Student name:\_\_\_\_\_\_\_\_\_\_

1. The employment forecast for well-trained medical insurance and coding specialists is/are

decreasing opportunities.

staying the same as today.

increasing opportunities.

remaining stagnant.

1. Medical insurance specialists ensure financial success of the medical practice by

using health information technology.

setting their own rules and regulations.

failing to communicate effectively.

recording only cash payments.

1. According to the textbook, pick the rising occupation in the health care industry that requires the employee to have the highest level of proficiency in dealing with the public professionally and pleasantly.

health information technician

medical assistant

lab technician

radiology technician

1. A computerized lifelong health care record for an individual that incorporates data from all sources is known as a(n)

electronic health record (EHR).

practice management program (PMP).

computerized health record (CHR).

lifelong health care record (LHR).

1. In a medical practice, cash flow is required to

pay for office expenses.

pay for hospital supplies.

pay for nursing home employees.

pay for the staff of an insurance company.

1. What is the definition of revenue cycle?

clinical care provided for patients, from appointment to discharge

all administrative and clinical functions which ensure that sufficient monies flow into the practice to pay bills

all coding and billing steps involved in preparing correct claims

complete documentation that is submitted to third-party payers

1. Medical insurance specialists use practice management programs to

schedule patients.

collect data on patients’ diagnoses and services.

record payments from insurance companies.

All of these are correct.

1. Examine the list of services in the answer choices below and determine which one would most likely be considered a noncovered service at a primary care medical office.

emergency medical care

employment-related injuries

surgical procedures

annual physical examinations

1. What kind of medical services are annual physical examinations and routine screening procedures?

covered

preventive

noncovered

surgical

1. Under an insurance contract, the patient is the first party and the physician is the second party. Who is the third party?

provider

PCP

insurance plan

federal government

1. In what ways can insurance policies be written?

an individual or group

only group

only individual

only workers

1. Medical insurance is a(n)\_\_\_\_\_\_\_\_\_\_ between a policyholder and a health plan.

verbal agreement

written agreement

informal agreement

exchange of money

1. Determine which of the following entities is not considered a provider.

nurse practitioners

long-term care facilities

insurance companies

medical supply companies

1. Dependents of a policyholder may include his/her

spouse and children.

only spouse.

only children.

physician.

1. Identify the type of service that is not considered to be a preventive medical service.

pediatric and adolescent immunizations

prenatal care

outpatient surgery

routine screening procedures

1. The key to receiving coverage and payment from a payer is the payer's definition of

provider.

medical necessity.

policyholder.

medical insurance.

1. Determine which of the following types of services a health plan will not pay for.

noncovered services

covered services

preventive medical services

hospitalization

1. Where do medical insurance companies summarize the payments they may make for medically necessary medical services?

medical necessity document

workers' compensation document

schedule of benefits document

encounter form

1. In general, how do the cost of policies written for groups compare to those written for individuals?

Policies written for groups are cheaper.

Policies written for individuals are cheaper.

Policies written for individuals and groups cost the same.

Policies written for groups are more expensive.

1. Review the choices below and select the most appropriate definition for health plan benefits, as defined by American's Health Insurance Plans (AHIP).

advantages offered to policyholders

provider services

payments for covered medical services

list of network providers

1. Compare the choices below to determine which type of provider service would most likely NOT be covered by a health plan.

a medical procedure that is not included in a plan's benefits

an illness that started after the insurance coverage began

a surgery performed on an outpatient basis

all elective procedures performed in the hospital

1. What type of insurance reimburses income lost because of a person's inability to work?

disability insurance

standard medical insurance

medical necessity coverage

self-insured coverage

1. Under a written insurance contract, the policyholder pays a premium, and the insurance company provides

payments for covered medical services.

preventive medical services.

surgery.

copayments.

1. Out-of-pocket expenses must be paid by

the provider.

the insured.

the health plan.

the insurance company.

1. Which of the following conditions must be met before payment is made under an indemnity plan?

payment of premium, deductible, and coinsurance

payment of the copayment

payment of the premium and coinsurance

payment of the deductible

1. Under an indemnity plan, typically a patient may use the services of

only HMO network providers.

any affiliated provider.

any provider.

only out-of-network providers.

1. Under a fee-for-service plan, the third-party payer makes a payment

before medical services are provided.

after medical services are provided.

at the time of the visit.

once a month under a PMPM.

1. Calculate the amount of money a patient would owe for a covered service costing $1,200 if their indemnity policy has a coinsurance rate of 75-25, and they have already met their deductible.

$0

$300

$900

$1,200

1. Calculate the amount of money a patient would owe for a noncovered service costing $900 if their indemnity policy has a coinsurance rate of 80-20, and they have already met their deductible.

$0

$180

$720

$900

1. Calculate the amount of money a patient would owe for a covered service costing $1,800 if their indemnity policy has a $400 deductible (which has not been met) and their coinsurance rate is 80-20.

$280

$680

$1,400

$1,800

1. When is a deductible paid?

before benefits begin

at the end of the year

after benefits begin

never

1. How is coinsurance defined?

the periodic payment the insured is required to make to keep a policy in effect

the amount that the insured pays on covered services before benefits begin

the percentage of each claim that the insured pays

a prepayment covering provider's services for a plan member for a specified period

1. What is a premium?

the periodic payment the insured is required to make to keep a policy in effect

the amount that the insured pays on covered services before benefits begin

the percentage of each claim that the insured pays

a prepayment covering provider's services for a plan member for a specified period

1. Calculate the amount of money the insurance company would owe on a covered service costing $850 if there is a $500 deductible (which has not yet been met) and no coinsurance.

$0

$150

$350

$500

1. In how many managed care plans may a physician participate?

zero

one

two

many

1. Identify the advantages offered to patients in managed care plans, as compared to indemnity insurance.

lower premiums and charges

higher premiums

higher deductibles

lower premiums, charges, and deductibles

1. Choose the entity(ies) that may form agreements with an MCO.

the patient and provider

the provider

the health plan

the provider and health plan

1. Name a benefit a provider usually gets from participation with a health plan.

an increased number of patients

a decreased number of patients

more contractual duties

no contractual duties

1. Health care claims report data to payers about\_\_\_\_\_\_\_\_\_\_ and\_\_\_\_\_\_\_\_\_\_.

the patient; the physician’s income taxes

the patient; the services provided by the physician

the physician; the services provided by the physician

the service; the deductible

1. An indemnity policy states that the coinsurance rate is 80-20. Which of the following is the payer’s portion?

20

60

80

100

1. In what format are health care claims sent?

only electronic

only hard copy

electronic or hard copy

claims do not need to be sent

1. What is the formula for calculating an insurance company payment in an indemnity plan?

charge − deductible

deductible − coinsurance

deductible + coinsurance

charge − deductible − coinsurance

1. A capitated payment amount is called a

copayment.

coinsurance payment.

retroactive payment.

prospective payment.

1. Identify the type of HMO cost-containment method that limits members to receiving services from the HMO's physician network.

cost-sharing

restricting patients' choice of providers

requiring preauthorization for services

controlling drug costs

1. Identify the type of HMO cost-containment method that requires providers to use a formulary.

cost-sharing

restricting patients' choice of providers

requiring preauthorization for services

controlling drug costs

1. Identify the type of HMO cost-containment method that requires the patient to pay a copayment.

cost-sharing

restricting patients' choice of providers

requiring preauthorization for services

controlling drug costs

1. Identify the type of HMO cost-containment method that requires patients to obtain approval for services before they receive the treatment.

cost-sharing

restricting patients' choice of providers

requiring preauthorization for services

controlling drug costs

1. If a POS HMO member elects to receive medical services from out-of-network providers they usually

pay an additional cost.

need only pay the standard copayment.

will receive inferior treatment.

pay less than in-network benefits.

1. Which term best describes medical services that meet professional medical standards?

medical etiquette

medical networks

medical necessity

medical ethics

1. Which of the following is required when an HMO patient is admitted to the hospital for nonemergency treatment?

referral

coinsurance

preauthorization

utilization

1. One of the advantages of an HMO for patients who face difficult treatments is Disease/Case Management by assigning a

referral.

PCP.

copayment.

case manager.

1. Under a capitated rate for each plan member, which of the following does a provider share with the third-party payer?

payments

risk

services

the premium

1. The capitated rate per member per month covers

all medical services.

services listed on the schedule of benefits.

the episode of care.

all members' premiums.

1. To be fully covered, patients who enroll in an HMO may use the services of

only HMO network providers.

any provider within 50 miles.

only out-of-network providers.

any provider.

1. For a patient insured by an HMO, the phrase “out-of-network” means providers who are

not under contract with the payer.

only acting as a specialist.

whose offices are more than 50 miles from the patient.

licensed by the state.

1. Patients who enroll in a point-of-service type of HMO may use the services of

only HMO network providers.

any affiliated provider.

only out-of-network providers.

HMO network or out-of-network providers.

1. When a POS option is elected under a health maintenance organization, the patient may

choose providers only from the HMO’s network.

choose providers who are not in the HMO’s network.

choose any provider without additional expense.

choose providers only from the IPA’s network.

1. Identify another name for a point-of-service (POS) plan.

closed HMO

open HMO

free HMO

restricted HMO

1. Calculate the monthly capitation payment a provider should receive from a health plan if they have 80 contracted patients and a capitated payment of $40 per month.

$1,200

$2,400

$3,200

$4,000

1. A physician has a contract to receive a $2,000 monthly capitation fee, based on a fee of $50 for 40 patients who are in the plan. If only 10 patients visited the practice in the last month, the capitation payment will be

$500.

$1,000.

$2,000.

$4,000.

1. Describe the role of a primary care physician (PCP) in an HMO.

coordinating patients' overall care

ensuring that some services are necessary

providing health care services for the patient

admitting the patient to the hospital regardless of the condition

1. Another term used for a primary care physician (PCP) is

controller.

practitioner.

gatekeeper.

specialist.

1. On what is the PMPM rate usually based?

health-related characteristics of the enrollees

a restricted choice of providers

the health plan’s formulary

fee for service

1. Higher copayments may be charged for patient visits to/for

preventive services.

the office of a specialist.

their primary care physician.

medical necessary services.

1. In a preferred provider organization (PPO) plan, referrals to specialists are

required.

not required.

more expensive.

less expensive.

1. What do providers participating in a PPO generally receive in exchange for accepting lower fees?

more patient visits

capitation payments

less patient visits

increased hospitalization rates

1. PPO members who use out-of-network providers may be subjected to

higher copayments.

lower copayments.

lower insurance rates.

decreased deductibles.

1. Imagine you are a patient who wants to regulate your health care expenses on your own; what type of insurance plan would you use?

health maintenance organization

preferred provider organization

consumer-driven health plan

point-of-service plan

1. Consumer-driven health plans combine a health plan with a special “savings account” that is used to pay what before the deductible is met?

coinsurance

medical bills

excluded services

non-medically necessary services

1. Name the two components of a consumer-driven health plan (CDHP).

a health plan and a gatekeeper

a health plan and a special “savings account”

a gatekeeper and a special “savings account”

a gatekeeper and a formulary

1. Employers that offer health plans to employees without using an insurance carrier are

third-party payers.

third-party administrators.

independent contractors.

self-funded (insured) health plans.

1. Determine which method a self-funded health plan most often uses in setting up its provider network.

hire a PCP to provide a network

set up their own provider network

buy the use of existing networks from managed care organizations

are not required to set up a network

1. Which of the following is an example of a private-sector payer?

Medicare

Medicaid

workers' compensation insurance

insurance company

1. Which of the following covers patients who are age 65 and over?

Medicare

Medicaid

TRICARE

CHAMPUS

1. Which of the following programs covers people who cannot otherwise afford medical care?

Medicare

Medicaid

TRICARE

CHAMPUS

1. Scheduling appointments is part of which revenue cycle step?

Step 1, preregister patients.

Step 10, follow up on patient payments.

Step 8, monitor patient adjudication.

Step 5, review coding compliance.

1. Collecting copayments is part of which revenue cycle step?

Step 3, check in patients.

Step 10, follow up payments and collections

Step 8, monitor patient adjudication.

Step 5, review billing compliance

1. When medical insurance specialists work with patient billing programs, they need

computer skills.

communication skills.

knowledge of anatomy.

flexibility.

1. A patient ledger records

the patient's illnesses.

the patient's financial transactions.

the patient's relatives.

the day's appointments and payments.

1. Imagine you are a medical insurance specialist; identify the impact your ability to prepare accurate, timely claims can have on the practice.

Preparing accurate and timely claims generally leads to full and timely reimbursement from the health plan.

Preparing accurate and timely claims generally leads to a higher capitation payment.

Preparing accurate and timely claims generally leads to a higher coinsurance rate.

Preparing accurate and timely claims generally leads to more patients.

1. What step is used when patient payments are later than permitted under the financial policy?

Step 3, check in patients.

Step 10, follow up patient payments and collections.

Step 2, establish financial responsibility for the visit.

Step 4, review coding compliance.

1. Verifying insurance is part of which revenue cycle step?

Step 3, check in patients.

Step 10, follow up patient payments.

Step 2, establish financial responsibility for the visit.

Step 4, review coding compliance.

1. Describe the process of adjudication.

the practice's monitoring of the money that is needed to run the practice

the payer's process of putting a claim through a series of steps designed to judge whether it should be paid

the process of appealing a rejected claim

the practice's comparison of each payment sent with a claim

1. In what step does the medical insurance specialist verify that charges are in compliance with insurance guidelines?

Step 3, check in patients.

Step 10, follow up patient payments.

Step 2, establish financial responsibility for the visit.

Step 5, review billing compliance.

1. What term is used to describe the action of satisfying official requirements?

adjudication

compliance

accounts receivable (A/R)

accounts payable (A/P)

1. What adds up to form a practice’s accounts receivable?

money due from health plans

money due from patients

money due from both health plans and patients

money owed to patients

1. Practice management programs may be used for

scheduling appointments and financial record keeping.

financial record keeping and billing.

billing only.

scheduling appointments, financial record keeping, and billing.

1. Which of the following characteristics should medical insurance specialists use when working with patients' records and handling finances?

able to work as a team member

honesty and integrity

knowledge of medical terms

communication skills

1. The statement that “coding professionals should not change codes. . .to increase billings” is an example of

professional ethics.

professional services.

professional etiquette.

personal ethics.

1. Courteous treatment of patients who visit the medical practice is an example of medical

ethics.

etiquette.

coding.

insurance.

1. In large medical practices, a medical insurance specialist is more likely to

need to use professionalism.

handle a variety of billing and collections tasks.

have more specialized duties.

have less specialized duties.

1. The most important characteristic for a medical insurance specialist to possess is

professionalism.

punctuality.

friendliness.

quickness.

1. What skills are required for successful mastery of the tasks of a medical insurance specialist?

professional appearance and attention to detail

courtesy and good attendance

initiative and communication skills

attention to detail and ability to work as a team member

1. Professional organizations generally have a(n)\_\_\_\_\_\_\_\_\_\_ that its members should follow/possess.

employee policy and procedure manual

list of attributes

code of ethics

financial policy

1. The designation of Registered Medical Assistant (RMA) is awarded by

AAMA.

AAPC.

AMT.

AHIMA.

1. Certification as a Certified Professional Coder (CPC) is awarded by

AAMA.

AAPC.

AMT.

AHIMA.

1. The titles of Certified Coding Specialist (CCS) and Certified Coding Specialist–Physician-based (CCS-P) are awarded by

AMA.

CNN.

ABC.

AHIMA.

1. Pick the most accurate definition of certification.

recognition of professionalism

recognition of a superior level of skill by an official organization

recognition of a successful career

recognition of higher level of degree of schooling

1. What is typically required of professional organizations?

good attendance

continuing education sessions

membership in more than one organization

there are no requirements

**Answer Key**Test name: chapter 1

C

Knowledgeable medical office employees are in demand.

A

Providers must compete in a complex environment of various health plans, managed care contracts, and federal and state regulations.

B

Medical assistants who are expected to excel are those best fit to deal with the public through a courteous, pleasant manner and a professional demeanor.

A

Electronic health record (EHR) is a computerized lifelong health care record for an individual that incorporates data from all sources.

A

Cash flow, the movement of monies into and out of the practice, is needed in order to pay for office expenses such as salaries and overhead.

B

The revenue cycle includes all administrative and clinical functions that ensure sufficient monies flow into the practice to pay bills.

D

Expertise in the use of practice management programs is an important skill in the medical practice. Medical insurance specialists use them to

* + Schedule patients.
	+ Organize patient and insurance information.
	+ Collect data on patients’ diagnoses and services.
	+ Generate, transmit, and report on the status of health care claims.
	+ Record payments from insurance companies.
	+ Generate patients’ statements, post payments, and update accounts.
	+ Create financial and productivity reports.

B

Most medical insurance policies do not cover employment-related injuries; emergency care and surgical procedures are generally covered services, while annual physical examinations are often covered as preventive medical services.

B

Annual physicals and screening procedures are examples of preventive medical services, because they help keep patients healthy and prevent illness.

C

The payer, or insurance plan, is the third party under an insurance contract.

A

A group or individual can be insured.

B

Medical insurance is a written policy that states the terms of an agreement between a policyholder (an individual) and a health plan (an insurance).

C

Providers include physicians, nurse-practitioners, physician assistants, therapists, hospitals, laboratories, long-term care facilities, and suppliers such as pharmacies and medical supply companies.

A

A policyholder's dependents, customarily the spouse and children, may also be covered for an additional cost.

C

Many health plans cover preventive medical services, such as annual physical examinations, pediatric and adolescent immunizations, prenatal care, and routine screening procedures; primary care is generally a covered service.

B

A payer's definition of medical necessity is the key to coverage and payment.

A

Medical insurance policies describe noncovered services, those for which they do not pay.

C

Medical insurance policies contain a schedule of benefits that summarizes the payments that may be made for medically necessary medical services that policyholders receive.

A

In general, policies that are written for groups costs policyholders less than those written for individuals.

C

Health plans provide benefits, which are defined by AHIP as payments for covered medical services.

A

Medical insurance policies describe noncovered services that they do not cover, which include excluded services.

A

Patients may have disability insurance that provides reimbursement for income lost because of a person's inability to work.

A

A written insurance contract requires the policyholder to pay a premium, in exchange for which the insurance company provides payments for covered medical services.

B

Insured individuals pay out-of-pocket expenses before receiving benefits.

A

Before a payment is made to an insured person under an indemnity plan, payments of the premium, deductible, and coinsurance must be up to date.

C

Under indemnity plans, patients are free to choose their providers.

B

Fee-for-service plans pay retroactively.

B

The patient must pay an out-of-pocket expense of $300 ($1,200 x 0.25 = $300) for this service.

D

The patient would owe the entire cost of $900, as insurance policies do not pay for noncovered services.

B

The patient must pay an out-of-pocket expense of $680 ($1,800 - $400 = $1,400; $1,400 x 0.20 = $280; $280 + $400 deductible = $680) for this service.

A

A deductible is an amount of money that the insured pays on covered services before benefits begin.

C

Coinsurance is the portion of charges an insured person must pay for health care services after the deductible.

A

A premium is money the insured pays to a health plan for a policy.

C

The health plan would owe $350 ($850 - $500 = $350).

D

A physician may choose to participate in many managed care plans.

D

Managed care offers a more restricted choice of (and access to) providers and treatments in exchange for lower premiums, deductibles, and other charges than traditional indemnity insurance.

A

Instead of only the patient having a policy with the health plan, both the patient and the provider have agreements with the MCO.

A

Participation brings providers benefits, such as more patients, as well as contractual duties, and usually, reduced fees.

B

Health care claims report data about the patient and the services provided by the physician.

C

The first number in the coinsurance rate is the payer's portion; the second is the insured's. In this case, the payer’s portion is 80% and the insured’s portion is 20%.

C

Health care claims are sent to payers in either electronic or hard copy format.

D

The formula for calculating an indemnity insurance payment is charge minus deductible minus coinsurance.

D

Capitated payments are paid prospectively, or in advance of services.

B

In order to restrict patients' choice of providers, HMOs require members to receive services from their network of physicians, hospitals, and other providers.

D

In controlling drug costs, HMOs require providers to prescribe drugs for patients only from the HMO's formulary.

A

In the cost-sharing method of cost-containment, HMOs require patients to pay a specified charge called a copayment when they see a provider.

C

Requiring patients to obtain preauthorization before they receive many types of services is an HMO cost-containment method.

A

POS members who receive medical services from out-of-network providers that they choose usually pay an additional cost.

C

For more information, the definition of medical necessity can be located in the Medicare.gov glossary. It is a payment concept—payers do not pay for medically unnecessary procedures and treatments.

C

Patients must secure preauthorization for nonemergency hospitalizations.

D

HMOs often assign case managers to work with patients who face difficult treatments.

B

In a capitated plan, providers and payers share the risk of increased demand for medical services.

B

The capitated rate of prepayment covers only services listed on the schedule of benefits.

A

HMOs require their members to see only network providers in order to be fully covered.

A

Out-of-network providers do not have any agreement with the patient's health plan.

D

POS plans expand patients’ options to include out-of-network providers.

B

POS plans provide patients with the option of using non-network providers.

B

A point-of-service (POS) plan is also called an open HMO.

C

The monthly capitation payment would total $3,200 (80 x $40 = $3,200).

C

The monthly capitation fee is $2,000, regardless of the number of patients who visit the physician.

A

A PCP coordinates patient's overall care to ensure that all services are, in the PCP's judgment, necessary.

C

A primary care physician (PCP) may also be called a gatekeeper.

A

The capitated rate, called PMPM, is usually based on the health-related characteristics of the enrollees, such as age and gender.

B

A higher copayment may be required for a visit to the office of a specialist or for the use of emergency department services.

B

PPOs do not usually demand a referral for a specialist visit.

A

In exchange for accepting lower fees, providers generally see more patients.

A

PPO members may use out-of-network providers, usually for higher copayments, increased deductibles, or both.

C

Cost containment in consumer-driven health plans begins with consumerism, which is the idea that patients who themselves pay for health care services become more careful consumers.

B

Consumer-driven health plans combine a health plan with a special “savings account” that is used to pay medical bills before the deductible is met.

B

Consumer-driven health plans (CDHPs) combine a health plan, usually a PPO with a high deductible and low premiums, with a special “savings account” used to pay medical bills before the deductible has been met.

D

Self-funded (insured) health plans offer health plans directly to employees.

C

Self-funded health plans most often buy the use of existing networks from managed care organizations.

D

An insurance company is considered a private-sector payer, as opposed to government programs such as Medicare.

A

Medicare covers the age 65 and over population.

B

Medicaid covers people who otherwise could not afford medical care.

A

Scheduling appointments is the first step in the revenue cycle.

A

Collecting copayments is done during patient check-in.

A

Most medical practices use computers to handle billing and process claims.

B

A patient ledger is a record of a particular patient's financial transactions with the practice.

A

When medical insurance specialists prepare accurate, timely claims, the practice is most likely to receive full and timely reimbursement from the health plan.

B

A collection process is often started when patient payments are later than permitted under the practice's financial policy.

C

Verifying insurance is part of establishing financial responsibility for a visit.

B

A health plan's process of examining claims and determining benefits is adjudication.

D

Medical insurance specialists apply their knowledge of payer guidelines to analyze what can be billed on health care claims.

B

Compliance means actions that satisfy official requirements, such as the proper assigning of codes.

C

The money due from plans, as well as payments due from patients, add up to form the practice's accounts receivable (A/R).

D

PMPs are used for scheduling appointments, billing, and financial record keeping.

B

Handling financial matters requires honesty and integrity.

A

Each professional organization has a code of ethics that is to be followed by its membership.

B

Medical etiquette requires courteous treatment of patients.

C

In large medical practices, the duties of medical insurance specialists may be more specialized.

A

The most important characteristic that medical insurance specialists should evidence is professionalism.

D

A number of skills and attributes are required for successful mastery of the tasks of a medical insurance specialist, including knowledge of medical terminology, anatomy, physiology, and medical coding; communication skills; attention to detail; flexibility; health information technology skills; honesty and integrity; and ability to work as a team member.

C

Each professional organization has a code of ethics that is to be followed by its membership.

C

The RMA is awarded by the AMT.

B

The American Academy of Professional Coders grants the Certified Professional Coder.

D

The CCS and CCS-P certifications are awarded by AHIMA.

B

Certification is recognition of a superior level of skill by an official organization.

B

Most professional organizations require certified members to keep up-to-date by taking annual training courses.