Certified Billing and Coding Specialist (CBCS) Study Guide

Quiz Addendum

Quiz 3: Coding and Coding Guidelines

1. A billing and coding specialist is preparing a claim for a patient who has chronic tonsillitis. According to the suffix *-itis*, which of the following is occurring with the tonsils?
   A. Abnormal condition
   B. Inflammation
   C. Enlargement
   D. Pain

2. A billing and coding specialist is processing a claim for a patient who has hypoglycemia. In the term hypoglycemia, the prefix *hypo-* means which of the following?
   A. Below
   B. Above
   C. Between
   D. Excessive

3. A patient is diagnosed with exudative otitis media. Which of the following is the anatomic location of this condition?
   A. Middle ear
   B. Inner ear
   C. Outer ear
   D. Eustachian tube

4. Which of the following categories in the ICD-10-CM is used to report a routine prenatal visit with no complications?
   A. Z00 Encounter for general examination without complain, suspected or reported diagnosis
   B. Z34 Encounter for supervision of normal pregnancy
   C. O09 Supervision of high-risk pregnancy
   D. O80 Encounter for full-term uncomplicated delivery

5. Refer to the code set below to answer the following question. A patient presents to their provider's office with a sore throat, and the provider diagnoses acute and chronic tonsillitis. Which of the following ICD-10-CM codes should the billing and coding specialist use for this diagnosis?

CODE	DESCRIPTION
J02.9	Acute pharyngitis, unspecified
J03.90	Acute tonsillitus, unspecified
J31.2	Chronic pharyngitis
J35.01	Chronic tonsillitis

   A. J02.9, J31.2
   B. J35.01, J31.2, J35.01, J03.90
   C. J35.01, J03.90
   D. J03.90, J35.01

6. Which of the following ICD-10-CM codes indicates chronic cholecystitis with cholelithiasis without obstruction?
   A. K80.00 Calculus of gallbladder with acute cholecystitis without obstruction
   B. K80.10 Calculus of gallbladder with chronic cholecystitis without obstruction
   C. K80.20 Calculus of gallbladder without cholecystitis without obstruction
   D. K80.31 Calculus of bile duct with cholangitis, unspecified, with obstruction

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7. Which of the following ICD-10-CM codes should a billing and coding specialist use for an encounter for human immunodeficiency virus (HIV) testing?
   A. Z11.3 Encounter fo screening for infections witha predominantly sexual mode of transmission
   B. Z11.4 Encounter for screening for human immunodeficiency virus (HIV)
   C. Z11.51 Encounter for screening for human papillomavirus (HPV)
   D. Z71.7 Human immunodeficiency virus (HIV) counseling

8. Refer to the code set below to answer the following question. Which of the following is the correct ICD-10-CM code to report for an encounter for gestational diabetes controlled with diet and insulin?

CODE	DESCRIPTION
O24.414	Gestational diabetes mellitus in pregnancy, insulin controlled
O24.410	Gestational diabetes mellitus in pregnancy, diet controlled
O24.419	Gestational diabetes mellitus in pregnancy, unspecified controlled
O24.819	Other pre-existing diabetes mellitus in pregnancy, unspecified trimester

   A. O24.414
   B. O24.410, O24.414
   C. O24.419
   D. O24.819

9. Refer to the code set below to answer the following question. Which of the following is the correct CPT® code for reporting a single-layer repair using tissue adhesive of a 2 cm laceration of the scalp?

CODE	DESCRIPTION
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet); 2.5 cm or less
12031	Repair, intermediate wounds of scalp, axillae, trunk, and/or extremities (including hands and feet); 2.5 cm or less
12051	Intermediate repair of superficial wounds of scalp, axillae, external genitalia, trunk, and/or extremities (including hands and feet)
13120	Repair, complex, scalp, arms and/or legs; 1.1 cm to 2.5 cm

   A. 12001
   B. 12031
   C. 12051
   D. 13120

10. Which of the following abbreviations describes the route in which a medication is introduced into the subdural space of the spinal cord?
    A. IM
    B. SC
    C. INH
    D. IT

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11. Refer to the code set below to answer the following question. A billing and coding specialist should use which of the following CPT® procedure codes to report a screening CT colonography?

CODE	DESCRIPTION
74150	Computed tomography, abdomen, without contrast material
74261	Computed tomographic colonography, diagnostic, including image postprocessing; without contrast material
74262	Computed tomographic colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed
74263	Computed tomographic colonography, diagnostic, including image postprocessing

A. 74150, 74263

B. 74261

C. 74263

D. 74262

12. Refer to the code set below to answer the following question. A child received a measles, mumps, rubella, and varicella (MMRV) injection with provider counseling. Which of the following CPT® codes should be reported for the vaccine and administration?

CODE	DESCRIPTION
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician; first or only component of each vaccine or toxoid administered
90461	each additional vaccine or toxoid administered
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular); one vaccine (single or combination vaccine/toxoid)
90472	each additional vaccine (single or comination vaccine/toxoid)
90707	Measles, mumps, and rubella virus vaccine (MMR), live, for subcutaneous use
90710	Measles, mumps, rubella, and varicella virus vaccine (MMR), live, for subcutaneous use
90716	Varicella virus vaccine (VAR), live, for subcutaneous use

A. 90707, 90716, 90471, 90472 x 3

B. 90707, 90716, 90460, 90461 x 3

C. 90710, 90460

D. 90710, 90460, 90461 x 3

13. Which of the following HCPCS codes is used to report a pediatric crib, hospital grade, fully enclosed?

A. E0293

B. E0296

C. E0300

D. E0303

14. Refer to the code set below to answer the following question. Which of the following HCPCS modifiers indicates the anatomical location of left hand, fifth digit?

CODE	DESCRIPTION
-FA	Left hand, thumb
-F2	Left hand, third digit
-F4	Left hand, fifth digit
-F9	Right hand, fifth digit

A. F2

B. F9

C. FA

D. F4

15. Refer to the code set below to answer the following question. A CRNA provides anesthesia services for a cholecystectomy procedure. Which of the following modifiers should be appended to the service code?

CODE	DESCRIPTION
-23	Unusual anesthesia
-AA	Anesthesia Services performed personally by the anesthesiologist
-QX	Qualified non-physician anesthetist with medical direction by a physician
-QZ	Qualified registered nurse anesthetist (CRNA) without medical direction by a physician

A. 23

B. AA

C. QX

D. QZ

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16. Which of the following CPT® modifiers indicates only the interpretation and report of a radiology service was provided?
    A. 26 Professional component
    B. 25 Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service
    C. 24 Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period
    D. 22 Increased procedural services

17. Refer to the code set below to answer the following question. Which of the following CPT® modifiers indicates the same provider returns to the operating room for surgical treatment of a complication that resulted from the initial procedure?

CODE	DESCRIPTION
-76	Repeat procedure by the same physician or other qualified health care professional
-77	Repeat procedure by another physician or other qualified health care professional
-78	Unplanned return to the operating/ procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period
-79	Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period

    A. 76
    B. 77
    C. 78
    D. 79

18. A billing and coding specialist is completing a claim for a new patient who reports swelling in their ankles. The provider performs a comprehensive history, examination, and spends 60 min with the patient. Which of the following Evaluation and Management (E/M) codes should the specialist select?
    A. 99285 Emergency department visit of a patient which requires a medically appropriate history and/or examination and high medical decision-making
    B. 99205 Office or other outpatient visit for a new patient which requires a medically appropriate history and/or examination and high medical decision-making
    C. 99214 Office or other outpatient visit for an established patient which requires a medically appropriate history and/ or examination and moderate medical decision-making
    D. 99215 Office or other outpatient visit for an established patient which requires a medically appropriate history and/or examination and high medical decision-making

19. Which of the following is the Evaluation and Management (E/M) code used to report a worsening patient who was admitted yesterday, with straightforward medical decision-making?
    A. 99234 Hospital inpatient or observation care including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision-making
    B. 99238 Hospital inpatient or observation discharge day management
    C. 99221 Hospital inpatient or observation care, per day, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision-making
    D. 99231 Subsequent hospital inpatient or observation care, per day, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision-making

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20. Which of the following Evaluation and Management (E/M) codes is used to report services for a 40-year-old patient who returns to the office for an annual exam?
    A. 99386 Initial comprehensive preventative medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticapatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnositc procedures, new patient; 40-64 years
    B. 99396 Periodic comprehensive preventative medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatoy guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient: 40-64 years
    C. 99215 Office or other outpatient visit for an established patient which requires a medically appropriate history and/or examination and high medical decision-making
    D. 99205 Office or other outpatient visit for a new patient which requires a medically appropriate history and/or examination and high medical decision-making

21. Which of the following Evaluation and Management (E/M) codes is used to report online communication with an established patient lasting 15 min?
    A. 99442 Telephone evaluation and management service provided by a physician to an established patient; 11-20 minutes of medical discussion
    B. 99421 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
    C. 99422 Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11-20 minutes
    D. 99423 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

22. A provider orders a bedside commode without further details. The supply company has multiple types available, so their billing specialist queries the provider. The provider sends a new order for an extra wide, heavy-duty commode chair. Which of the following HCPCS codes should the specialist use?
    A. E0163 Commode chair, mobile or stationary, with fixed arms
    B. E0165 Commode chair with detachable arms
    C. E0168 Extra wide/heavy duty commode chairs
    D. E0171 Commode with seat lift mechanism

23. Refer to the code set below to answer the following question. A billing and coding specialist is coding a patient's visit with a provider. After querying the provider, the diagnosis is confirmed to be type 1 diabetes mellitus with hyperglycemia. Which of the following codes should the specialist use for this condition?

CODE	DESCRIPTION
E10.65	Type 1 diabetes mellitus with hyperglycemia
E10.9	Type 1 diabetes mellitus without complications
E11.65	Type 2 diabetes mellitus with hyperglycemia
E11.9	Type 2 diabetes mellitus without complications
R73.9	Hyperglycemia, unspecified

    A. E10.9, R73.9
    B. E11.9
    C. E10.65
    D. E11.65

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24. Refer to the code set below to answer the following question. A billing and coding specialist is coding a claim for a surgery. After querying the provider, it is determined that the documentation supports a total abdominal hysterectomy with colpo-urethrocystopexy. Which of the following CPT® codes should be reported?

CODE	DESCRIPTION
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58152	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s), with colpo-urethrocystopexy
58260	Vaginal hysterectomy, for uterus 250 g or less
58267	Vaginal hysterectomy, for uterus 250 g or less with removal of tube(s) and/or ovary(s)

A. 58152
B. 58150
C. 58260
D. 58267

25. A billing and coding specialist is coding an initial encounter with a provider. The chief complaint states the patient fell a week ago and is concerned by the lingering pain in the left leg, but x-rays indicate a right femur fracture. The specialist queries the provider who confirms a right femur fracture. Which of the following codes should be used to report the fracture?

A. S72.001 Fracture of unspecified part of neck of right femur
B. S72.002A Fracture of unspecified part of neck of left femur, initial encounter for closed fracture
C. S72.001A Fracture of unspecified part of neck of right femur, initial encounter for closed fracture
D. S72.001B Fracture of unspecified part of neck of right femur, initial encounter for open fracture type I or II

Quiz 4: Billing and Reimbursement

1. Which of the following is an example of a billing abstraction error?

A. Incorrect date of service is used.
B. Authorization was not obtained.
C. Referred services are billed as charges.
D. Secondary insurance was billed as primary insurance.

2. A billing and coding specialist is reviewing claims for submission. Which of the following is considered a charge capture error?

A. Preauthorization not obtained
B. Patient demographics
C. Data entry errors
D. Incorrect code assignment

3. A billing and coding specialist is completing a claim form for a Medicare beneficiary who is being seen for a wellness visit with their primary care provider who is a PAR provider. Which of the following information is required on the form?

A. Medicare identification number, date of birth, and date of injury
B. Medicare identification number, date of birth, and date of discharge
C. Medicare identification number, date of birth, and referring physician's national provider identifier (NPI)
D. Medicare identification number, date of birth, and accept assignment

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4. A billing and coding specialist is preparing a claim with two types of third-party payer coverage. Which of the following is a process that determines the order of third-party payers for the claim?
   A. Coordination of benefits
   B. Insurance claim cycle
   C. Electronic data interchange
   D. Explanation of benefits

5. Which of the following occurs when claims are submitted in batches using a clearinghouse?
   A. All claims are submitted to the same carrier and software edits are conducted.
   B. Claims are sorted by payer type and are examined for errors.
   C. The clearinghouse prints the claim forms and mails them to each carrier.
   D. After the batched claims are submitted, they are reimbursed.

6. Which of the following is a unique HIPAA-mandated number that is required to submit a claim for surgical procedures performed by a thoracic surgeon?
   A. National provider identifier (NPI)
   B. Employer identification number (EIN)
   C. Provider's Social Security number (SSN)
   D. Diagnosis related group (DRG)

7. A patient has Medicare and TRICARE insurance plans. Which of the following should be collected as patient financial responsibility after a procedure?
   A. 20% of the total charge of the procedure
   B. 20% of the allowable amount for the procedure
   C. $0.00
   D. $1,000.00

8. Which of the following resources is used to understand Medicare coverage circumstances, such as indications and coding guidance?
   A. NCD articles
   B. NCCI edits
   C. Mutually exclusive edits (MUE)
   D. Alternative payment model (APM)

9. A billing and coding specialist is reviewing a claims denial for a surgical procedure. After reviewing the original claim, it is determined that services should have been paid. Which of the following scenarios eliminates the need for prior authorization?
   A. The patient had already been admitted to the hospital.
   B. The patient required an emergency procedure.
   C. The patient received an elective procedure.
   D. The patient is a Medicare beneficiary.

10. A billing and coding specialist has received numerous denials from a third-party payer for a preauthorized service. Which of the following actions should the specialist take to resolve the denied claim?
    A. Request that the third-party payer review for reconsideration.
    B. Bill the patient for the denied services.
    C. Have the charges adjusted off the patient's account.
    D. Submit a new claim.

11. A billing and coding specialist is reviewing a remittance advice from a third-party payer that indicates $250 out of the $500 charge is a contractual adjustment. Which of the following actions should the specialist take?
    A. Bill the patient for the difference.
    B. Resubmit the claim for additional review.
    C. Change the cost for the services on future claims.
    D. Post the adjustment.

12. A billing and coding specialist is reviewing a remittance advice that has a remark code that indicates a claim is pended for review of medical records. Which of the following actions should the specialist take?
    A. Send the requested medical records to the third-party payer.
    B. Resubmit the claim to the third-party payer as a corrected claim.
    C. Notify the third-party payer to review the claim for payment.
    D. Advise the patient that they will be responsible for the charges not covered by the payer.

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13. A billing and coding specialist is reviewing a Medicare electronic remittance advice. The remittance advice indicates a payment of $80.00 for a wellness exam. The billed amount was $220.00 and the allowed amount was $80.00. Which of the following actions should the specialist take?
    A. Resubmit the claim to be reprocessed for additional payment.
    B. Post the payment and write off the difference.
    C. Ask the patient to pay the difference.
    D. Submit an appeal for the previously processed claim.

14. Which of the following documents is used to review claim reimbursements and denials?
    A. CMS-1500
    B. Remittance advice
    C. Authorization
    D. Concurrent review

15. The letters “PR” (Patient Responsibility) on a remittance advice are an example of which of the following universally accepted codes?
    A. National Correct Coding Initiative (NCCI)
    B. Current Procedural Terminology (CPT®) codes
    C. Claim Adjustment Reason Code (CARC)
    D. International Classification of Diseases (ICD) codes

16. A billing and coding specialist is reviewing a partially-paid claim that was submitted without modifier 22 for increased procedural services. Which of the following actions should the specialist take to obtain accurate reimbursement?
    A. Resubmit the claim with copies of the medical record documentation.
    B. Submit an appeal with copies of the medical record documentation.
    C. Contact the patient for additional reimbursement.
    D. Post the payment and write off the difference.

17. A claim is denied with a reason code that the service was not medically necessary. Which of the following actions should a billing and coding specialist take next to process the appeal?
    A. Record the denial with the reason code and make a note in the patient’s account.
    B. Review the diagnosis entered on the claim against the diagnosis entered in the provider note.
    C. Call the third-party payer and ask for their explanation of the adjudication.
    D. Send proof of valid diagnosis with a letter to the third-party payer.

18. A billing and coding specialist receives a denial from a third-party payer due to missing information. Which of the following actions should the specialist take to receive reimbursement?
    A. Request reimbursement from the patient.
    B. Submit an adjustment.
    C. Contact the third-party payer to provide the information.
    D. Resubmit the claim with the completed information.

19. Which of the following unpaid claims listed on a current aging report should a billing and coding specialist review first?
    A. 14 days outstanding
    B. 21 days outstanding
    C. 28 days outstanding
    D. 35 days outstanding

20. After running a report, a billing and coding specialist discovers several claims are being denied for coding errors. To prevent future errors, which of the following actions should the specialist take?
    A. Educate the third-party payer on researching coding issues.
    B. Implement external audit processes.
    C. Retrain staff on proper documentation and coding guidelines.
    D. Write off the claims that were incorrectly submitted.

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21. A billing and coding specialist is reviewing a remittance advice (RA). The specialist should identify that which of the following provides the reason for a claim denial?
    A. Patient statements
    B. Payer website
    C. Claim adjustment reason code (CARC)
    D. Electronic health record (EHR) scrubbing tool

22. Which of the following information is needed to accurately review, evaluate, and resolve denied claims?
    A. An aging report breakdown of a patient's account
    B. A remittance advice with reason codes
    C. Registration notes
    D. SOAP notes

23. After a claim is processed by a third-party payer, which of the following actions should a billing and coding specialist take to collect the remaining allowed amount?
    A. Write off the remaining balance.
    B. Submit an adjustment for additional reimbursement.
    C. Call the third-party payer to negotiate a higher rate of reimbursement.
    D. Prepare and send a patient statement.

24. Which of the following information is required by third-party payers when processing a CMS-1500/837P claim?
    A. Prior medical provider
    B. Patient's address
    C. Place of service
    D. Patient deductible amount

25. Which of the following information is required for third-party payers to process a CMS-1500/837P claim for an evaluation and management service, performed using televisual devices?
    A. Patient's account number
    B. Provider's phone number
    C. Modifier(s)
    D. Prior authorization number

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Quiz Answers

QUIZ 3: CODING AND CODING GUIDELINES

1. A. Abnormal condition is indicated by the suffix -*osis*.

   B. CORRECT. Inflammation is indicated by the suffix -*itis*.

   C. Enlargement is indicated by the suffix -*megaly*.

   D. Pain is indicated by the suffix -*algia* or -*dynia*.

2. A. CORRECT. The prefixes *hypo*- and *sub*- mean below.

   B. The prefixes *hyper*- and *epi*- mean above.

   C. The prefix *inter*- means between.

   D. The prefixes *hyper*- and *poly*- mean excessive.

3. A. CORRECT. The condition of exudative otitis media is located the middle ear.

   B. The condition of exudative otitis media is located in the middle ear; the inner ear would be otitis interna.

   C. The condition of exudative otitis media is located in the middle ear; the outer ear would be otitis externa.

   D. The condition of exudative otitis media is located in the middle ear; the eustachian tube is located in the inner ear.

4. A. Category Z00 is used to report regular examination encounters without complications.

   B. CORRECT. Category Z34 is used to report encounters for supervision of a normal pregnancy.

   C. Category O09 is used to report encounters for supervision of a high-risk pregnancy.

   D. Category O80 is used to report encounters for a full-term uncomplicated delivery.

5. A. The ICD-10-CM code J02.9 identifies acute pharyngitis, sore throat. The ICD-10-CM code J31.2 identifies chronic pharyngitis, sore throat. Since sore throat is a symptom of tonsillitis, the sore throat diagnoses are not reported.

   B. The ICD-10-CM code J02.9 identifies chronic pharyngitis, which is a symptom of tonsillitis and is not separately reported with the chronic and acute tonsillitis codes.

   C. The ICD-10-CM code J35.01 identifies chronic tonsillitis and J03.90 identifies acute tonsillitis. When both acute and chronic exist, the specialist should code acute first. Both codes are required for a complete diagnosis.

   D. CORRECT. The ICD-10-CM code J03.90 identifies acute tonsillitis and J35.01 identifies chronic tonsillitis. When both acute and chronic exist, the specialist should code acute first. Both codes are required for a complete diagnosis.

6. A. The ICD-10-CM code K80.00 identifies calculus of the gallbladder with acute cholecystitis, not chronic cholecystitis.

   B. CORRECT. The ICD-10-CM code K80.10 identifies calculus of the gallbladder with chronic cholecystitis without obstruction.

   C. The ICD-10-CM code K80.20 identifies calculus of the gallbladder without cholecystitis, not with cholecystitis.

   D. The ICD-10-CM code K80.31 identifies calculus of the bile duct with cholangitis, unspecified with obstruction.

7. A. The ICD-10-CM code Z11.3 identifies an encounter for screening for infections with a predominantly sexual mode of transmission. The Excludes2 note states Z11.4 is for HIV testing.

   B. CORRECT. The ICD-10-CM code Z11.4 identifies an encounter for screening for HIV.

   C. The ICD-10-CM code Z11.51 identifies an encounter for screening for human papillomavirus.

   D. The ICD-10-CM code Z71.7 identifies HIV counseling.

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8. A. CORRECT. The ICD-10-CM code O24.414 identifies gestational diabetes mellitus in pregnancy, insulin controlled. The Official Guideline I.C.15.i states that if a patient with gestational diabetes is treated with both diet and insulin, only the code for insulin-controlled is required.

   B. The ICD-10-CM code O24.414 identifies gestational diabetes mellitus in pregnancy, insulin controlled. Reference Official Guideline I.C.15.i for instructions on coding gestational diabetes controlled with both diet and insulin.

   C. The ICD-10-CM code O24.419 identifies gestational diabetes mellitus in pregnancy, unspecified control. This description does not match the diagnostic statement.

   D. The ICD-10-CM code O24.819 identifies preexisting diabetes mellitus in pregnancy. This description does not match the diagnostic statement.

9. A. CORRECT. CPT® code 12001 identifies a simple repair of superficial wounds of the scalp measuring 2.5 cm or less. This description matches the procedural documentation of the site of closure as the scalp and the size of 2 cm.

   B. CPT® code 12031 identifies an intermediate repair of wounds of the scalp measuring 2.5 cm or less. This description does not match the procedural documentation.

   C. CPT® code 12051 identifies an intermediate repair of wounds of the face measuring 2.5 cm or less. This description does not match the procedural documentation.

   D. CPT® code 13120 identifies a complex repair of wounds of the scalp measuring 1.1 cm to 2.5 cm. This description does not match the procedural documentation.

10. A. The abbreviation IM represents a medication that is introduced intramuscularly, or directly into a muscle.

    B. The abbreviation SC represents a medication that is introduced subcutaneously, or just under the skin.

    C. The abbreviation INH represents a medication that is introduced by administration of an inhaled solution.

    D. CORRECT. The abbreviation IT represents a medication that is introduced intrathecally, or into the subdural space of the spinal cord.

11. A. CPT® code 74150 identifies computed tomography, abdomen, without contrast material. CPT® code 74263 identifies computed tomographic colonography, screening, including image postprocessing. This description does not match the procedural documentation.

    B. CPT® code 74261 identifies computed tomographic colonography, diagnostic, including image postprocessing without contrast material. This description does not match the procedural documentation.

    C. CORRECT. CPT® code 74263 identifies computed tomographic colonography, screening, including image postprocessing. This description matches the procedural documentation of the purpose of the test for a screening.

    D. CPT® code 74262 identifies computed tomography, abdomen, with contrast material, including non-contrast images if performed. This description does not match the procedural documentation.

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12. A. CPT® code 90707 indicates the measles, mumps, and rubella (MMR) vaccine and code 90716 identifies the varicella virus vaccine (VAR). Since a combination code (90710 MMRV) exists, it must be used when performed. Administration codes 90471 and 90472 report administration without counseling.

    B. CPT® code 90707 indicates the measles, mumps, and rubella (MMR) vaccine. CPT© code 90716 identifies the varicella virus vaccine (VAR). Since a combination code (90710 MMRV) exists, it must be used when performed. Since there are four separate components in MMRV, code 90460 is used with code 90461 x 3 to report the administration and counseling.

    C. Although MMRV is one vaccine, there are four separate components, and code 90460 is used with code 90461 x 3 to report the administration and counseling.

    D. CORRECT. CPT® code 90710 indicates the measles, mumps, rubella, and varicella (MMRV) vaccine, which are used with an administration and counseling code for the injection service. Since there are multiple components to MMRV, code 90460 is reported for the first component and 90461 x 3 for the remaining components.

13. A. HCPCS code E0293 identifies a hospital bed, variable height, hi-lo, without side rails, without mattress.

    B. HCPCS code E0296 identifies a hospital bed, total electric, without side rails, with mattress.

    C. CORRECT. HCPCS code E0300 identifies a pediatric crib, hospital grade, fully enclosed, with or without top enclosure.

    D. HCPCS code E0303 identifies a hospital bed, heavy duty, extra wide, with weight capacity greater than 158.8 kg (350 lb) but less than or equal to 272 kg (600 lb), with any type of side rails, with mattress.

14. A. HCPCS modifier F2 indicates the anatomical location of left hand, third digit.

    B. HCPCS modifier F9 indicates the anatomical location of right hand, fifth digit.

    C. HCPCS modifier FA indicates the anatomical location of left hand, thumb.

    D. CORRECT. HCPCS modifier F4 indicates the anatomical location of left hand, fifth digit.

15. A. HCPCS modifier 23 indicates unusual anesthesia.

    B. HCPCS modifier AA indicates anesthesia services performed personally by an anesthesiologist.

    C. HCPCS modifier QX indicates a CRNA service, with medical direction by a provider.

    D. CORRECT. HCPCS modifier QZ indicates a CRNA service, without medical direction by a provider.

16. A. CORRECT. CPT® modifier 26 indicates only the professional component of a radiology service was provided.

    B. CPT® modifier 25 indicates a significant, separately identifiable Evaluation and Management (E/M) service was performed by the same provider on the same day as a procedure or other service was performed.

    C. CPT® modifier 24 indicates an Evaluation and Management (E/M) service was performed by the same provider during a postoperative period that is unrelated to the recovery from the surgical procedure.

    D. CPT® modifier 22 indicates the service provided involved more work from the provider than is usually required for the service reported.

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17. A. CPT® modifier 76 indicates a repeated procedure by the same provider that performed the initial procedure.

    B. CPT® modifier 77 indicates a repeated procedure by a provider other than the provider who performed the initial procedure.

    C. CORRECT. CPT® modifier 78 indicates an unplanned return to the operating room by the same provider following the initial procedure for a related procedure during the postoperative period.

    D. CPT® modifier 79 indicates an unrelated procedure by the same provider during the postoperative period.

18. A. E/M code 99285 describes emergency department services, including a high complexity of medical decision-making.

    B. CORRECT. The specialist should select E/M code 99205. This code describes new patient E/M services, including a reported time spent with the patient of at least 60 min.

    C. E/M code 99214 describes an established patient E/M service, including a reported time spent with the patient between 30 to 39 min.

    D. E/M code 99215 describes an established patient E/M service, including a reported time spent with the patient between 40 to 54 min.

19. A. E/M code 99234 describes hospital inpatient or observation care when the patient is admitted and discharged on the same date of service.

    B. E/M code 99238 describes hospital inpatient or observation discharge day management services.

    C. E/M code 99221 describes initial hospital inpatient or observation care with straightforward medical decision-making.

    D. CORRECT. E/M code 99231 describes subsequent hospital inpatient or observation care with straightforward medical decision-making.

20. A. E/M code 99386 describes comprehensive preventative services for a new patient between the ages of 40 and 64 years.

    B. CORRECT. E/M code 99396 describes comprehensive preventative services for an established patient between the ages of 40 and 64 years.

    C. E/M code 99215 describes a comprehensive office visit for an established patient.

    D. E/M code 99205 describes a comprehensive office visit for a new patient.

21. A. E/M code 99442 describes telephonic services. This service does not meet the requirements of online digital face-to-face evaluation regulations for telehealth services. This code is for 11 to 20 min telephonic services.

    B. E/M code 99421 meets the requirements of online digital face-to-face evaluation for an established patient; however, the total time recorded exceeds the listed time of 5 to 10 min.

    C. CORRECT. E/M code 99422 meets the requirements of online digital face-to-face evaluation for an established patient, and the total time recorded is within the listed time of 11 to 20 min.

    D. E/M code 99423 meets the requirements of online digital face-to-face evaluation for an established patient; however, the listed time of 21 min or more exceeds the total time recorded.

22. A. This code describes a commode chair with fixed arms but is not extra wide or heavy duty.

    B. This code describes a commode chair with detachable arms but is not extra wide or heavy duty.

    C. CORRECT. This code describes a commode chair that is extra wide and/or heavy duty. Therefore, this fits the requirement from the provider.

    D. This code describes a commode chair that comes with an integrated seat lift mechanism, which was not a requirement from the provider.

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23. A. Code E10.9 reports type 1 diabetes mellitus without complications and code R73.9 reports hyperglycemia with a category note that excludes it from being reported with diabetes codes (E08-E13).

    B. Code E11.9 reports type 2 or unspecified diabetes mellitus without complications.

    C. CORRECT. E10.65 reports type 1 diabetes mellitus with hyperglycemia.

    D. Code E11.65 reports type 2, not type 1, diabetes mellitus with hyperglycemia.

24. A. CORRECT. This code describes an abdominal hysterectomy with the colpo-urethrocystopexy.

    B. This code describes an abdominal hysterectomy without the colpo-urethrocystopexy.

    C. This code describes a vaginal hysterectomy for a uterus of 250 g or less.

    D. This code describes a vaginal hysterectomy with colpo-urethrocystopexy.

25. A. A 7th character is required to report the code to the highest level of specificity and "A" in ICD-10-CM Chapter 19 indicates an initial encounter for a closed fracture.

    B. This code reports an initial encounter for a closed left femur fracture, not a closed right femur fracture.

    C. CORRECT. This code reports an initial encounter for a closed right femur fracture. Per ICD-10-CM coding guidelines, if a fracture is not reported as open or closed, the default code should be reported as closed.

    D. This code reports an initial encounter for an open right femur fracture. Per ICD-10-CM coding guidelines, if a fracture is not reported as open or closed, the default code should be reported as closed.

QUIZ 4: BILLING AND REIMBURSEMENT

1. A. Incorrect date of service is not an abstraction error.

   B. Failing to obtain prior authorization is not an abstraction error.

   C. CORRECT. Examples of billing abstraction errors include charging for a service that was referred, not performed.

   D. Billing insurances in the wrong order is not an abstraction error.

2. A. Charge capture errors include incorrect code assignment. Preauthorization is not a charge capture error.

   B. Charge capture errors include incorrect code assignment. Patient demographics are not a charge capture error.

   C. Charge capture errors include incorrect code assignment. Data entry errors are not a charge capture error.

   D. CORRECT. Charge capture errors include incorrect code assignment.

3. A. Because this is only a wellness visit, there would be no date of injury recorded.

   B. Because the patient has not been admitted or discharged from a hospital, there would be no date of discharge.

   C. Because the patient is seeing their primary care provider, there would be no need for a referring provider.

   D. CORRECT. These are all elements that are required for a Medicare claim for a wellness visit.

4. A. CORRECT. Coordination of benefits is a process that ensures patient benefits are paid in the correct order when more than one third-party payer provides coverage.

   B. The insurance claim cycle is a four-stage process that all claims go through regardless of how many payers there are.

   C. Electronic data interchange is the system through which computers transfer data in health care financial transactions.

   D. Explanation of benefits is a document that details claim adjudication and applies to all claims regardless of how many payers there are.

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5. A. Claims are sorted by carrier type, software edits are conducted, and then the claim is sent electronically to the correct payers.

   B. CORRECT. After the clearinghouse receives a batch, it separates the claims by carrier and performs software edits for each claim.

   C. After the clearinghouse receives a batch, it separates the claims by carrier and performs software edits for each claim. Then, the clearinghouse will send on only electronic claims.

   D. Claims need to be scrubbed for errors and must pass all edits before being sent to the correct third-party payers for consideration of payment.

6. A. CORRECT. An NPI is required by HIPAA for all health care provider transactions.

   B. An EIN is required by HIPAA for health care transactions that do not involve a provider.

   C. The provider's Social Security number is not required to be on a claim form.

   D. A DRG is a grouping of ICD10 codes that are required by HIPAA to identify care provided in a hospital.

7. A. The patient is no longer financially responsible for their health care costs because of the dual coverage with Medicare and TRICARE.

   B. The patient is no longer financially responsible for their health care costs because of the dual coverage with Medicare and TRICARE.

   C. CORRECT. The patient is no longer financially responsible for their health care costs because of the dual coverage with Medicare and TRICARE.

   D. The patient is no longer financially responsible for their health care costs because of the dual coverage with Medicare and TRICARE.

8. A. CORRECT. NCD articles explain the coverage circumstances of certain services, including indications and any limitations for the service and coding guidance.

   B. NCCI edits identify codes that are bundled into another service. They do not provide coverage circumstances such as indications and coding guidance.

   C. Mutually exclusive edits identify issues such as code combinations that are restricted by CPT® guidelines or procedures that cannot be reasonably performed during the same encounter. They do not provide coverage circumstances such as indications and coding guidance.

   D. Procedure-to-Procedure (PTP) edits are code pair edits that prevent improper payment when certain codes are submitted together. They do not provide coverage circumstances such as indications and coding guidance.

9. A. Admission to a hospital does not eliminate the need for prior authorization.

   B. CORRECT. An emergency procedure eliminates the need for prior authorization.

   C. Elective procedures require prior authorization.

   D. Medicare beneficiaries still require prior authorization for certain procedures.

10. A. CORRECT. The preauthorized services should be considered medically necessary if billed accurately; therefore, the claim would need to be reconsidered for payment.

    B. The payer should be contacted for reconsideration before billing the patient for preauthorized services.

    C. Adjusting charges from a patient's account without proof of appropriate steps to have the claim reexamined for payment is considered fraud.

    D. The specialist should avoid submitting a new claim because it will result in a denial for duplicate services.

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11. A. It is not appropriate to balance bill the patient based on the contract with the payer.

B. Resubmitting the claim for additional review is not necessary because both parties have agreed to the contractual agreement.

C. Changing the cost for the services does not change the contractual agreement.

D. CORRECT. According to the contract with the third-party payer, the specialist should post the adjustment amount indicated on the remittance advice and enter the adjustment reason in the patient's account.

12. A. CORRECT. The specialist should send the requested medical records to the third-party payer for processing.

B. A corrected claim would not resolve the issue because the claim has not been denied.

C. Notifying the third-party payer will not result in a payment without submitting the requested medical records.

D. The patient should not be contacted and billed for a pended claim.

13. A. Because the payer determined the allowed amount was $80.00 and reimbursed $80.00, the patient financial responsibility is $0.00. The remainder should be written off and there would be no need to resubmit.

B. CORRECT. Because the payer determined the allowed amount was $80.00 and reimbursed $80.00, the patient financial responsibility is $0.00. The remainder should be written off.

C. Because the payer determined the allowed amount was $80.00 and reimbursed $80.00, the patient financial responsibility is $0.00. The remainder should be written off.

D. Because the payer determined the allowed amount was $80.00 and reimbursed $80.00, the patient financial responsibility is $0.00. The remainder should be written off and there would be no need to appeal.

14. A. This document is used to submit claims.

B. CORRECT. A remittance advice is a document that explains the adjudication, including claim rejections and denials, of a claim by a third-party payer.

C. This document is used to obtain and receive authorization for services.

D. This document is used to determine if medical necessity is still current and if it is appropriate to keep a patient hospitalized.

15. A. The NCCI initiative for Medicare speaks to the policy for correct coding.

B. Current Procedural Terminology (CPT®) codes are used to describe services provided.

C. CORRECT. The CARC list is managed by Medicare and used universally within insurance plans for coding denials listed on explanation of benefits (EOBs). The letters PR on a remittance advice indicates patient responsibility.

D. ICD is the diagnosis indicated which explains the health of the patient during the session.

16. A. Resubmitting the claim, even with copies of the medical record documentation, is incorrect because it would result in a duplicate claim submission denial.

B. CORRECT. Submitting an appeal with copies of the medical record documentation is the action required to receive correct reimbursement for increased procedural services.

C. Contacting the patient for additional reimbursement is incorrect because it is a billing error, which is not the patient's responsibility.

D. Posting the payment and writing off the difference is incorrect because it is a billing error, which must be adjusted with the third-party payer.

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17. A. Although the specialist will need to record the denial with the reason code and make a note in the patient's account, the specialist should first research the denial.

    B. Denied claims are reviewed prior to determination about whether to submit for an appeal.

    C. This action is not needed because the denial with the reason code has already been received.

    D. CORRECT. Send supporting documentation for the diagnosis and procedure to the third-party payer.

18. A. This is a billing error, so it is not the patient's responsibility to make a payment.

    B. There is no indication that this claim had any payments, so an adjustment would not be necessary.

    C. The specialist should not contact the third-party payer to provide the information. Instead, they should resubmit the claim with the completed information.

    D. CORRECT. The specialist should resubmit the claim with the completed information.

19. A. This unpaid claim should be reviewed; however, the specialist should review another unpaid claim first because this claim is still within the normal processing time frame for insurance plans.

    B. This unpaid claim should be reviewed; however, the specialist should review another unpaid claim first because this claim is still within the normal processing time frame for insurance plans.

    C. This unpaid claim should be reviewed; however, the specialist should review another unpaid claim first because this claim is still within the normal processing time frame for insurance plans.

    D. CORRECT. This unpaid claim should be reviewed first. The provider needs to file claims with the third-party payer in a timely manner, so the specialist should focus first on unpaid claims that are 31 to 60 days old.

20. A. The third-party payer creates the rules that specialists abide by. The specialist should retrain staff, not the third-party payer, about the rules.

    B. The specialist should implement internal, not external, audit processes to prevent future errors.

    C. CORRECT. The specialist should retrain the provider on proper documentation and coding guidelines to prevent future errors.

    D. Incorrectly submitted claims should be fixed and resubmitted as corrected claims.

21. A. Patient statements are generated by the office after the third-party payer has adjudicated the claim. This would not be a place to find claim denial reasons.

    B. The payer website does not provide the reason for a claim denial.

    C. CORRECT. A CARC identifies the reason for a claim denial.

    D. An EHR scrubbing tool does not provide the reason for a claim denial. Scrubbing tools are used on clean claims before being sent to a third-party payer.

22. A. An aging report breakdown of a patient's account will only show patient balances or payer balances. It will not show denial reason codes.

    B. CORRECT. The remittance advice from the third-party payer shows the allowed amount, adjustments, or reason for denial.

    C. The registration notes can pertain to the patient, but they would not include any reason denial codes.

    D. SOAP notes are the provider's notes pertaining to the patient encounter.

23. A. The ledger cannot be balanced without making all collection efforts.

    B. An adjustment would not be submitted to collect patient financial responsibility.

    C. It has already been determined that the balance falls under patient financial responsibility, so legally the provider must collect that debt from the client.

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D. CORRECT. As per the contract, providers are obligated to collect all patient financial responsibility from the client as their benefits dictate.

24. A. This is not a required field on the CMS-1500/837P claim form.

B. This is a not a required field on the CMS-1500/837P claim form.

C. CORRECT. This is a required field on the CMS-1500/837P claim form.

D. This is not a required field on the CMS-1500/837P claim form.

25. A. The patient account number is assigned by the provider and is not required by the third-party payer to process a claim.

B. The phone number is not required for claims processing.

C. CORRECT. Because this is an evaluation and management telehealth service, a modifier is required to process the claim.

D. No prior authorization is needed for evaluation and management telehealth services.

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