Medical Insurance - A Revenue Cycle Process Approach 9th edition Valerius Test Bank

SKU: 9781266283246-TEST-BANK

CH-01: Test Bank

CORRECT ANSWERS ARE LOCATED IN THE 2ND HALF OF THIS DOC.

MULTIPLE CHOICE - Choose the one alternative that best completes the statement or answers the question.

1) The employment forecast for well-trained medical insurance and coding specialists is/are
   A) decreasing opportunities.
   B) staying the same as today.
   C) increasing opportunities.
   D) remaining stagnant.

2) Medical insurance specialists ensure financial success of the medical practice by
   A) using health information technology.
   B) setting their own rules and regulations.
   C) failing to communicate effectively.
   D) recording only cash payments.

3) 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.
   A) health information technician
   B) medical assistant
   C) lab technician
   D) radiology technician

4) A computerized lifelong health care record for an individual that incorporates data from all sources is known as a(n)
   A) electronic health record (EHR).
   B) practice management program (PMP).
   C) computerized health record (CHR).
   D) lifelong health care record (LHR).

5) In a medical practice, cash flow is required to
   A) pay for office expenses.
   B) pay for hospital supplies.
   C) pay for nursing home employees.
   D) pay for the staff of an insurance company.

6) What is the definition of revenue cycle?
   A) clinical care provided for patients, from appointment to discharge
   B) all administrative and clinical functions which ensure that sufficient monies flow into the practice to pay bills
   C) all coding and billing steps involved in preparing correct claims
   D) complete documentation that is submitted to third-party payers

Medical Insurance - A Revenue Cycle Process Approach 9th edition Valerius Test Bank

7) Medical insurance specialists use practice management programs to
   A) schedule patients.
   B) collect data on patients' diagnoses and services.
   C) record payments from insurance companies.
   D) All of these are correct.

8) 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.
   A) emergency medical care
   B) employment-related injuries
   C) surgical procedures
   D) annual physical examinations

9) What kind of medical services are annual physical examinations and routine screening procedures?
   A) covered
   B) preventive
   C) noncovered
   D) surgical

10) Under an insurance contract, the patient is the first party and the physician is the second party. Who is the third party?
   A) provider
   B) PCP
   C) insurance plan
   D) federal government

11) In what ways can insurance policies be written?
   A) an individual or group
   B) only group
   C) only individual
   D) only workers

12) Medical insurance is a(n)_____ between a policyholder and a health plan.
   A) verbal agreement
   B) written agreement
   C) informal agreement
   D) exchange of money

13) Determine which of the following entities is not considered a provider.
   A) nurse practitioners
   B) long-term care facilities
   C) insurance companies
   D) medical supply companies

14) Dependents of a policyholder may include his/her
   A) spouse and children.
   B) only spouse.
   C) only children.
   D) physician.

Medical Insurance - A Revenue Cycle Process Approach 9th edition Valerius Test Bank

15) Identify the type of service that is not considered to be a preventive medical service.
   A) pediatric and adolescent immunizations
   B) prenatal care
   C) outpatient surgery
   D) routine screening procedures

16) The key to receiving coverage and payment from a payer is the payer's definition of
   A) provider.
   B) medical necessity.
   C) policyholder.
   D) medical insurance.

17) Determine which of the following types of services a health plan will not pay for.
   A) noncovered services
   B) covered services
   C) preventive medical services
   D) hospitalization

18) Where do medical insurance companies summarize the payments they may make for medically necessary medical services?
   A) medical necessity document
   B) workers' compensation document
   C) schedule of benefits document
   D) encounter form

19) In general, how do the cost of policies written for groups compare to those written for individuals?
   A) Policies written for groups are cheaper.
   B) Policies written for individuals are cheaper.
   C) Policies written for individuals and groups cost the same.
   D) Policies written for groups are more expensive.

20) Review the choices below and select the most appropriate definition for health plan benefits, as defined by American's Health Insurance Plans (AHIP).
   A) advantages offered to policyholders
   B) provider services
   C) payments for covered medical services
   D) list of network providers

21) Compare the choices below to determine which type of provider service would most likely NOT be covered by a health plan.
   A) a medical procedure that is not included in a plan's benefits
   B) an illness that started after the insurance coverage began
   C) a surgery performed on an outpatient basis
   D) all elective procedures performed in the hospital

Medical Insurance - A Revenue Cycle Process Approach 9th edition Valerius Test Bank

22) What type of insurance reimburses income lost because of a person's inability to work?
A) disability insurance
B) standard medical insurance
C) medical necessity coverage
D) self-insured coverage

23) Under a written insurance contract, the policyholder pays a premium, and the insurance company provides
A) payments for covered medical services.
B) preventive medical services.
C) surgery.
D) copayments.

24) Out-of-pocket expenses must be paid by
A) the provider.
B) the insured.
C) the health plan.
D) the insurance company.

25) Which of the following conditions must be met before payment is made under an indemnity plan?
A) payment of premium, deductible, and coinsurance
B) payment of the copayment
C) payment of the premium and coinsurance
D) payment of the deductible

26) Under an indemnity plan, typically a patient may use the services of
A) only HMO network providers.
B) any affiliated provider.
C) any provider.
D) only out-of-network providers.

27) Under a fee-for-service plan, the third-party payer makes a payment
A) before medical services are provided.
B) after medical services are provided.
C) at the time of the visit.
D) once a month under a PMPM.

28) 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.
A) $0
B) $300
C) $900
D) $1,200

29) 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.
A) $0
B) $180
C) $720
D) $900

Medical Insurance - A Revenue Cycle Process Approach 9th edition Valerius Test Bank

30) 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.
A) $280
B) $680
C) $1,400
D) $1,800

31) When is a deductible paid?
A) before benefits begin
B) at the end of the year
C) after benefits begin
D) never

32) How is coinsurance defined?
A) the periodic payment the insured is required to make to keep a policy in effect
B) the amount that the insured pays on covered services before benefits begin
C) the percentage of each claim that the insured pays
D) a prepayment covering provider's services for a plan member for a specified period

33) What is a premium?
A) the periodic payment the insured is required to make to keep a policy in effect
B) the amount that the insured pays on covered services before benefits begin
C) the percentage of each claim that the insured pays
D) a prepayment covering provider's services for a plan member for a specified period

34) 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.
A) $0
B) $150
C) $350
D) $500

35) In how many managed care plans may a physician participate?
A) zero
B) one
C) two
D) many

Medical Insurance - A Revenue Cycle Process Approach 9th edition Valerius Test Bank

36) Identify the advantages offered to patients in managed care plans, as compared to indemnity insurance.
A) lower premiums and charges
B) higher premiums
C) higher deductibles
D) lower premiums, charges, and deductibles

37) Choose the entity(ies) that may form agreements with an MCO.
A) the patient and provider
B) the provider
C) the health plan
D) the provider and health plan

38) Name a benefit a provider usually gets from participation with a health plan.
A) an increased number of patients
B) a decreased number of patients
C) more contractual duties
D) no contractual duties

39) Health care claims report data to payers about_____ and_____.
A) the patient; the physician's income taxes
B) the patient; the services provided by the physician
C) the physician; the services provided by the physician
D) the service; the deductible

40) An indemnity policy states that the coinsurance rate is 80-20. Which of the following is the payer's portion?
A) 20
B) 60
C) 80
D) 100

41) In what format are health care claims sent?
A) only electronic
B) only hard copy
C) electronic or hard copy
D) claims do not need to be sent

42) What is the formula for calculating an insurance company payment in an indemnity plan?
A) charge − deductible
B) deductible − coinsurance
C) deductible + coinsurance
D) charge − deductible − coinsurance

43) A capitated payment amount is called a
A) copayment.
B) coinsurance payment.
C) retroactive payment.
D) prospective payment.

Medical Insurance - A Revenue Cycle Process Approach 9th edition Valerius Test Bank

44) Identify the type of HMO cost-containment method that limits members to receiving services from the HMO's physician network.
A) cost-sharing
B) restricting patients' choice of providers
C) requiring preauthorization for services
D) controlling drug costs

45) Identify the type of HMO cost-containment method that requires providers to use a formulary.
A) cost-sharing
B) restricting patients' choice of providers
C) requiring preauthorization for services
D) controlling drug costs

46) Identify the type of HMO cost-containment method that requires the patient to pay a copayment.
A) cost-sharing
B) restricting patients' choice of providers
C) requiring preauthorization for services
D) controlling drug costs

47) Identify the type of HMO cost-containment method that requires patients to obtain approval for services before they receive the treatment.
A) cost-sharing
B) restricting patients' choice of providers
C) requiring preauthorization for services
D) controlling drug costs

48) If a POS HMO member elects to receive medical services from out-of-network providers they usually
A) pay an additional cost.
B) need only pay the standard copayment.
C) will receive inferior treatment.
D) pay less than in-network benefits.

49) Which term best describes medical services that meet professional medical standards?
A) medical etiquette
B) medical networks
C) medical necessity
D) medical ethics

50) Which of the following is required when an HMO patient is admitted to the hospital for nonemergency treatment?
A) referral
B) coinsurance
C) preauthorization
D) utilization

Medical Insurance - A Revenue Cycle Process Approach 9th edition Valerius Test Bank

51) One of the advantages of an HMO for patients who face difficult treatments is Disease/Case Management by assigning a
A) referral.
B) PCP.
C) copayment.
D) case manager.

52) Under a capitated rate for each plan member, which of the following does a provider share with the third-party payer?
A) payments
B) risk
C) services
D) the premium

53) The capitated rate per member per month covers
A) all medical services.
B) services listed on the schedule of benefits.
C) the episode of care.
D) all members' premiums.

54) To be fully covered, patients who enroll in an HMO may use the services of
A) only HMO network providers.
B) any provider within 50 miles.
C) only out-of-network providers.
D) any provider.

55) For a patient insured by an HMO, the phrase "out-of-network" means providers who are
A) not under contract with the payer.
B) only acting as a specialist.
C) whose offices are more than 50 miles from the patient.
D) licensed by the state.

56) Patients who enroll in a point-of-service type of HMO may use the services of
A) only HMO network providers.
B) any affiliated provider.
C) only out-of-network providers.
D) HMO network or out-of-network providers.

57) When a POS option is elected under a health maintenance organization, the patient may
A) choose providers only from the HMO's network.
B) choose providers who are not in the HMO's network.
C) choose any provider without additional expense.
D) choose providers only from the IPA's network.

58) Identify another name for a point-of-service (POS) plan.
A) closed HMO
B) open HMO
C) free HMO
D) restricted HMO

Medical Insurance - A Revenue Cycle Process Approach 9th edition Valerius Test Bank

59) 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.
A) $1,200
B) $2,400
C) $3,200
D) $4,000

60) 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
A) $500.
B) $1,000.
C) $2,000.
D) $4,000.

61) Describe the role of a primary care physician (PCP) in an HMO.
A) coordinating patients' overall care
B) ensuring that some services are necessary
C) providing health care services for the patient
D) admitting the patient to the hospital regardless of the condition

62) Another term used for a primary care physician (PCP) is
A) controller.
B) practitioner.
C) gatekeeper.
D) specialist.

63) On what is the PMPM rate usually based?
A) health-related characteristics of the enrollees
B) a restricted choice of providers
C) the health plan's formulary
D) fee for service

64) Higher copayments may be charged for patient visits to/for
A) preventive services.
B) the office of a specialist.
C) their primary care physician.
D) medical necessary services.

65) In a preferred provider organization (PPO) plan, referrals to specialists are
A) required.
B) not required.
C) more expensive.
D) less expensive.

Medical Insurance - A Revenue Cycle Process Approach 9th edition Valerius Test Bank

66) What do providers participating in a PPO generally receive in exchange for accepting lower fees?
A) more patient visits
B) capitation payments
C) less patient visits
D) increased hospitalization rates

67) PPO members who use out-of-network providers may be subjected to
A) higher copayments.
B) lower copayments.
C) lower insurance rates.
D) decreased deductibles.

68) Imagine you are a patient who wants to regulate your health care expenses on your own; what type of insurance plan would you use?
A) health maintenance organization
B) preferred provider organization
C) consumer-driven health plan
D) point-of-service plan

69) Consumer-driven health plans combine a health plan with a special "savings account" that is used to pay what before the deductible is met?
A) coinsurance
B) medical bills
C) excluded services
D) non-medically necessary services

70) Name the two components of a consumer-driven health plan (CDHP).
A) a health plan and a gatekeeper
B) a health plan and a special "savings account"
C) a gatekeeper and a special "savings account"
D) a gatekeeper and a formulary

71) Employers that offer health plans to employees without using an insurance carrier are
A) third-party payers.
B) third-party administrators.
C) independent contractors.
D) self-funded (insured) health plans.

72) Determine which method a self-funded health plan most often uses in setting up its provider network.
A) hire a PCP to provide a network
B) set up their own provider network
C) buy the use of existing networks from managed care organizations
D) are not required to set up a network

73) Which of the following is an example of a private-sector payer?
A) Medicare
B) Medicaid
C) workers' compensation insurance
D) insurance company

Medical Insurance - A Revenue Cycle Process Approach 9th edition Valerius Test Bank

74) Which of the following covers patients who are age 65 and over?
A) Medicare
B) Medicaid
C) TRICARE
D) CHAMPUS

75) Which of the following programs covers people who cannot otherwise afford medical care?
A) Medicare
B) Medicaid
C) TRICARE
D) CHAMPUS

76) Scheduling appointments is part of which revenue cycle step?
A) Step 1, preregister patients.
B) Step 10, follow up on patient payments.
C) Step 8, monitor patient adjudication.
D) Step 5, review coding compliance.

77) Collecting copayments is part of which revenue cycle step?
A) Step 3, check in patients.
B) Step 10, follow up payments and collections
C) Step 8, monitor patient adjudication.
D) Step 5, review billing compliance

78) When medical insurance specialists work with patient billing programs, they need
A) computer skills.
B) communication skills.
C) knowledge of anatomy.
D) flexibility.

79) A patient ledger records
A) the patient's illnesses.
B) the patient's financial transactions.
C) the patient's relatives.
D) the day's appointments and payments.

80) Imagine you are a medical insurance specialist; identify the impact your ability to prepare accurate, timely claims can have on the practice.
A) Preparing accurate and timely claims generally leads to full and timely reimbursement from the health plan.
B) Preparing accurate and timely claims generally leads to a higher capitation payment.
C) Preparing accurate and timely claims generally leads to a higher coinsurance rate.
D) Preparing accurate and timely claims generally leads to more patients.

Medical Insurance - A Revenue Cycle Process Approach 9th edition Valerius Test Bank

81) What step is used when patient payments are later than permitted under the financial policy?
A) Step 3, check in patients.
B) Step 10, follow up patient payments and collections.
C) Step 2, establish financial responsibility for the visit.
D) Step 4, review coding compliance.

82) Verifying insurance is part of which revenue cycle step?
A) Step 3, check in patients.
B) Step 10, follow up patient payments.
C) Step 2, establish financial responsibility for the visit.
D) Step 4, review coding compliance.

83) Describe the process of adjudication.
A) the practice's monitoring of the money that is needed to run the practice
B) the payer's process of putting a claim through a series of steps designed to judge whether it should be paid
C) the process of appealing a rejected claim
D) the practice's comparison of each payment sent with a claim

84) In what step does the medical insurance specialist verify that charges are in compliance with insurance guidelines?
A) Step 3, check in patients.
B) Step 10, follow up patient payments.
C) Step 2, establish financial responsibility for the visit.
D) Step 5, review billing compliance.

85) What term is used to describe the action of satisfying official requirements?
A) adjudication
B) compliance
C) accounts receivable (A/R)
D) accounts payable (A/P)

86) What adds up to form a practice's accounts receivable?
A) money due from health plans
B) money due from patients
C) money due from both health plans and patients
D) money owed to patients

87) Practice management programs may be used for
A) scheduling appointments and financial record keeping.
B) financial record keeping and billing.
C) billing only.
D) scheduling appointments, financial record keeping, and billing.

Medical Insurance - A Revenue Cycle Process Approach 9th edition Valerius Test Bank

88) Which of the following characteristics should medical insurance specialists use when working with patients' records and handling finances?
A) able to work as a team member
B) honesty and integrity
C) knowledge of medical terms
D) communication skills

89) The statement that “coding professionals should not change codes. . .to increase billings” is an example of
A) professional ethics.
B) professional services.
C) professional etiquette.
D) personal ethics.

90) Courteous treatment of patients who visit the medical practice is an example of medical
A) ethics.
B) etiquette.
C) coding.
D) insurance.

91) In large medical practices, a medical insurance specialist is more likely to
A) need to use professionalism.
B) handle a variety of billing and collections tasks.
C) have more specialized duties.
D) have less specialized duties.

92) The most important characteristic for a medical insurance specialist to possess is
A) professionalism.
B) punctuality.
C) friendliness.
D) quickness.

93) What skills are required for successful mastery of the tasks of a medical insurance specialist?
A) professional appearance and attention to detail
B) courtesy and good attendance
C) initiative and communication skills
D) attention to detail and ability to work as a team member

94) Professional organizations generally have a(n)_____ that its members should follow/possess.
A) employee policy and procedure manual
B) list of attributes
C) code of ethics
D) financial policy

95) The designation of Registered Medical Assistant (RMA) is awarded by
A) AAMA.
B) AAPC.
C) AMT.
D) AHIMA.

Medical Insurance - A Revenue Cycle Process Approach 9th edition Valerius Test Bank

96) Certification as a Certified Professional Coder (CPC) is awarded by
A) AAMA.
B) AAPC.
C) AMT.
D) AHIMA.

97) The titles of Certified Coding Specialist (CCS) and Certified Coding Specialist–Physician-based (CCS-P) are awarded by
A) AMA.
B) CNN.
C) ABC.
D) AHIMA.

98) Pick the most accurate definition of certification.
A) recognition of professionalism
B) recognition of a superior level of skill by an official organization
C) recognition of a successful career
D) recognition of higher level of degree of schooling

99) What is typically required of professional organizations?
A) good attendance
B) continuing education sessions
C) membership in more than one organization
D) there are no requirements

Medical Insurance - A Revenue Cycle Process Approach 9th edition Valerius Test Bank

CH-01: Test Bank

Answer Key

Test name: CH-01: Test Bank

1) C
2) A
3) B
4) A
5) A
6) B
7) D
8) B
9) B
10) C
11) A
12) B
13) C
14) A
15) C
16) B
17) A
18) C
19) A
20) C
21) A
22) A
23) A
24) B
25) A
26) C
27) B
28) B
29) D
30) B
31) A
32) C
33) A
34) C
35) D
36) D
37) A
38) A
39) B
40) C
41) C
42) D
43) D
44) B
45) D
46) A
47) C
48) A
49) C
50) C
51) D
52) B
53) B
54) A
55) A
56) D
57) B
58) B
59) C
60) C
61) A
62) C
63) A
64) B
65) B
66) A
67) A
68) C
69) B
70) B
71) D
72) C
73) D
74) A
75) B
76) A
77) A

Medical Insurance - A Revenue Cycle Process Approach 9th edition Valerius Test Bank

78) A
79) B
80) A
81) B
82) C
83) B
84) D
85) B
86) C
87) D
88) B
89) A
90) B
91) C
92) A
93) D
94) C
95) C
96) B
97) D
98) B
99) B

Medical Insurance - A Revenue Cycle Process Approach 9th edition Valerius Test Bank