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TEXTBOOK TESTBANKS

Test Bank for Bucks Step-by-Step Medical Coding, 2025 Edition 1st Elsevier

TEST BANK SAMPLE PREVIEW

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Test Bank - Chapter 01

Q: The coder's responsibility is to ensure that the data are as accurate as possible not only for classification and study purposes but also to obtain appropriate reimbursement.

A. True (Correct)
B. False

Q: The *Federal Register* is the official publication for all "Presidential Documents," "Rules and Regulations," "Proposed Rules," and "Notices."

A. True (Correct)
B. False

Q: Nationally, unit values have been assigned for each service by Medicare (CPT and HCPCS) and determined on the basis of the resources necessary for the physician's performance of the service.

A. True (Correct)
B. False

Q: Fraud is an intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person.

A. True (Correct)
B. False

Q: Kickbacks from patients are allowed under certain circumstances according to Medicare guidelines.

A. True
B. False (Correct)

Q: The Medicare program was established in:

A. 1955
B. 1960
C. 1965 (Correct)
D. 1970

Q: Medicare Part A pays for:

A. professional services and durable medical equipment
B. hospital/facility care (Correct)
C. physician services and durable medical equipment
D. hospital/facility care and durable medical equipment

Q: Medicare Part B pays for:

A. durable medical equipment
B. hospital/facility care
C. physician services and durable medical equipment (Correct)

D. hospital/facility care and durable medical equipment

Q: Who handles the day-to-day operation of the Medicare program for the CMS?

A. HCFA
B. peer review organization
C. MACs (Correct)
D. IPPS

Q: Medicare pays for what percentage of covered charges?

A. 70%
B. 75%
C. 80% (Correct)
D. 85%

Q: The incentive to Medicare participating providers is:

A. direct payment on all claims
B. a 5% higher fee schedule
C. faster processing
D. all are correct (Correct)

Q: Part B services are billed using:

A. RBRVS, GPCI, and RVUs
B. ICD-10-CM, CPT, HCPCS (Correct)
C. MS-DRGs
D. APCs

Q: Who is the largest third-party payer in the nation?

A. Blue Cross Blue Shield
B. Aetna
C. Cigna
D. the government (Correct)

Q: A major change took place in Medicare in ____ with the enactment of the Omnibus Budget Reconciliation Act.

A. 1989 (Correct)
B. 1992
C. 1997
D. 2000

Q: The physician fee schedule is updated each April 15 and is composed of:

A. the relative value units for each service
B. a geographic adjustment factor to adjust for regional variations in the cost of operating a health care facility
C. a national conversion factor
D. all are correct (Correct)
E. none are correct

Q: If a surgeon performs more than one procedure on the same patient on the same day, and discounts were made on all subsequent procedures, Medicare would pay what percentages for the first, second, third, fourth, and fifth procedures?

A. 100%, 100%, 100%, 100%, 100%
B. 100%, 50%, 50%, 50%, 25%
C. 100%, 50%, 50%, 25%, 25%
D. 100%, 50%, 50%, 50%, 50% (Correct)

Q: Medicare sets the payment level for assistant surgeons at a percentage of the fee schedule amount for the ____ surgical service.

A. global (Correct)
B. united
C. partial
D. subsequent

Q: What edition of the *Federal Register* would hospital facilities be especially interested in?

A. October (Correct)
B. November or December
C. January
D. July

Q: What edition of the *Federal Register* would outpatient facilities be especially interested in?

A. October
B. November or December (Correct)
C. January
D. July

Q: What are the three items that the Medicare beneficiaries are responsible for paying before Medicare will begin to pay for services?

A. personal care items
B. deductibles, drug costs, personal care items
C. premiums
D. deductibles, premiums, and coinsurance (Correct)

Q: Medicare funds are collected by:

A. U.S. Food and Drug Administration
B. Social Security Administration (Correct)
C. National Centers for Health Statistics
D. Department of the Treasury

Q: CMS handles the daily operation of the Medicare program through the use of ____ ____ ____, formerly Fiscal Intermediaries.

A. Medical Adjustment Contractor
B. Medicare Administrative Cooperative
C. Medicare Administrative Contractors (Correct)

D. Medical Administrative Contractors

Q: Which of the following is NOT a stated goal of the Physician Payment Reform?

A. decrease Medicare expenditures
B. assure quality health care at a reasonable cost
C. limit provider liabilities (Correct)
D. redistribute physician payment more equitably

Q: If a QIO provider renders a covered service that costs $100 and bills Medicare for the service and Medicare allowed $58, the provider would bill this amount to the patient.

A. $42
B. $58
C. $100
D. $0 (Correct)

Q: The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established these new benefits available under the Medicare program.

A. Part A
B. Part B
C. Part C
D. Part D (Correct)

Q: This program is also known as Medicare Advantage.

A. Part A
B. Part B
C. Part C (Correct)
D. Part D

Q: ____ are activities involving the transfer of health care information and ____ means the movement of electronic data between two entities and the technology that supports the transfer.

A. Transmissions, transaction
B. Transactions, transmission (Correct)
C. Interchanges, transmission
D. Transmissions, interchange

Q: The _____ program was developed by Congress to monitor the necessity of hospital admissions and review the treatment costs and medical records of hospitals.

A. Medicare Administrative Contractors (MACs)
B. Quality Improvement Organizations (QIO) (Correct)
C. Health Maintenance Organization (HMO)
D. Special Needs Plan (SNP)

Q: The conversion factor (CF) is a national dollar amount that is applied to all services paid on the basis of the _____.

A. Special Needs Plan
B. Affordable Care Act

C. Private Fee-for-Service Plan
D. Medicare Fee Schedule (Correct)

Q: Identify the Medicare part with this coverage: Hospice care

A. Part A (Correct)
B. Part B
C. Part D

Q: Identify the Medicare part with this coverage: Prescription drug

A. Part A
B. Part B
C. Part D (Correct)

Q: Identify the Medicare part with this coverage: Physician visits

A. Part A
B. Part B (Correct)
C. Part D

Q: Identify the Medicare part with this coverage: Automatic coverage when age 65

A. Part A (Correct)
B. Part B
C. Part D

Q: *Identify these acronyms.*

CMS __
(Fill in the blank)

Answer: Centers for Medicare and Medicaid Services

Q: *Identify these acronyms.*

QIO __
(Fill in the blank)

Answer: Quality Improvement Organizations

Q: *Identify these acronyms.*

RBRVS __
(Fill in the blank)

Answer: Resource Based Relative Value Scale

Q: *Identify these acronyms.*

OBRA __
(Fill in the blank)

Answer: Omnibus Budget Reconciliation Act

Q: *Identify these acronyms.*

MAAC __
(Fill in the blank)

Answer: Maximum Actual Allowable Charge

Q: *Identify these acronyms.*

RVU __
(Fill in the blank)

Answer: Relative Value Unit

Q: *Identify these acronyms.*

OIG __
(Fill in the blank)

Answer: Office of the Inspector General

Q: *Identify these acronyms.*

DHHS __
(Fill in the blank)

Answer: Department of Health and Human Services

Q: *Answer the following.*

In the role as a medical coder, it is your responsibility to ensure that you code __ and completely to optimize reimbursement for services provided.
(Fill in the blank)

Answer: accurately

Q: *Answer the following.*

The __ (two words) is a national dollar amount that is applied to all services paid on the basis of the MFS.
(Fill in the blank)

Answer: conversion factor

Q: *Answer the following.*

The amount determined by multiplying the RVU weight by the geographic index and the conversion factor is called the __ (two words) amount.
(Fill in the blank)

Answer: fee schedule

Q: *Answer the following.*

For endoscopic procedures, Medicare allows the full value of the highest valued endoscopy, plus

the difference between the next highest endoscopy and the __ endoscopy.
(Fill in the blank)

Answer: highest

Q: *Answer the following.*

The provider or facility is __ when the payment goes directly to the patient.
(Fill in the blank)

Answer: nonparticipating

Q: *Answer the following.*

Under the RBRVS, the unit value is termed __ Value Unit.
(Fill in the blank)

Answer: Relative

Q: Select the three goals of the Physician Payment Reform.
(Select all that apply.)

A. increase maximum allowable charge
B. decrease Medicare expenditures (Correct)
C. redistribute physician payments more equitably (Correct)
D. remove standard rates of increase
E. clarify the provisions of the physician fee schedule
F. assure quality health care at a reasonable cost (Correct)

Q: Select the three components of the relative value unit.
(Select all that apply.)

A. work (Correct)
B. beneficiary
C. training
D. malpractice (Correct)
E. processing
F. overhead (Correct)

Q: Select the three types of persons eligible for Medicare.
(Select all that apply.)

A. those with permanent kidney failure (Correct)
B. those with chronic conditions
C. those 65 and over (Correct)
D. those 60 and over
E. those with disability benefits (Correct)

Ready-Made Tests - Chapter 01

Q: *THEORY questions. Without the use of reference material, answer the following:*

What edition of the *Federal Register* would outpatient facilities be especially interested in?

A. October
B. November or December (Correct)
C. January
D. July

Q: *THEORY questions. Without the use of reference material, answer the following:*

What is the largest third-party payer?

A. U.S. Food and Drug Administration
B. Social Security Administration
C. American government (Correct)
D. Department of Health and Human Services

Q: *THEORY questions. Without the use of reference material, answer the following:*

What government organization is responsible for administering the Medicare program?

A. Centers for Medicare and Medicaid Services (CMS) (Correct)
B. Social Security Administration
C. National Center for Health Statistics
D. Department of Health and Human Services

Q: *THEORY questions. Without the use of reference material, answer the following:*

What are the three items that the Medicare beneficiaries are responsible to pay before Medicare will begin to pay for services?

A. personal care items
B. deductibles, drug costs, personal care items
C. premiums
D. deductibles, premiums, and coinsurance (Correct)

Q: *THEORY questions. Without the use of reference material, answer the following:*

Medicare funds are collected by:

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B. Social Security Administration (Correct)
C. National Center for Health Statistics
D. Department of the Treasury

Q: *THEORY questions. Without the use of reference material, answer the following:*

CMS handles the daily operation of the Medicare program through the use of _____ _____ _____, formerly Fiscal Intermediaries.

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B. Medicare Administrative Cooperative
C. Medicare Administrative Contractors (Correct)
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Q: *THEORY questions. Without the use of reference material, answer the following:*

Which of the following is NOT a stated goal of the Physician Payment Reform?

A. decrease Medicare expenditures
B. assure quality health care at a reasonable cost
C. limit provider liabilities (Correct)
D. redistribute physician payment more equitably

Q: *THEORY questions. Without the use of reference material, answer the following:*

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established this new benefit available under the Medicare program.

A. Part A
B. Part B
C. Part C
D. Part D (Correct)

Q: *THEORY questions. Without the use of reference material, answer the following:*

This program is also known as Medicare Advantage Organization (MAO).

A. Part A
B. Part B
C. Part C (Correct)
D. Part D

Q: *THEORY questions. Without the use of reference material, answer the following:*

_____ are activities involving the transfer of health care information and _____ means the movement of electronic data between two entities and the technology that supports the transfer.

A. Transmission, transactions
B. Transactions, transmissions (Correct)
C. Interchange, transmission
D. Transmission, interchange

Q: *THEORY questions. Without the use of reference material, answer the following:*

Under the __ (three words) systems, unit values are assigned to each service and are determined on the basis of the resources necessary to the physician's performance of the service.
(Fill in the blank)

Answer: Relative Value Unit

Q: *THEORY questions. Without the use of reference material, answer the following:*

The __ charge historically was specific for each physician, but in 1993, the charge for a service

was the same for all physicians within a locality, regardless of the specialty.
(Fill in the blank)

Answer: limiting

Q: *THEORY questions. Without the use of reference material, answer the following:*

For co-surgeons, Medicare pays __ % of the global fee, dividing the payment equally between the two surgeons.
(Fill in the blank)

Answer: 125

Q: *THEORY questions. Without the use of reference material, answer the following:*

Specific regulations for __ are contained in the Internet Only Manual.
(Fill in the blank)

Answer: Medicare

Q: *THEORY questions. Without the use of reference material, answer the following:*

Within an HMO, there is usually an individual who has been assigned to monitor the services provided to the patient both inside the facility and outside the facility. This person is known as the __.
(Fill in the blank)

Answer: gatekeeper

Q: *THEORY questions. Without the use of reference material, answer the following:*

In this model of HMO, the HMO directly employs the physicians. __ Model
(Fill in the blank)

Answer: Staff

Q: *THEORY questions. Without the use of reference material, answer the following:*

In this model of HMO, the HMO contracts with the physician to provide the service at a set fee. __ Practice Associations
(Fill in the blank)

Answer: Individual

Q: *THEORY questions. Without the use of reference material, answer the following:*

The Medicare __ Contractors do the paperwork for Medicare and are usually insurance companies that have bid for a contract with CMS to handle the Medicare program for a specific area.
(Fill in the blank)

Answer: Administrative

Q: *THEORY questions. Without the use of reference material, answer the following:*

HIPAA stands for __ (three words) and Accountability Act.
(Fill in the blank)

Answer: Health Insurance Portability

TEACH Pretests - Chapter 01

Q: __ is the largest third-party payer in the United States.
(Fill in the blank)

Answer: Medicare

Q: A(n) __ (three words), usually an insurance company, handles the daily operations for Medicare, including paperwork claims payments.
(Fill in the blank)

Answer: Medicare Administrative Contractor

Q: A medical coder's responsibility is to code accurately and __.
(Fill in the blank)

Answer: completely

Q: The __ is the fastest growing segment of the population.
(Fill in the blank)

Answer: elderly

Q: A(n) __ assignment is when a provider does not bill the patient for the difference between the service cost and Medicare allowed.
(Fill in the blank)

Answer: accepting

Q: Medicare Part __ is a prescription drug benefit.
(Fill in the blank)

Answer: D

Q: Which group does the Medicare program not cover?

A. people eligible for disability benefits under Social Security
B. prisoners (Correct)
C. people with permanent kidney failure

Q: In which issue of the *Federal Register* are updates to Medicare outpatient reimbursement NOT published?

A. October (Correct)
B. November
C. December

Q: Which is not a component that is taken into account with a Relative Value Unit (RVU)?

A. overhead
B. work
C. all are components (Correct)
D. malpractice

Q: Which of the following is an example of a discount that would be permitted as a “safe harbor” from fraud and abuse regulations?

A. An item or service is furnished free of charge or at a reduced charge in exchange for agreement to buy a different item or service.

B. An HMO contracts with a laboratory for all laboratory services and receives a discounted price. (Correct)

C. The price of an item or service is reduced for one payer but not for Medicare.