

Pre-Employment Test for Business Office Staff Answer Key

1. Mr. Walker owes \$83.25. His health plan requires a 20% coinsurance. How much does he owe?

Answer: \$16.65

2. Scenario: Your practice submits a claim on behalf of a patient with whose insurance company your physician does not participate. 60 days have elapsed. During that time, you have called the insurance company three times. What action should you take next?

Answer: Contact the patient to apprise him/her of the situation, and that he/she (or the guarantor) is responsible for the bill. Transfer the balance to the guarantor immediately, sending a statement for the full balance to the guarantor.

(Note: The candidate's answer need not match the sample response, but the key is that the candidate identified that the physician does not participate with the insurance, and that the balance should be immediately transferred to the guarantor of the account.)

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: \$345.81

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: Reverse the bad debt write-off, thus creating a balance on the patient's account. According to the practice's collection protocols, send the patient a statement and place a phone call to the patient regarding the balance. Concurrently, contact the collection agency to request the account back, indicating that the agency should no longer pursue payment of that account.

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(Note: The candidate's answer need not match the sample response, but the key is that the candidate recognizes that bad debt can be reversed, and payment should be pursued.)

5. NPI is an acronym for:

- A. National Procedure Impact
- B. Normative Provider Identity
- C. National Practitioner Illustrator
- D. National Provider Identifier

Answer: D

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: \$582.46

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: \$149.10

8. An ICD-9 code describes the _____ related to the patient's visit?

- A. Diagnosis
- B. Lab results
- C. Procedure
- D. Payer

Answer: A

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

Answer: Transfer the balance to guarantor responsibility immediately; send the guarantor a statement.

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(Note: The candidate's answer need not match the sample response, but the key is that the candidate recognizes that payment should be pursued from the guarantor, not the payer.)

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: B

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: D

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: D

13. When making collection calls to request that patients pay their outstanding balance, a collector should ask patients:

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- 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: B

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

True or false? Answer: False

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: B

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: C

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: A

18. An EOB is:
- A. Explanation of Benefits
 - B. Explanation of Beneficiary
 - C. Entire Outstanding Balance

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D. Electronic Online Billing

Answer: A

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: B

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: A

21. LCD stands for:

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

Answer: B

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: C

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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: The date of service was 1/1/10, but the charge wasn't submitted until 3/13/10. The claim was denied for "timely filing". The poster wrote off the entire charge as a "Uniform" contractual adjustment on 4/19. Three issues are a problem here: the charge was posted 40+ days late, the charge is written off as a contractual adjustment, and there are no notes to support the employee's actions.

(Note: The candidate's answer need not match the sample response, but the key is that the candidate recognizes the problems related to the delay in charge entry and the contractual adjustment. It would also be valuable for them to recognize that there are no notes to support any of these actions. Use your judgment to evaluate whether the candidate recognizes what is occurring, even if the system is not one on which they are trained.)

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: The claim was rejected twice for patient ineligibility. The claim was submitted a total of three times, and is now pending payment from the insurance company. Three issues are a problem here: the practice should have verified insurance coverage at the time of service, thus avoiding this denial altogether; the biller should not have continued to submit the claim, but should have researched coverage for the patient; there are no notes associated with the invoice.

(Note: The candidate's answer need not match the sample response, but the key is that the candidate recognizes the problems that occurred related to the patient's insurance coverage, and the inappropriateness of just resubmitting the claim. It would also be valuable for them to recognize that there are no notes to support any of these actions. Use your judgment to evaluate whether the

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candidate recognizes what is occurring, even if the system is not one on which they are trained.)

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: A

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: D

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

True or False? False.

CMS is the acronym for "Centers for Medicare and Medicaid Services"

28. PCP stands for:
- A. Physician Care Plan
 - B. Primary Coverage Plan
 - C. Physician Capitated Plan
 - D. Primary Care Physician

Answer: D

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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: D

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: C

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