CHAMPA
Medicare
TRICARE - Medicaid

A provider charged $500 to a claim that had an allowable amount of $400. In which of the following columns should the CBCS apply the non allowed charge?
-Reference column (For notations)
-Description column
-Payment column
-Adjustment column of the credits - Adjustment column of the credits

Which of the following statements is correct regarding a deductible?
-Coinsurance is a type of deductible
-The physician should write off the deductible
-The insurance company pays for the deductible
-The deductible is the patient's responsibility - The deductible is the patient's responsibility

Which of the following color formats allows optical scanning of the CMS-1500 claim form?
-Red
-Blue
-Green
-black - red

Ambulatory surgery centers, home health and hospice organizations use the _____.
-CMS-1500 claim form
-UB-04 claim form
-Advance Beneficiary notice
-First report of injury form - UB-04

Claims that are submitted without an NPI number will delay payment to the provider because _____.
-The number is the patient' id number
-The number is needed to identify the provider
-Is is used as a claim number
-It is used as a pre authorization number - The number is needed to identify the provider

Which of the following terms describes when a plan pays 70% of the allowed amount and the patient pays 30%?
-Coinsurance
-Deductible
-Premium
-copayment - coinsurance

Medicare
Medicaid
TRICARE
Blue cross/shield - blue cross/shield

Which of the following sections of the medical record is used to determine the correct evaluation and management code for billing and coding?
-Codes used during prior patient visit
-Patient's insurance plan
-Plan of care
-History and physical - History ad physicals

Which of the following describes the reason for a claim rejection because of Medicare NCCI edits?
- Reporting codes without proper modifiers
- Coding without proper documentation
- Medicare NCCI edit will trigger a claim rejection for improper code combination
- Use of outside codes - Medicare NCCI edit will trigger a claim rejection for improper code combination

Which of the following departments should a patient be seen for psoriasis?
- Cardiologist
- Dermatologist
- Otolaryngology
- gastroenterology - dermatologist

A nurse is reviewing a patient's lab results prior to discharge and discovers an elevated glucose level. Which of the following health care providers should be alerted before the nurse can proceed with discharge planning?
- The attending physician
- The admitting physician
- The nursing supervisor
- The physician assistant - attending physician

On the CMS-1500 claim form, blocks 14 to 33 contain information about which of the following?
- Patient demographics
- The patient's condition and the provider's information
- The insurance name and address
- The patient's medical history - - The patient's condition and the provider's information

The star symbol in the CPT code book is used to indicate which of the following?
- New code
- Exempt from the used of modifier 51
- Revised code
- telemedicine - telemedicine

Which of the following should the CBCS complete to be reimbursed for the provider's service?
- CMS-1500 claim form
- CMSC-1450
- Superbill
- Leger - CMS-1500 claim form
- CMSC-1450 (used by institutions)
- Superbill (encounter form)
- Leger (financial document)

Which of the following is a HIPAA compliance guideline affecting electronic health records?
- The privacy requirements cover facilities health information, whether paper of electronic
- Electronic health records should be sent to the insurance at 835P format (remittance advice is in the 835 P format)
- The electronic transmission and code set standards require every p provider to use the health care transaction, code set and identifiers
- The Health information technology of economic and clinical health (HITECH) act encrypts provider PHI. - The electronic transmission and code set standards require every p provider to use the health care transaction, code set and identifiers
- (remittance advice is in the 835 P format)

Which of the following is the purpose of precertification?
- Verification of coverage
- Assignment of benefits
- Determining the annual deductible amount
- Determining the coinsurance amount - verification of coverage

Which of the following should the CBCS include in an authorization to release information?
- The number of pages to be released
- The health record number
- The entity to whom the information is to be released
- The name of the physician - the entity to whom the information is to be released

Which of the following actions should the CBCS take if he observes a colleague in an unethical situation?
- File a complaint with the company compliance officer
- Confront the employee
- Report the incident to a supervisor
- Ignore the incident - report the incident to a supervisor

When posting payment accurately, which of the following items should the CBCS include?

- Right upper quadrant (right lobe of liver, gallbladder, part of pancreas, small and large intestine)
- Right lower quadrant (small and large intestines, appendix, and right ureter
- Left lower quadrant (parts of small and large intestine, left ureter - Left upper quadrant
- Right upper quadrant (right lobe of liver, gallbladder, part of pancreas, small and large intestine)
- Right lower quadrant (small and large intestines, appendix, and right ureter
- Left lower quadrant (parts of small and large intestine, left ureter)

Which of the following would result in a claim being denied?
- An italicized code used as the first listed diagnosis
- A CPT code used as the procedure code in an outpatient setting
- An ICD-10-PCS code used as the primary diagnosis code in an inpatient setting
- A HCPCS code used as the procedure code in an outpatient setting - An italicized code used as the first listed diagnosis

The authorization number for a service that was approved before the service was rendered is indicated in which of the following blocks on the CMS-1500 claim form?
22 (Medicaid resubmission code)
23 (prior authorization number)
25 (federal tax ID number)
26 (patient's account number) - 23 (prior authorization number)
- 22 (Medicaid resubmission code)
- 25 (federal tax ID number)
- 26 (patient's account number)

Which of the following HMO managed care services requires a referral?
- Durable medical equipment
- Annual physical examination
- Emergency room visit
- Annual gynecological services - durable medical equipment

In which of the following blocks on the S=CMS-1500 form should the CBCS enter the referring provider's NPI?
- 17b (referring providers NPI)
- 24J (rendering provider's NPI)
- 24D (CPT code)
-25 (federal tax ID) - 17b (referring providers NPI)
- 24J (rendering provider's NPI)
- 24D (CPT code)
-25 (federal tax ID)

In the anesthesia section of the CPT code manual, which of the following are considered qualifying circumstances?
- Physical status modifiers
- Primary procedure code

- National committee of quality assurance (NCQA)
- Electronic data interchange (EDI)
- National correct code initiative (NCCI)
- Procedural coding system (PCS) - National correct code initiative (NCCI)

A CBCS submitted a claim to Medicare electronically. No errors were found by the billing software or clearinghouse. Which of the following describes this claim?
- Pending claim
- Clean claim
- Tertiary claim (processed by both primary and secondary insurance)
- Physically clean claim (no staples, no highlighters) - clean

The explanation of benefits states the amount billed was $80. The allowed amount is $60, and the patient is required to pay a $20 copayment. Which of the following describes the insurance check amount to be posted?
$40
$80
$60
$20 - $80

Urine moves from the kidney to the bladder through which of the following parts of the body?
- Ureters
- Renal pelvis (hollow chamber that passes waste material)
- Urethra (discharges urine from the bladder
- Adrenal gland (above the kidney, part of endocrine system - Ureter
- Renal pelvis (hollow chamber that passes waste material)
- Urethra (discharges urine from the bladder
- Adrenal gland (above the kidney, part of endocrine system

Which of the following blocks should the CBCS complete on the CMS-1500 form for procedure, services, and supplies?
12 (patient authorization)
2 (patient name)
24D
24J (rendering provider) - 24D
- 12 (patient authorization)
- 2 (patient name)
- 24J (rendering provider)

Which of the following describes the organization of an aging report?
- By date
- By amount
- By patient name
- By insurance carrier - by date