Pre-Employment Test for Business Office Staff

1. The fee for Mr. Walker's service is $100, but the allowable rate that has been negotiated between the practice and the insurance company is $83.25. Mr. Walker's health plan requires a 20% coinsurance. How much does he owe?

Answer: _____

2. Scenario: Your practice does not participate with Ms. Jones' insurance company but you agree to submit a claim on behalf of the patient to the insurance company. 60 days have elapsed. During that time, you have called the insurance company three times but payment still has not been received. What action should you take next?

Answer: _____

3. The fee for Mrs. Smith's service is $400 but the allowable rate that has been negotiated between the practice and the insurance company is $345.81. Mrs. Smith has not yet met her $500 deductible. How much does she owe?

Answer: _____

4. Scenario: You discover a charge that was written off as "bad debt" last year, but the patient has since been seen in the practice – and paid for her current charges. What action should you take?

Answer: _____

5. NPI is an acronym for:
   A. National Procedure Impact
   B. Normative Provider Identity
   C. National Practitioner Illustrator
   D. National Provider Identifier

Answer: _____

6. The mother of Jill Brown is the guarantor for her daughter's account. The services that Jill received equal $1,765.03. Her mother's health plan requires a 33% coinsurance. How much does Jill's mother owe?

Answer: _____

7. Mr. Wood does not have insurance, but he would like to take advantage of your discount for uninsured patients who pay in full at the time of service. His bill is $213, and your practice offers a 30% discount for payment in full. How much does he owe if he pays in full today?

Answer: _____

8. An ICD-9 code describes the _____ related to the patient's visit.
A. Diagnosis
B. Lab results
C. Procedure
D. Payer

Answer: _____

9. If the payer applies the outstanding balance to the beneficiary's deductible, what action should you take?

Answer: _____

10. The patient has been sent a statement and she calls to indicate that she has insurance and that her insurance company should be billed. The next step that you should take is:

A. Submit a claim to the insurance company.
B. Verify the insurance that she has provided, then submit a claim.
C. Require the patient to pay, suggesting that she submit a claim for reimbursement to her insurance company.
D. Ask the patient to send in a copy of her insurance card.

Answer: _____

11. A written financial policy should include how a medical practice addresses the following:

A. Payment for non-covered services
B. Patients who have insurance with which the practice does not participate
C. Contact information for the business office
D. All of the above

Answer: _____

12. In the event that a practice receives a bankruptcy declaration for a patient who has a balance, a collector should immediately:

A. Take the patient to small claims court
B. Call the patient and harass him or her
C. Schedule an appointment
D. Suspend collection activities and file a "proof of claim" with the local bankruptcy court

Answer: _____

13. When making collection calls to request that patients pay their outstanding balance, a collector should ask patients:
    A. Would you like to pay the balance on your account?
    B. How would you like to take care of the balance on your account?
    C. Would you like for us to bill your insurance company first?
    D. Would you like to call your human resources office first?

Answer: _____

14. The guarantor on the account is always the patient.

    True or false? Answer: _____

15. The "birthday rule" refers to a rule that governs the following situation:
    A. How staff birthdays will be celebrated at a practice
    B. Which spouse is the guarantor for a dependent
    C. Which payer is responsible for coverage determinations
    D. How accounts will be distributed among billing staff

Answer: _____

16. ERISA, also known as self-funded, plans are regulated by:
    A. The state in which the employer's corporate office resides.
    B. The Insurance Commissioner
    C. The Department of Labor
    D. Medicaid

Answer: _____

17. On-line claims status is:
    A. Querying a payer's website to determine the status of a claim
    B. Reviewing a clearinghouse report on the Internet
    C. Looking up a patient's account in the practice management system
    D. Going online to "google" "claims status"

Answer: _____

18. An EOB is an:
    A. Explanation of Benefits
    B. Explanation of Beneficiary
    C. Entire Outstanding Balance
    D. Electronic Online Billing

Answer: _____

19. When a payer "downcodes", it is:
    A. Requesting a refund
    B. Changing the level of a submitted procedure code to a lower one (e.g., 99214 to 99213)
    C. Altering the diagnosis code submitted on the claim to a more specific one
    D. Bundling two procedure codes together

Answer: _____

20. On the CMS-1500 claim form, Field 19 can be used for reporting:
    A. Description of services that might otherwise not be specified by the codes
    B. Referring physician NPI
    C. Accident date
    D. Diagnoses

Answer: _____

21. LCD stands for:

    A. Lengthy CPT Detail
    B. Local Coverage Determinations
    C. Logistical Coding Drills
    D. Local Current Determinations

Answer: _____

22. The relationship between more than one payer covering an insured patient is known as:

A. Coordination of billing
B. Conjunction of beneficiaries
C. Coordination of benefits
D. Change of benefits

Answer: _____

23. You come across the following invoice regarding a patient who was covered by Uniform Insurance when you are working at an urgent care practice. The account has no notes associated with this date of service. What occurred here? Would you have done anything differently if you had been working on this invoice?

Answer: _____

Key:
UCD – Urgent Care Doctor
UNTD insurance – "Uniform" Insurance Code
UNTD adjustment code – "Uniform" Insurance Code Contractual Adjustment
OFF – Place of Service Office; POS Identifier = 3; POS Claim Code = 11
UNPY – "Uniform" Payment

Transaction Detail:

SAMPLE ONLY

```
ACCOUNT: 177                  INQUIRY - TRANSACTIONS              (YOU) 02/07/10
--------------------------------------------------------------------------------
JOHN DOE                                                ACCOUNT TOTAL: 0.00
PERS: 0.00          INS: 0.00          COLL: 0.00          W/COMP: 0.00
--------------------------------------------------------------------------------
    CHG-# CTRL  PAT    DOC TRNCODE/MO   DESCRIPTION  INS        AMOUNT  DATE
                POS    DX          SET# NAME         HISTORY #
     2822   100 JOHN   UCD 99214       99214 OFFICE UNTD/IO    150.00  01/01/10
                OFF    2491         1   NEWMED              1*
                  ** POSTED: 03/13/10 JJON **
   *PMT*    100           UNPY         UNITED PAY               0.00  04/19/10
   *MSG*                  QELTM        Reject: Timely Filing
                  ** POSTED: 04/19/10 EWOO **
   *ADJ*    100           UNTD         UNITED ADJUS           150.00- 04/19/10
                  ** POSTED: 04/19/10 EWOO **
     2822 *TOTAL*                      DUE FROM      UNTD/IO     0.00  AGE=0

TRANSACTION TOTALS: CHGS:       150.00  PAYS:          0.00  ADJS:       150.00
  INS SET 1 TOTALS: CHGS:       150.00  PAYS:          0.00  ADJS:       150.00

PROV GRP       TOT: CHGS:       150.00  PAYS:          0.00  ADJS:       150.00
 ENTER (M)ORE, (P)REVIOUS OR A SPECIFIC CHARGE NUMBER FOR DETAIL: (         )
 F2=APPTS/COLLECT/REF              F6=PATIENT          F8=ANOTHER ACCOUNT
 F5=BILLING       F7=TRANSACTIONS  F9=SETS/CODED/NOTES F10=PRINT INQUIRY
```

```
CCOUNT: 177                   INQUIRY - TRANSACTIONS              (YOU) 02/07/10
--------------------------------------------------------------------------------
JOHN DOE                                                ACCOUNT TOTAL: 0.00
PERS: 0.00          INS: 0.00          COLL: 0.00          W/COMP: 0.00
--------------------------------------------------------------------------------
   CHG-# PATIENT    DOC TRNCODE/MO   DX     INS      FORM  RUN DLY-DATE
   CLAIM ID                                 SET HISTORY #     USER ID  PRINTED
     2822 JOHN      UCD 99214        2491   UNTD/IO E:1    17
   0000000204                               1          1*       EWOO 03/14/10
```

24. You come across the following invoice regarding a patient who presented with a card from Uniform Insurance when you are working at a cardiology practice. The account has no notes associated with this date of service. What occurred here? Would you have done anything differently if you had been working on this invoice?

Answer: _____

Key:
CARD – Cardiology Doctor
UNTD insurance – "Uniform" Insurance Code
HOSP – Place of Service Hospital; POS Claim Code = 21
UNPY Payment Code – "Uniform" Payment Code

Transaction Detail

```
ACCOUNT: 177                  INQUIRY - TRANSACTIONS              (YOU) 02/07/10
------------------------------------------------------------------------------
JOHN DOE                                                ACCOUNT TOTAL: 0.00
PERS: 0.00          INS: 150.00        COLL: 0.00           W/COMP: 0.00
------------------------------------------------------------------------------
    CHG-# CTRL  PAT    DOC TRNCODE/MO   DESCRIPTION  INS        AMOUNT  DATE
                POS    DX          SET# NAME         HISTORY #
     2823   100 JOHN   CARD 99214       OFFICE       UNTD/IO    150.00  07/03/09
                HOSP    425.8        1   NEWMED                 1*
                  ** POSTED: 07/06/09 JJON **
   *PMT*    100            UNPY         UNITED PAY                0.00  08/05/09
   *MSG*                   QELPA        Reject: Patient Eligibility
                  ** POSTED: 08/05/09 EWOO **
   *PMT*    100            UNPY         UNITED PAY                0.00  10/07/09
   *MSG*                   QELPA        Reject: Patient Eligibility
                  ** POSTED: 10/07/09 EWOO **
     2823 *TOTAL*                       DUE FROM      UNTD/IO    150.00  AGE=0

TRANSACTION TOTALS: CHGS:       150.00  PAYS:          0.00  ADJS:       150.00
  INS SET 1 TOTALS: CHGS:       150.00  PAYS:          0.00  ADJS:       150.00

PROV GRP       TOT: CHGS:       150.00  PAYS:          0.00  ADJS:       150.00
 ENTER (M)ORE, (P)REVIOUS OR A SPECIFIC CHARGE NUMBER FOR DETAIL: (         )
 F2=APPTS/COLLECT/REF              F6=PATIENT          F8=ANOTHER ACCOUNT
 F5=BILLING       F7=TRANSACTIONS  F9=SETS/CODED/NOTES  F10=PRINT INQUIRY
```

Claim Detail

```
CCOUNT: 177                   INQUIRY - TRANSACTIONS              (YOU) 02/07/10
------------------------------------------------------------------------------
JOHN DOE                                                ACCOUNT TOTAL: 0.00
PERS: 0.00          INS: 240.00        COLL: 0.00           W/COMP: 0.00
------------------------------------------------------------------------------
   CHG-# PATIENT    DOC TRNCODE/MO   DX      INS      FORM  RUN DLY-DATE
   CLAIM ID                                  SET HISTORY #     USER ID  PRINTED
     2823 JOHN      UCD 99214        425.8    UNTD/IO E:1     17
   0000000205                                 1           1*        EWOO 07/07/09
                                             UNTD/IO E:1     31     EWOO
   0000000206                                 1           1*        EWOO 08/06/09
                                             UNTD/IO E:1     42     EWOO
   0000000207                                 1           1*        EWOO 10/09/09
```

25. A patient calls to indicate that he is out of work and cannot pay the outstanding balance on his account. The next step that you should take is:

A. Put the patient on a payment plan.
B. Call the referring physician to see if the patient is honorable.
C. Require the patient to send a copy of his termination letter to the practice.
D. Discharge the patient from the practice.

Answer: _____

26. The EOB indicates that the service has been denied due to timely filing. The first step you should take is:

A. Adjust the account off as a contractual adjustment.
B. Adjust the account off as a non-contractual adjustment
C. Appeal the denial
D. Investigate the situation to determine whether the claim was filed pursuant to contract terms.

Answer: _____

27. CMS stands for "The Center for Medical Statutes"

True or False?

Answer: _____

28. PCP stands for:

A. Physician Care Plan
B. Primary Coverage Plan
C. Physician Capitated Plan
D. Primary Care Physician

Answer: _____

29. Medicare is a health insurance program for:
    A. People 65 years of age or older
    B. Some people with disabilities who have been receiving Social Security for a set amount of time
    C. People with End-Stage Renal Disease
    D. All of the above

Answer: _____

30. The "allowable" is:
    A. The amount of money owed by the patient.
    B. The amount of money to be paid by the insurance company.
    C. The reimbursement level that is contractually agreed to by the practice and the insurance company.
    D. The specific CPT codes that are allowed by the insurance company.

Answer: _____