Q1: Which insurance plan is designed specifically for active-duty military personnel and their families?
A. Medicare
B. Medicaid
C. TRICARE
D. Medigap
Correct Answer: C

Q2: Medicare Part A primarily covers:
A. Inpatient hospital services
B. Outpatient physician services
C. Prescription drugs
D. Dental services
Correct Answer: A

Q3: Medicare Part B is used to reimburse:
A. Inpatient hospital stays
B. Outpatient services and physician office visits
C. Long-term care services
D. Hospice care
Correct Answer: B

Q4: Medigap policies are designed to:
A. Cover prescription drugs
B. Supplement Medicare by covering deductibles and coinsurance
C. Provide dental and vision benefits
D. Replace Medicare coverage entirely
Correct Answer: B

Q5: Medicaid eligibility is generally based on:
A. Age
B. Income and medical need
C. Employment status
D. Military service
Correct Answer: B

Q6: TRICARE provides health coverage for:
A. Retired military personnel only
B. Active-duty military members and their dependents
C. Low-income individuals
D. Medicare beneficiaries
Correct Answer: B

Q7: Which of the following is a private insurance carrier?

A. Aetna
B. United Healthcare
C. Cigna
D. All of the above
Correct Answer: D

Q8: In an HMO plan, patients are typically required to:
A. See only in-network providers
B. Obtain referrals from a primary care physician
C. Pay higher premiums for out-of-network care
D. Both A and B
Correct Answer: D

Q9: A PPO plan allows patients to:
A. Receive care only from in-network providers
B. Visit out-of-network providers at a higher cost without a referral
C. Only use a primary care provider
D. Have no cost-sharing
Correct Answer: B

Q10: An Exclusive Provider Organization (EPO) plan generally:
A. Provides coverage for both in-network and out-of-network services
B. Requires patients to use only in-network providers
C. Has high deductibles and no copays
D. Is a government-sponsored plan
Correct Answer: B

Q11: Self-funded health plans are most commonly offered by:
A. Small businesses
B. Large employers
C. Medicare
D. Medicaid
Correct Answer: A

Q12: Which insurance program is most closely associated with retirees?
A. TRICARE
B. Medicare
C. Medicaid
D. PPO
Correct Answer: B

Q13: Medicaid primarily serves:
A. Retirees
B. Low-income and disabled individuals

C. Active-duty military families
D. Employees of large corporations
Correct Answer: B

Q14: A consumer-directed health plan (CDHP) is characterized by:
A. Low deductibles
B. High deductibles combined with a Health Savings Account (HSA)
C. No coinsurance
D. Only in-network services
Correct Answer: B

Q15: Coordination of Benefits (COB) is necessary when:
A. A patient has only one insurance policy
B. A patient is covered by multiple insurance policies
C. A claim is submitted late
D. The patient has a high deductible
Correct Answer: B

Q16: The timely filing limit for Medicare claims is generally:
A. 90 days
B. 180 days
C. 365 days
D. 30 days
Correct Answer: C

Q17: The CMS-1500 form is used primarily for billing:
A. Hospital inpatient services
B. Physician professional services
C. Pharmacy claims
D. Durable medical equipment
Correct Answer: B

Q18: The UB-04 form is used for:
A. Physician office billing
B. Facility billing for inpatient and outpatient services
C. Laboratory services only
D. Radiology claims exclusively
Correct Answer: B

Q19: The False Claims Act applies primarily to claims submitted to:
A. Private insurers
B. Government payers
C. Both private and government payers
D. None of the above

Correct Answer: B

Q20: A claim submitted after the timely filing limit will most likely be:
A. Paid with a penalty
B. Rejected for timely filing
C. Processed normally
D. Automatically resubmitted
Correct Answer: B

Q21: Correct coding and billing are dependent on:
A. Complete and accurate documentation
B. Verbal instructions from the provider
C. The insurance company's guidelines only
D. Assumptions based on past claims
Correct Answer: A

Q22: A duplicate claim occurs when:
A. Two identical claims are submitted for the same service
B. Multiple services are bundled into one claim
C. A claim is resubmitted after correction
D. The patient has dual coverage
Correct Answer: A

Q23: Which of the following is prohibited under proper billing regulations?
A. Unbundling of procedures
B. Use of combination codes when appropriate
C. Correcting a claim before submission
D. Submitting duplicate claims
Correct Answer: D

Q24: An Excludes1 note in the coding manual indicates that:
A. The two codes should never be used together
B. The codes may be used together if necessary
C. The code must be used as a secondary code
D. The code is optional
Correct Answer: A

Q25: An Excludes2 note means:
A. The excluded condition is not part of the primary condition but may coexist
B. The codes must never be reported together
C. The code is not applicable
D. It is the default code for that condition
Correct Answer: A

Q26: When a service is provided within a global period, the related services are:
A. Billed separately
B. Included in the initial surgical fee
C. Not reimbursed at all
D. Submitted on a separate claim
Correct Answer: B

Q27: Billing modifiers should be used only when:
A. Documentation clearly supports their use
B. They are applied to every service regardless of documentation
C. They are not necessary
D. They increase reimbursement automatically
Correct Answer: A

Q28: The National Correct Coding Initiative (NCCI) is intended to:
A. Increase reimbursement rates
B. Prevent improper coding and unbundling
C. Simplify the claims process
D. Eliminate the need for modifiers
Correct Answer: B

Q29: When using a combination code, the code must:
A. Include all components of the service provided
B. Only include the primary component
C. Be reported separately for each component
D. Always be accompanied by a modifier
Correct Answer: A

Q30: A replacement claim is indicated on the CMS-1500 form by:
A. A handwritten note on the form
B. Using Code 7 in the appropriate box
C. Resubmitting the original claim
D. Contacting the payer directly
Correct Answer: B

Q31: The term "clean claim" refers to:
A. A claim that is error-free and processed smoothly
B. A claim that is pending further review
C. A claim that is denied
D. A claim that must be resubmitted
Correct Answer: A

Q32: On the CMS-1500 form, the provider’s National Provider Identifier (NPI) is reported in:
A. Box 17

B. Box 24J
C. Box 11
D. Box 10
Correct Answer: B

Q33: For a billing error related to coding, the first corrective step is to:
A. Correct the error and resubmit the claim
B. Contact the patient for clarification
C. File an appeal immediately
D. Cancel the claim entirely
Correct Answer: A

Q34: A claim denial due to "timely filing" indicates that:
A. The claim was submitted after the allowable period
B. The claim was underpaid
C. The claim was duplicated
D. The claim was overcharged
Correct Answer: A

Q35: Which of the following is a common reason for claim denials?
A. Insufficient documentation
B. Overcoding
C. Undercoding
D. All of the above
Correct Answer: D

Q36: HIPAA stands for:
A. Health Insurance Portability and Accountability Act
B. Health Information Privacy and Accountability Act
C. Health Insurance Privacy and Accountability Act
D. Health Information Portability and Administrative Act
Correct Answer: A

Q37: The primary purpose of the HIPAA Privacy Rule is to:
A. Allow unrestricted access to patient records
B. Protect the confidentiality of patient health information
C. Eliminate the use of electronic records
D. Enable free sharing of patient information
Correct Answer: B

Q38: If a breach of unsecured protected health information affects 500 or more individuals, the provider must:
A. Notify affected individuals only
B. Notify the Secretary of HHS and local media

C. Take no action if fewer than 500 records are involved
D. Immediately shut down operations
Correct Answer: B

Q39: Under HIPAA, a patient has the right to request:
A. Unrestricted access to all records
B. Amendments to their medical record
C. Immediate deletion of their records
D. Transfer of records to any party without consent
Correct Answer: B

Q40: The "minimum necessary" standard requires that:
A. All patient information is shared
B. Only the least amount of information needed is disclosed
C. No patient information is ever shared
D. Providers ignore patient requests for information
Correct Answer: B

Q41: Accessing a patient’s record for personal curiosity is considered:
A. Acceptable if the information is not shared
B. A violation of HIPAA
C. Standard practice
D. Necessary for billing purposes
Correct Answer: B

Q42: Covered entities under HIPAA must implement:
A. Only physical safeguards
B. Physical, technical, and administrative safeguards
C. Only technical safeguards
D. No safeguards if information is shared securely
Correct Answer: B

Q43: A Business Associate Agreement (BAA) is required when:
A. A covered entity contracts with a vendor to process PHI
B. A patient requests their records
C. A provider works independently
D. A claim is denied
Correct Answer: A

Q44: The HIPAA Security Rule specifically protects:
A. Paper records only
B. Electronic Protected Health Information (ePHI)
C. Billing records only
D. Non-sensitive information

Correct Answer: B

Q45: When a patient requests a copy of their medical records, the provider must comply within:
A. 5 business days
B. 10 business days
C. 30 days (with a possible extension)
D. 60 days
Correct Answer: C

Q46: Accessing a patient's record without a work-related reason is considered:
A. Standard procedure
B. A breach of HIPAA
C. Encouraged for quality control
D. Required for billing
Correct Answer: B

Q47: Which of the following is NOT considered Protected Health Information (PHI) under HIPAA?
A. Patient name
B. Social Security number
C. Information that is publicly available
D. Medical record number
Correct Answer: C

Q48: Upon discovering a breach of PHI, a covered entity must:
A. Notify affected individuals and the Secretary of HHS
B. Ignore the breach if minor
C. Notify affected individuals only
D. Wait for an external audit
Correct Answer: A

Q49: HIPAA applies to:
A. Healthcare providers
B. Health plans
C. Healthcare clearinghouses
D. All of the above
Correct Answer: D

Q50: "De-identified" data under HIPAA means that:
A. All personal identifiers have been removed
B. The data is still linked to the patient
C. The data can be re-identified easily
D. The data is published without any restrictions
Correct Answer: A

Q51: Patients under HIPAA have the right to:
A. Receive a copy of their records electronically
B. Request corrections to their records
C. Obtain an accounting of disclosures of their PHI
D. All of the above
Correct Answer: D

Q52: The HIPAA Enforcement Rule is designed to:
A. Establish penalties for noncompliance
B. Provide guidelines for claim filing
C. Outline reimbursement procedures
D. Determine coding standards
Correct Answer: A

Q53: "Breaking the glass" in an electronic health record system is:
A. A routine procedure with no consequences
B. Monitored and can trigger an audit
C. Encouraged for quick access
D. Not tracked by compliance systems
Correct Answer: B

Q54: A HIPAA breach can result in:
A. Civil penalties
B. Criminal penalties
C. Both civil and criminal penalties
D. No penalties if unintentional
Correct Answer: C

Q55: A Notice of Privacy Practices (NPP) must be provided to patients:
A. Only when requested
B. At the first service encounter
C. Annually
D. Only if the patient is enrolled in a health plan
Correct Answer: B

Q56: The term “contractual discount” refers to:
A. The reduction applied to the provider’s charge per the payer contract
B. A discount given directly to the patient
C. A percentage added to the billed charge
D. A fee for early payment
Correct Answer: A

Q57: If a provider’s charge is $600 and the allowed amount is $450, the contractual discount is:

A. $150
B. $50
C. $600
D. $450
Correct Answer: A

Q58: Coinsurance is defined as:
A. A flat fee per service
B. A percentage of the allowed amount that the patient pays
C. A discount applied by the provider
D. The insurer’s payment
Correct Answer: B

Q59: A copayment (copay) is:
A. A fixed fee paid by the patient at the time of service
B. A percentage of the billed charge
C. Calculated after claim processing
D. Identical to coinsurance
Correct Answer: A

Q60: Capitation is best described as:
A. Payment per service rendered
B. A fixed payment per patient per month
C. A bonus payment system
D. Fee-for-service reimbursement
Correct Answer: B

Q61: An Advance Beneficiary Notice (ABN) is used to:
A. Notify patients that a service may not be covered
B. Confirm patient eligibility
C. Obtain patient consent for treatment
D. Serve as a billing receipt
Correct Answer: A

Q62: A clearinghouse’s role in billing is to:
A. Distribute payments directly to providers
B. Serve as an intermediary for electronic claim submission
C. Approve claim reimbursements
D. Determine contractual discounts
Correct Answer: B

Q63: The term “remittance advice” (ERA) refers to:
A. A notice of claim payment or adjustment
B. A claim denial letter

C. A provider invoice
D. A summary of patient charges
Correct Answer: A

Q64: Coordination of Benefits (COB) is used to:
A. Determine which insurance is primary when multiple coverages exist
B. Calculate the patient's copay
C. Unbundle multiple procedures
D. Bundle services for payment
Correct Answer: A

Q65: If a claim is underpaid by the primary insurer, the secondary insurer may be billed if:
A. The claim is resubmitted uncorrected
B. The secondary insurer is the payer of last resort
C. Coordination of benefits applies
D. The claim includes duplicate charges
Correct Answer: C

Q66: In claims processing, an "adjustment" refers to:
A. A complete claim denial
B. A modification of the allowed amount based on contractual or regulatory factors
C. An error in service dates
D. A patient's responsibility portion
Correct Answer: B

Q67: Payment posting involves:
A. Documenting payments received for services rendered
B. Submitting claims to payers
C. Denying claims for nonpayment
D. Requesting additional patient payments
Correct Answer: A

Q68: A provider's "charge master" is:
A. A comprehensive list of all services and their charges
B. A document for auditing insurance companies
C. A summary of patient payments
D. An outdated billing tool
Correct Answer: A

Q69: For a patient with a high deductible health plan, it is expected that:
A. The insurer covers all costs
B. The patient pays most costs out-of-pocket until the deductible is met
C. The provider absorbs the costs
D. There is no difference in billing

Correct Answer: B

Q70: “Bundled payment” means that:
A. Each service is billed separately
B. Multiple services during one encounter are paid as a single package
C. Services are unbundled for higher reimbursement
D. It is identical to coinsurance
Correct Answer: B

Q71: An overpayment by an insurer should be:
A. Kept by the provider
B. Returned to the payer
C. Applied to future claims
D. Reported to the patient
Correct Answer: B

Q72: Which of the following is NOT typically part of revenue cycle management?
A. Claim submission
B. Payment posting
C. Patient scheduling
D. Accounts receivable follow-up
Correct Answer: C

Q73: “Allowable amount” is defined as:
A. The provider’s billed charge
B. The maximum amount the payer will reimburse for a service
C. The patient’s responsibility
D. The sum of copays and deductibles
Correct Answer: B

Q74: “Denial management” involves:
A. Ignoring denied claims
B. Reviewing, appealing, and resolving claim denials
C. Resubmitting the same claim repeatedly
D. Not billing certain services
Correct Answer: B

Q75: The purpose of the appeals process is to:
A. Accept initial denials without challenge
B. Challenge claim denials to obtain appropriate reimbursement
C. Reduce patient financial responsibility
D. Avoid billing altogether
Correct Answer: B

Q76: Which form is primarily used to submit claims for physician professional services?
A. UB-04
B. CMS-1500
C. CMS-1450
D. ADA claim form
Correct Answer: B

Q77: Patient insurance eligibility is typically verified:
A. After claim submission
B. Prior to scheduling the appointment
C. At the time of service
D. Not necessary in modern billing
Correct Answer: B

Q78: Prior authorization is required when:
A. The service is low cost
B. The payer mandates pre-approval for the service
C. The patient has private insurance
D. The provider is in-network
Correct Answer: B

Q79: A “superbill” is:
A. A detailed summary of services rendered used to prepare a claim
B. A claim denial notice
C. A patient invoice only
D. A summary of payer payments
Correct Answer: A

Q80: The “explanation of benefits” (EOB) is:
A. A statement to the patient detailing services and payment amounts
B. The provider’s charge list
C. A claim submission form
D. A reimbursement schedule
Correct Answer: A

Q81: Which of the following is a step in the billing process?
A. Patient registration
B. Claim submission
C. Payment posting
D. All of the above
Correct Answer: D

Q82: A patient’s financial responsibility is determined by:
A. The provider’s charge master alone

B. The payer’s allowed amount and the patient’s benefit design
C. The total billed amount
D. A standard flat fee
Correct Answer: B

Q83: A claim resubmitted due to a denial is known as a:
A. Replacement claim
B. Duplicate claim
C. Initial claim
D. Supplementary claim
Correct Answer: A

Q84: A claim scrubber is used to:
A. Increase the claim amount
B. Identify and correct errors before claim submission
C. Automatically deny claims
D. Remove patient information
Correct Answer: B

Q85: An essential component of the billing process is:
A. Accurate coding
B. Complete documentation
C. Timely claim submission
D. All of the above
Correct Answer: D

Q86: “Charge capture” refers to:
A. Recording all services provided for billing purposes
B. Charging patients directly
C. Capturing insurer payments
D. None of the above
Correct Answer: A

Q87: The purpose of modifiers in billing is to:
A. Provide additional service details
B. Increase claim amounts arbitrarily
C. Simplify coding by eliminating details
D. None of the above
Correct Answer: A

Q88: An “aging report” in billing is used to:
A. Determine the patient’s age
B. Track unpaid claims over time
C. Monitor provider performance

D. Calculate insurer payments
Correct Answer: B

Q89: “Remittance processing” involves:
A. Processing payment instructions from insurers
B. Generating patient invoices
C. Submitting claims to multiple payers
D. Reviewing denied claims
Correct Answer: A

Q90: Which department is typically responsible for following up on unpaid claims?
A. Front desk
B. Accounts receivable
C. Medical records
D. Scheduling
Correct Answer: B

Q91: Which CPT code is commonly used for a typical office visit of moderate complexity?
A. 99211
B. 99213
C. 99214
D. 99215
Correct Answer: B

Q92: Modifier 25 is used when:
A. A significant, separately identifiable E/M service is performed on the same day as a procedure
B. Indicating bilateral procedures
C. Denoting reduced services
D. Indicating repeat procedures
Correct Answer: A

Q93: Modifier 57 indicates that:
A. A decision for surgery was made during an E/M service
B. The procedure is repeated
C. A bilateral procedure was performed
D. A reduced service was provided
Correct Answer: A

Q94: Modifier 50 is used for:
A. Bilateral procedures
B. Multiple procedures on the same day
C. Split services
D. None of the above

Correct Answer: A

Q95: A correct use of a modifier requires:
A. No supporting documentation
B. Documentation that substantiates the separate service or procedure
C. Use in every claim
D. Increasing reimbursement regardless of service
Correct Answer: B

Q96: “Unbundling” refers to:
A. Combining multiple procedures into one code
B. Separately coding parts of a procedure that should be reported together
C. Bundling services for higher reimbursement
D. None of the above
Correct Answer: B

Q97: When an injection is performed separately from an E/M service on the same day, the appropriate modifier for the E/M service is:
A. Modifier 25
B. Modifier 59
C. Modifier 76
D. Modifier 51
Correct Answer: A

Q98: ICD-10-CM codes are used for:
A. Diagnoses
B. Office procedures
C. Inpatient procedures
D. All of the above
Correct Answer: A

Q99: HCPCS Level II codes are used primarily for:
A. Physician office visits
B. Drugs, supplies, and services not included in CPT
C. Inpatient procedures
D. Laboratory tests
Correct Answer: B

Q100: CPT codes are maintained by:
A. The American Medical Association (AMA)
B. The Centers for Medicare & Medicaid Services (CMS)
C. The Department of Health and Human Services
D. The American Hospital Association
Correct Answer: A

Q101: Which modifier is commonly used to indicate a repeat procedure by the same provider on the same day?
A. Modifier 25
B. Modifier 76
C. Modifier 59
D. Modifier 50
Correct Answer: B

Q102: Modifier 59 is used to:
A. Indicate distinct procedural services
B. Denote bilateral procedures
C. Show reduced services
D. Indicate repeat procedures
Correct Answer: A

Q103: A global surgical package includes:
A. Only the surgery itself
B. All preoperative and postoperative care related to the surgery
C. Only the postoperative care
D. Only the preoperative care
Correct Answer: B

Q104: When coding an etiology and manifestation pair, the correct sequence is to:
A. List the manifestation first, then the etiology
B. List the etiology first, then the manifestation
C. List both codes simultaneously
D. Only code the etiology
Correct Answer: B

Q105: A combination code is defined as one that:
A. Represents a diagnosis with multiple components
B. Is used only for billing reimbursement
C. Represents a procedure that includes separate components that must be coded together
D. None of the above
Correct Answer: C

Q106: In CPT coding, modifier 76 is used to indicate:
A. A repeat procedure by the same provider
B. A bilateral procedure
C. A distinct procedural service
D. A reduced service
Correct Answer: A

Q107: “Laterality” in coding refers to:
A. The number of procedures performed
B. The side of the body on which a procedure is performed
C. The intensity of the service
D. The provider’s geographic location
Correct Answer: B

Q108: When a procedure is performed on both sides of the body, you should:
A. Code it once without modifiers
B. Use a bilateral modifier
C. Code each side separately without modifiers
D. Code only the dominant side
Correct Answer: B

Q109: A Category III CPT code is used for:
A. New and emerging procedures or technologies
B. Common office visits
C. Routine surgical procedures
D. Standard diagnostic tests
Correct Answer: A

Q110: A “global period” for a surgical procedure means that:
A. Postoperative care is billed separately
B. Postoperative care is included in the surgical fee
C. Preoperative care is billed separately
D. Only the surgical procedure is reimbursed
Correct Answer: B

Q111: A modifier should always be supported by:
A. Appropriate documentation
B. A verbal explanation
C. A waiver from the insurer
D. Nothing else
Correct Answer: A

Q112: ICD-10-PCS codes are used for:
A. Inpatient hospital procedure coding
B. Outpatient office visits
C. Pharmacy claims
D. Ambulatory surgery centers
Correct Answer: A

Q113: CPT code 99214 is typically used for:
A. Low complexity office visits

B. Moderate complexity office visits
C. High complexity office visits
D. Emergency department visits
Correct Answer: B

Q114: The term “modifier” in medical coding is used to:
A. Arbitrarily increase reimbursement
B. Provide additional information about a service
C. Reduce the number of codes submitted
D. Indicate bundled services
Correct Answer: B

Q115: When an E/M service is performed on the same day as a procedure and is significant and separate, the correct action is to:
A. Use modifier 25 on the E/M service
B. Use modifier 57 on the E/M service
C. Combine the E/M service with the procedure code
D. Omit the E/M service
Correct Answer: A

Q116: A Medicare patient presents with both a chronic condition and an acute infection. Which coding strategy is most appropriate if the acute infection is the primary reason for the visit?
A. Code only the chronic condition
B. Code only the acute infection
C. Code both conditions with the chronic condition first
D. Code both conditions with the acute infection listed as the principal diagnosis
Correct Answer: D

Q117: A patient with dual coverage (Medicare and private insurance) shows Medicare as the primary payer. The billing process should:
A. Bill the private insurer first
B. Bill Medicare first
C. Submit a combined claim to both payers
D. Wait for a coordination of benefits statement
Correct Answer: B

Q118: During an office visit, the provider determines that surgery is necessary. Which modifier should be appended to the E/M service?
A. Modifier 25
B. Modifier 57
C. Modifier 59
D. Modifier 76
Correct Answer: B

Q119: A claim is denied due to the absence of a required 7th character on a combination code. The correct action is to:
A. Resubmit the claim with the complete 7th character
B. Resubmit the claim as a paper claim
C. Cancel the claim
D. Contact the patient for additional documentation
Correct Answer: A

Q120: A claim is denied because the service was provided within the global period. The appropriate response is to:
A. Resubmit the claim with a modifier for global services
B. Inform the patient that the service is not separately billable
C. Appeal the denial with additional documentation
D. Reclassify the service as a new encounter
Correct Answer: B

Q121: In an emergency department visit, which service is most likely bundled into the facility payment?
A. Laboratory work
B. Evaluation and management
C. IV medication administration
D. Minor surgical procedure
Correct Answer: A

Q122: If the documentation is incomplete for a diagnosis, the correct coding practice is to:
A. Code to the highest level of detail regardless
B. Use unspecified codes when necessary
C. Guess the diagnosis based on common conditions
D. Omit the diagnosis entirely
Correct Answer: B

Q123: A provider's claim is rejected for unbundling of services. The proper correction is to:
A. Resubmit each service as a separate line item
B. Use the appropriate combination code that bundles the services
C. Submit the claim without any modifiers
D. Add a modifier to indicate separate billing
Correct Answer: B

Q124: A patient receives post-operative care within the global period of a surgical procedure. The correct billing is to:
A. Bill the post-operative service separately
B. Include the post-operative care in the global surgical package
C. Bill the evaluation service separately with a modifier
D. Resubmit the claim with a global period modifier

Correct Answer: B

Q125: When a patient's claim is denied by the secondary payer after coordination of benefits, the next step is to:
A. Ignore the denial
B. Rebill the primary insurer
C. Follow up with the secondary payer with supporting documentation
D. Cancel the claim
Correct Answer: C

Q126: A claim is underpaid due to an incorrect modifier. The proper resolution is to:
A. Submit a corrected claim with the appropriate modifier
B. Request a manual override from the payer
C. Accept the reduced payment
D. Contact the patient for payment adjustment
Correct Answer: A

Q127: A consultation results in the scheduling of surgery at a later date. The consultation should be coded with:
A. No modifier
B. Modifier 57 to indicate a decision for surgery
C. Modifier 25
D. Modifier 59
Correct Answer: B

Q128: When an E/M service and a procedure are performed on the same day, the E/M service should have:
A. Modifier 25 to indicate a significant, separately identifiable service
B. Modifier 57
C. Modifier 59
D. No modifier is necessary
Correct Answer: A

Q129: A billing record shows an injection and a separate E/M service on the same day. If documentation supports that the E/M service is significant and separate, which modifier should be used?
A. Modifier 25 on the E/M service
B. Modifier 59 on the injection
C. Modifier 76 on the E/M service
D. No modifier
Correct Answer: A

Q130: For services that are normally paid as a bundled package, the correct coding approach is to:

A. Unbundle the services for maximum reimbursement
B. Use the appropriate combination code that reflects the bundle
C. Submit separate claims for each service
D. Add modifiers to unbundle the services
Correct Answer: B

Q131: When a payer makes an adjustment that reduces the payment due to its fee schedule, this adjustment is:
A. A contractual discount
B. An allowed reduction based on the fee schedule
C. Patient responsibility
D. An error that must be appealed
Correct Answer: B

Q132: If a claim is denied for duplicate billing, the proper action is to:
A. Resubmit the claim without changes
B. Correct the duplicate error and resubmit
C. Appeal the denial
D. Wait for the payer to reverse the denial
Correct Answer: B

Q133: A claim is denied due to missing required information on the CMS-1500 form. The next step is to:
A. File an appeal with additional documentation
B. Resubmit a corrected claim with the missing information
C. Request the patient to supply the missing data
D. Submit a claim with a modifier indicating correction
Correct Answer: B

Q134: A remittance advice indicates a deduction because the patient did not meet the deductible. This amount should be:
A. Written off by the provider
B. Collected from the patient
C. Re-submitted to the payer
D. Ignored as it is non-negotiable
Correct Answer: B

Q135: The process of reviewing denied claims to determine reasons for denial and taking corrective action is known as:
A. Claim submission
B. Denial management
C. Payment posting
D. Revenue cycle management
Correct Answer: B