to submit claims appropriately.

PTS: 1 DIF: Moderate

35. ANS: C
Rationale: The following list of components, as set forth in previous OIG Compliance Program Guidance for Individual and Small Group Physician Practices, can form the basis of a voluntary compliance program for a provider practice:
- Conducting internal monitoring and auditing through the performance of periodic audits;
- Implementing compliance and practice standards through the development of written standards and procedures;
- Designating a compliance officer or contact(s) to monitor compliance efforts and enforce practice standards;
- Conducting appropriate training and education on practice standards and procedures;
- Responding appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate Government entities;
- Developing open lines of communication, such as (1) discussions at staff meetings regarding how to avoid erroneous or fraudulent conduct, and (2) community bulletin boards, to keep practice employees updated regarding compliance activities; and
- Enforcing disciplinary standards through well-publicized guidelines.

These seven components provide a solid basis upon which a provider practice can create a compliance program.

PTS: 1 DIF: Moderate

36. ANS: D
Rationale: AAPC members shall use only legal and ethical means in all professional dealings and shall refuse to cooperate with, or condone by silence, the actions of those who engage in fraudulent, deceptive or illegal acts.

PTS: 1 DIF: Moderate

37. ANS: C
Rationale: Medicare Part D is a prescription drug program available to all Medicare beneficiaries for a fee. Private companies approved by Medicare provide the coverage.

PTS: 1 DIF: Moderate

38. ANS: A
Rationale: Medicaid is a health insurance assistance program for some low-income people (especially children and pregnant women) sponsored by federal and state governments.

PTS: 1 DIF: Moderate

39. ANS: B

Rationale: Protected health information under the Health Information Portability and Accountability Act (HIPAA) is any information, whether oral or recorded, in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university or health care clearinghouse relating to the past, present or future physical or mental health or condition of an individual, the provision of health services to that individual or payment around those services. Only health information at the individual level is covered; health information of groups is not.

PTS: 1 DIF: Moderate

40. ANS: B
Rationale: Once documentation is translated into codes, it is then sent on a CMS-1500 form to the insurance carrier for reimbursement.

PTS: 1 DIF: Moderate

41. ANS: D
Rationale: The definition of health plan in the HIPAA regulations excludes any policy, plan or program that provides or pays for the cost of excepted benefits. Excepted benefits include:
- Coverage only for accident or disability income insurance, or any combination thereof;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Coverage for on-site medical clinics;
- Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

PTS: 1 DIF: Moderate

42. ANS: C
Rationale: Electronic claims benefit the provider office by allowing timely submissions to the insurance carrier and proof of transmission of the claims.

PTS: 1 DIF: Moderate

43. ANS: B
Rationale: The determination of the payer is sent to the provider in the form of a remittance advice. The remittance advice explains the outcome of the insurance adjudication on the claim, including the payment amount, contractual adjustments and reason(s) for denial.

PTS: 1 DIF: Moderate

44. ANS: C
Rationale: The OIG recommends that a provider practice's enforcement and disciplinary mechanisms ensure that violations of the practice's compliance policies will result in consistent and appropriate sanctions, including the possibility of termination, against the offending individual.

PTS: 1 DIF: Moderate

45. ANS: C
Rationale: The OIG Work Plan sets forth various projects to be addressed during the fiscal year by the Office of Audit Services, Office of Evaluation and Inspections, Office of Investigations, and Office of Counsel to the Inspector General.

PTS: 1 DIF: Moderate

46. ANS: C
Rationale: Mid-level providers include physician assistants (PA) and nurse practitioners (NP). An anesthesiologist is a physician. Mid-level providers are also known as physician extenders because they extend the work of a physician.

PTS: 1 DIF: Moderate

47. ANS: D
Rationale: The AAPC was founded in 1988.

PTS: 1 DIF: Moderate

48. ANS: C
Rationale: It shall be the responsibility of every AAPC member, as a condition of continued membership, to conduct themselves in all professional activities in a manner consistent with ALL of the following ethical principles of professional conduct:

- Integrity
- Respect
- Commitment
- Competence
- Fairness
- Responsibility

PTS: 1 DIF: Moderate

49. ANS: D
Rationale: AAPC credentialed coders have proven mastery of all code sets, evaluation and management principles, and documentation guidelines.

PTS: 1 DIF: Moderate

50. ANS: A
Rationale: The AAPC offers over 500 local chapters across the country. Through local chapters, AAPC members can obtain continuing education, gain leadership skills and network.

PTS: 1 DIF: Moderate