

Name: _____ Date: _____

FINAL SCORE: _____

You have one hour to complete this test. No outside resources are allowed. No phone calls or text messages are allowed during the test. YOU must score at least an 80% or better to pass this test Please double check your answers if time allows.

Medical Billing Pre-Employment Test

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True/False

Indicate whether the sentence or statement is true or false.

- _____ 1. If a patient refuses to sign an ABN form and the refusal is witnessed and documented on the ABN form by a staff member, and the claim is denied by Medicare, you are still prohibited from billing patient.
- _____ 2. Mrs. Jones has Medicare Part B and the provider's staff did not have Mrs. Jones sign an ABN form prior to rendering the outpatient medical care. Medicare denied the claim stating that the patient exceeded the number of visits for the year. You can now bill Mrs. Jones and require her to pay 100% of the charges for the visit.
- _____ 3. Mr Smith was seen in the hospital urgent care center for an open wound of the hand. The global period for the surgical procedure is 5 days. Three days after surgery, Mr. Smith comes to your providers and the wound is now infected. The wound is opened again, cleaned and dressed. Mr Smith has personal health insurance. You cannot charge for the infected wound visit because it falls within the global surgical period.
- _____ 4. Mr Smith was seen in the hospital urgent care center for an open wound of the hand. The global period for the surgical procedure is 5 days. Three days after surgery, Mr. Smith returns and is asking to be seen for a back ache from heavy lifting. Mr Smith has personal health insurance. You can charge for the back ache visit even though the visit falls within the global surgical period.

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H E A L T H P L A N S

January 27, 2006

P.O. Box 569000

Member Number: 123456789
Member Name: Jones, John
Date of Service: 1/26/04

Dear Provider:

An audit of the above referenced claim indicates that there was an overpayment of \$259.00 that resulted from services paid in error, Workers Compensation is liable.

Please submit a refund to AvMed Health Plan, attention Claims Adjustment Unit at the above address.

Florida Statute 641.355, Section 5, indicates you have 35 days to refund the overpayment, deny or contest this claim for overpayment. If you decide to contest the claim, please identify the contested portion and provide the specific reason for contesting. If you do not deny or contest this request, or issue a refund within 35 days of the receipt of this letter, the above amount will be offset against your future payments.

5.

The date is today's date. The member name and number have been sanitized due to HIPAA. Using the above letter, how will you resolve this situation?

- a. Deny the refund due to timely filing limits
- b. Return the overpayment
- c. Send a claim to the workers comp carrier.
- d. Require AvMed to provide proof this is a workers compensation claim.



Aetna Health Management, Inc.

Statement of Payments

FEB 18 2003

| PAYMENT OF CLAIMS | | | | | | | | | | |
|-------------------|-----------|---------|---------------|-------|-----------|------|-----------------|-----------------------|-----------------|---------|
| MEMBER NAME | INVOICE # | DDS | MEMBER NUMBER | UNITS | PROCEDURE | MOOS | BILLED | MEMBER RESPONSIBILITY | PAID | MSG |
| SARAH . | | 1/10/03 | 1.00 | 99285 | PDS :E | | \$553.00 | \$0.00 | \$378.53 | PPX P17 |
| SARAH . | | 1/04/03 | 1.00 | 99285 | PDS :E | | \$553.00 | \$0.00 | \$378.53 | PPX P17 |
| ANDREA | | 1/09/03 | 1.00 | 99283 | PDS :E | | \$279.00 | \$0.00 | \$155.51 | PPX P17 |
| ANDREA | | 1/04/03 | 1.00 | 99283 | PDS :E | | \$279.00 | \$0.00 | \$155.51 | PPX P17 |
| JOSEPH | | 1/09/03 | 1.00 | 99285 | PDS :E | | \$553.00 | \$0.00 | \$378.53 | PPX P17 |
| JAMES C | | 1/11/03 | 1.00 | 99285 | PDS :E | | \$553.00 | \$0.00 | \$378.53 | PPX P17 |
| LINDA E | | 1/13/03 | 1.00 | 99284 | PDS :E | | \$444.00 | \$0.00 | \$242.08 | PPX P17 |
| STEVEN | | 1/05/03 | 1.00 | 99283 | PDS :E | | \$279.00 | \$0.00 | \$155.51 | PPX P17 |
| BRANDON | | 1/04/03 | 1.00 | 99285 | PDS :E | | \$553.00 | \$0.00 | \$378.53 | PPX P17 |

6. P17: Contract Discount Allowed as a savings to the member. No Balance Billing.

Refer to the above information.

Dr. Jones submitted a claim to Cigna. These are PPO claims. Dr. Jones is not contracted with Cigna. The claim for James E paid \$378.53 to Dr. Jones. Msg P17: Contract Discount Applied. No Balance Billing is Allowed. When reviewing the claim for James C, how much does James owe for the visit?

- a. \$553.00
- b. \$378.53
- c. \$174.47
- d. \$0.00 because the EOB shows \$0 for patient responsibility.

| PERF | PROV | SERV DATE | POS NOS | PROC | MODS | BILLED | ALLOWED | DEDUCT | COINS | GRP/RC-AMT | PROV PD |
|--|-------------|------------|-------------|--------------|-----------|--------------|-------------|--------------|-----------|---------------------|---------------|
| NAME | Haffarrarr | | | HIC | | ACNT 4178 | | ICN | | ASG Y MOA MA01 MA18 | |
| | 0227 | 022703 | 23 | 1 99285 | | 553.00 | 128.24 | 0.00 | 25.65 | CO-42 | 424.76 102.59 |
| PT RESP | 25.65 | | | CLAIM TOTALS | | 553.00 | 128.24 | 0.00 | 25.65 | | 424.76 102.59 |
| CLAIM INFORMATION FORWARDED TO: AARP UNITED HEALTHCARE | | | | | | | | | | | |
| 102.59 NET | | | | | | | | | | | |
| NAME | MARVIN | | | HIC | | ACNT 4089 | | ICN | | ASG Y MOA MA01 MA18 | |
| | 0227 | 022703 | 23 | 1 99285 | | 553.00 | 150.87 | 0.00 | 30.17 | CO-42 | 402.13 120.70 |
| PT RESP | 30.17 | | | CLAIM TOTALS | | 553.00 | 150.87 | 0.00 | 30.17 | | 402.13 120.70 |
| 120.70 NET | | | | | | | | | | | |
| NAME | HENNE | | | HIC | | ACNT 4984 | | ICN | | ASG Y MOA MA01 | |
| | 0307 | 030703 | 23 | 1 99285 | | 553.00 | 0.00 | 0.00 | 0.00 | PR-22 | 553.00 0.00 |
| PT RESP | 553.00 | | | CLAIM TOTALS | | 553.00 | 0.00 | 0.00 | 0.00 | | 553.00 0.00 |
| 0.00 NET | | | | | | | | | | | |
| NAME | LOUIS | | | HIC | | ACNT 639 | | ICN | | ASG Y MOA MA01 | |
| | 0109 | 010903 | 23 | 1 99285 | | 553.00 | 0.00 | 0.00 | 0.00 | OA-B11 | 553.00 0.00 |
| PT RESP | 0.00 | | | CLAIM TOTALS | | 553.00 | 0.00 | 0.00 | 0.00 | | 553.00 0.00 |
| 0.00 NET | | | | | | | | | | | |
| NAME | ANNE | | | HIC | | ACNT 351 | | ICN | | ASG Y MOA MA01 | |
| | 0220 | 022003 | 23 | 1 99283 | | 279.00 | 0.00 | 0.00 | 0.00 | OA-B11 | 279.00 0.00 |
| PT RESP | 0.00 | | | CLAIM TOTALS | | 279.00 | 0.00 | 0.00 | 0.00 | | 279.00 0.00 |
| 0.00 NET | | | | | | | | | | | |
| NAME | , PALMA | | | HIC | | ACNT 2077 | | ICN | | ASG Y MOA MA01 | |
| | 0130 | 013003 | 23 | 1 99283 | | 279.00 | 0.00 | 0.00 | 0.00 | OA-B11 | 279.00 0.00 |
| PT RESP | 0.00 | | | CLAIM TOTALS | | 279.00 | 0.00 | 0.00 | 0.00 | | 279.00 0.00 |
| 0.00 NET | | | | | | | | | | | |
| TOTALS: | # OF CLAIMS | BILLED AMT | ALLOWED AMT | DEDUCT AMT | COINS AMT | TOTAL RC-AMT | PROV PD AMT | PROV ADJ AMT | CHECK AMT | | |
| | 6 | 2770.00 | 279.11 | 0.00 | 55.82 | 2490.89 | 223.29 | 0.00 | 223.29 | | |

GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes
 CO Contractual Obligation. Amount for which the provider is financially liable. The patient may not be billed for this amount.
 PR Patient Responsibility. Amount that may be billed to a patient or another payer.
 OA Other Adjustment.
 B11 The claim/service has been transferred to the proper payer/ processor for processing. Claim/service not covered by this payer/processor.

7.

Using the above Medicare Remittance, how much does account 4089 owe your provider?

- a. \$25.65
- b. \$30.17
- c. \$102.59
- d. \$120.70

EXPLANATION OF BENEFITS - THIS IS NOT A BILL
 Please retain this explanation for your records. It is the only copy that you will receive.

| Line No. | Provider | Date(s) Of Service | Procedure Code | Total Charges | Excluded Charges | Co-Pay/Deductible | Covered Expense | Paid At | Balance Paid By Plan |
|---------------|----------|--------------------|----------------|---------------|------------------|-------------------|-----------------|-------------------------------|----------------------|
| 01 | | 03/02-03/02/2003 | 99283 | 279.00 | 9.00 | 115.43 | 154.57 | 60% | 92.74 |
| TOTALS | | | | 279.00 | 9.00 | 115.43 | 154.57 | | 92.74 |
| | | | | | | | | Amount Payable | 92.74 |
| | | | | | | | | Patient Responsibility | 186.26 |

| | | |
|---------------------|-------------------------|---------------|
| Accumulators | Check Issued To: | Amount |
| | | 92.74 |

| Claim Remarks Line No. | Explanation |
|------------------------|--|
| 1 | (Line 01-\$9.00)CHARGES IN EXCESS OF THE REASONABLE AND CUSTOMARY AMOUNT ARE NOT COVERED UNDER YOUR PLAN. |
| 1 | BENEFITS HAVE BEEN PAID AS OUT-OF-NETWORK. TO MAXIMIZE FUTURE BENEFITS USE PRIVATE HEALTH CARE SYSTEM PROVIDERS. |

8.

Using the above EOB, the provider is not contracted with the insurance company. After receiving the check, how much will you require the patient to pay your provider?

- a. \$279.00
- b. \$186.26
- c. \$115.43
- d. \$9.00

9. Mrs. Jones was seen in your outpatient clinic. She had an ICD implanted and went home the same day. The physician's services are sent to the insurance company using a _____ claim form.

- a. DWC-9
- b. UB-04
- c. UB-92
- d. CMS 1500

10. How many modifiers may be added to a line item HCPCS or CPT code on the CMS 1500 form

- a. 1
- b. 2
- c. 3
- d. 4

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11. Refer to the following simulated EOB from ABC Insurance Company.

| Claim | Patient Name | Service Date | Procedure | Amount Billed | Amount Approved | Note | Deductible | Coins | Paayment Amount |
|-------|--------------|--------------|-----------|---------------|-----------------|------|------------|-------|-----------------|
| 1 | D. Jones | 1/12/07 | 99283 | \$385 | \$308 | A1 | \$0 | \$0 | \$308 |
| 2 | S. Claus | 1/05/07 | 99214 | \$225 | \$0 | B2 | \$0 | \$0 | \$0 |
| 3 | C. Brown | 2/14/07 | 26789 | \$475 | \$380 | A1 | \$0 | \$0 | \$380 |
| 4 | M. Spock | 2/17/07 | 12002 | \$125 | \$87.50 | A1 | \$0 | \$0 | \$87.50 |

Reason Code:

A1: Amount approved is per contract with Provider.

B2: Timely Filing

The provider has a contract to be paid at 80% of billed charges. Which claim, was not paid per the terms of the contract?

- a. Claim 1
- b. Claim 2 Only
- c. Claim 3
- d. Claim 2 and 4

12.

| Insurance | Current | 31-60 | 61-90 | 91-120 | 120+ | Totals |
|---------------|---------|---------|---------|---------|---------|---------|
| ABC Insurance | \$250 | \$175 | \$350 | \$725 | \$400 | \$1,900 |
| White Cross | \$175 | \$250 | \$725 | \$350 | \$100 | \$1,600 |
| XYZ Insurance | \$725 | \$350 | \$175 | \$250 | \$600 | \$2,100 |
| Green Cross | \$350 | \$725 | \$250 | \$175 | \$500 | \$2,000 |
| Totals | \$1,500 | \$1,500 | \$1,500 | \$1,500 | \$1,600 | \$7,600 |

Which of the above insurance companies will you work as a priority to recoup the outstanding monies owed to the hospital? All of the insurance companies are contracted with the hospital.

- a. ABC Insurance
- b. White Cross
- c. XYZ Insurance
- d. Green Cross

13.

| Insurance | Current | 31-60 | 61-90 | 91-120 | 120+ | Totals |
|---------------|---------|---------|---------|---------|---------|---------|
| ABC Insurance | \$250 | \$175 | \$350 | \$725 | \$400 | \$1,900 |
| White Cross | \$175 | \$250 | \$725 | \$350 | \$100 | \$1,600 |
| XYZ Insurance | \$725 | \$350 | \$175 | \$250 | \$600 | \$2,100 |
| Green Cross | \$350 | \$725 | \$250 | \$175 | \$500 | \$2,000 |
| Totals | \$1,500 | \$1,500 | \$1,500 | \$1,500 | \$1,600 | \$7,600 |

Which of the above insurance companies will you work second as a priority to recoup the outstanding monies owed to the hospital? All of the insurance companies are contracted with the hospital.

- a. ABC Insurance
- b. White Cross
- c. XYZ Insurance
- d. Green Cross

- _____ 14. The Federal Law, ERISA, which regulates health benefits for employees, is also called
- a. Employer Retirement Income Security Act
 - b. Employment Recoupment Income Security Act
 - c. Employee Retirement Income Security Act
 - d. Employment Retirement Income Safety Act.
- _____ 15. An EOB shows total billed charges for CPT code 99214 in the amount of \$250.00. The covered amount is shown to be \$120.00, The PPO discount is \$130.00. The patient's insurance is an 80%-20% plan. Which of the following correctly reflects the patient's coinsurance amount for the above claim?
- a. \$154
 - b. \$26
 - c. \$24
 - d. \$20
- _____ 16. The acronym EOB stands for:
- a. Explanation of Billing
 - b. Encounter of Billing
 - c. Exception of Benefits
 - d. Explanation of Benefits
- _____ 17. Mr. Smith sustained an open wound on his left hand while at work. Mr. Smith has workers' compensation insurance with ABC Insurance. Dr. Jones tells Mr. Smith to return every day for dressing changes and to have the sutures removed in 7 days. Per the State Workers' Compensation Manual, the global period for the procedure is 0 days. Mr. Smith returns each day for care. How would you bill this to ABC Insurance?
- a. You charge for the initial visit only.
 - b. You charge for the initial visit and just the visit for the suture removal.
 - c. You charge for the initial visit and for every days follow up visit.
 - d. You charge for the initial visit and 50% of your charges for each subsequent visit.
- _____ 18. A fixed dollar amount that a patient must pay before their insurance company begins to pay for a covered medical service.
- a. A co-payment.
 - b. A co-insurance amount
 - c. A residual
 - d. A deductible.
- _____ 19. Mary Johnson is from New York and is visiting relatives in Florida. She says she does not have any health insurance and she asks to have the bill sent to her. The bill is sent and it is returned to you with a note saying she had New York Medicaid when she was seen and demands you send the claim to New York Medicaid. Your doctor is not enrolled with New York Medicaid. What do you do in this situation?
- a. Submit the claim to New York Medicaid.
 - b. Submit the claim to Florida Medicaid.
 - c. Have her pay the bill because she made a freedom of choice decision to be treated as a self-pay patient at the time of service.
 - d. Contact New York Medicaid for back-authorization to treat the patient.

- _____ 20. Mrs. Smith visits your clinic for a splinter in her finger. She has insurance through XZY Insurance. She says if you want to be paid, you deal with her insurance. XYZ Insurance is an HMO and the clinic/provider is not contracted with XZY Insurance. State law prohibits balance billing. Mrs. Smith's HMO coverage, a group health plan, is through her employer, Pay More Shoes. You call the HMO and after being on hold for 30 minutes, you are sent to a voice mail that asks you to leave a message. A message is left but no one returns the call. Your past experience with XYZ Insurance shows they do not pay for out of network visits. How do you handle this situation?
- a. You tell her to seek care from her PCP but if she wishes to continue with care, she signs an affidavit stating she knows you are not contracted and she will pay for the care herself. You collect from Mrs. Smith at the time of service. Billing is permitted per ERISA.
 - b. You provide the care. You do not send a claim. You write the balance off because the HMO won't pay and your State law prohibits you from billing the patient.
 - c. You provide the care and send the claim to Mrs. Smith's insurance company. When the claim is denied, you write off the balance..
 - d. You provide the care for free.
- _____ 21. Mrs. Jones visits your clinic. She calls you on the phone and says she has a PPO policy with ZXY Insurance. You are not contracted with her insurance. You contact her insurance company to verify benefits and they tell you that her policy terminated last month. Mrs. Jones swears and yells at you, screaming that there is a mistake, you are incompetent, and she is still covered. She demands to speak to someone in charge. What do you do?
- a. You send the claim anyway because you are tired of hearing her scream at you.
 - b. You inform Mrs. Jones you are not contracted with her insurance company and she must pay for the service herself.
 - c. You write the bill off because you don't want her yelling at you again.
 - d. You apologize for making a mistake and you tell Mrs. Jones you will take care of everything.
- _____ 22. Mary and John were married and had a child named Brenda born January 1. Mary and John divorced. Mary remarried to Harry and John remarried to Joan. Each person has health insurance through their individual employers. Brenda is covered under each policy. Mary was born March 5, Harry is born November 2, John is born January 3 and Joan is born in December 23. Whose insurance company will you send the claim to first?
- a. Mary
 - b. John
 - c. Harry
 - d. Joan

- _____ 23. SSG Jones, age 65, served in the military, did not retire, and has coverage with the Veteran's Administration. He has coverage with Medicare Part A and B. SSG Jones was treated in your practice and now you need to send the bill. SSG Jones doesn't specify to whom the claim is to be sent. Somehow the VA was never contacted for permission to treat SSG Jones. To whom will you send the bill?
- a. The Veteran's Administration as primary and Medicare Part B as secondary.
 - b. The Veteran's Administration accepting payment as payment in full.
 - c. Medicare Part A as Primary and Medicare Part B as secondary
 - d. Medicare Part B as primary and the Veteran's Administration as Secondary.
- _____ 24. ABC Insurance paid your claim in June 2005. It is today and ABC Insurance is demanding a return of the payment for CPT 12001 stating that they have reviewed the claim and have determined that CPT 12001 is included with CPT 99212. You are not contracted with ABC Insurance. What do you do?
- a. You return the payment for CPT 12001 and bill the member.
 - b. You deny their claim by submitting proof that CPT 12001 is not included with CPT 99212.
 - c. You contact the patient and ask them if they have another insurance policy that will pay the 12001
 - d. You submit a bill to the patient for the entire claim and once you are paid by the patient, you refund the insurance company.
- _____ 25. Mr. Jones has insurance with ABC Insurance and XZY Insurance. The Provider is not contracted with either insurance. ABC Insurance is primary. XZY Insurance is secondary. The claim is for \$200.00. ABC allowed \$160 and paid \$128. XZY denied the claim stating that the amount paid by the primary is more than what they allow. Per NAIC rules, what do you do?
- a. Post the \$128 payment and collect the \$72 from the member.
 - b. Post the \$128 payment and write the balance off.
 - c. Resubmit the claim to the primary for the \$72
 - d. Resubmit the claim to the secondary for the \$32
- _____ 26. Mary Jones, age 72, presents herself to your clinic. You see an insurance card with a copy of the medical record. On the card, there is a policy number: A212356779. To which insurance company will you send the claim, strictly on the policy number?
- a. Medicare
 - b. Florida Medicaid
 - c. Railroad Medicare
 - d. Florida Blue Cross and Blue Shield
- _____ 27. Which one of the following would you not want to try to collect when working accounts receivables recovery?
- a. Patients with discharged bankruptcy.
 - b. An HMO account over 300 days old.
 - c. A Medicaid account over 240 days old.
 - d. A Medicare account 12 months old

- _____ 28. Dr. John Smith came to you for treatment. He is a plastic surgeon with his own practice. The claim is \$200.00. Dr. Smith has ABC Insurance and you have a contract with ABC Insurance that has a clause that requires you to collect all co-pays and deductibles. The EOB shows that ABC allowed \$160 and applied \$80 to Dr. Smith's deductible. When Dr. Smith receives his bill, he contacts you and demands that you write off the balance as a professional courtesy. What do you do?
- a. You inform Dr. Smith that he must pay his debt of \$160.00 c. You inform Dr. Smith that he must pay his debt of \$200.00
b. You inform Dr. Smith that he must pay his debt of \$80.00 d. You inform Dr. Smith that his bill has been written off as a professional courtesy.
- _____ 29. Mr. Smith comes to you with a sprained finger he sustained while working in a coal mine. Mr. Smith provides his Federal Black Lung Card and his Medicare card, which shows he has Medicare Part A and B. Referring to the above scenario, to which one of the following do you send the claim for the outpatient services rendered by the provider?
- a. Federal Black Lung c. Medicare Part A
b. The patient's employer d. Medicare Part B
- _____ 30. Dr. Smith signs a contract with ABC Insurance. Dr. Smith is assigned 1,000 patients and is paid \$3.75 per month for each patient, regardless of how many patients are seen. What type of contract payment has Dr. Smith signed with ABC Insurance?
- a. HMO c. PPO
b. Capitation d. POS
- _____ 31. Mary Jones is a new patient and was admitted to the hospital. She has insurance with ABC Insurance. Your provider was called by her PCP to see Ms. Jones. Your doctor is not contracted with ABC Insurance. The hospital was unable to obtain authorization or precertification from Mary's HMO. The HMO denies the claim stating no authorization or precertification was obtained to treat Mary. There is a State Law prohibiting the billing of an HMO member. This is not an ERISA plan. What do you do?
- a. Have the patient appeal the denial. c. Appeal the denial because you are not contracted and are due payment.
b. Write off the bill. d. File a complaint with your State Insurance Commissioner
- _____ 32. Which one of the following would you want to collect when working accounts receivables recovery?
- a. Patients with discharged bankruptcy. c. A Medicaid account over 240 days old.
b. An HMO account over 300 days old. d. All of the above
- _____ 33. Which one of the following is a Railroad Medicare Part B identification number?
- a. MCR122564312 c. 122564312A
b. A122564312 d. 122564312 R

EXPLANATION OF MEDICAL BENEFITS

Michigan Mutual Insurance Company

Bill Review: 3/24/2003
 Process Date: 3/26/2003
 Carrier Received Date:
 ITN#: 97048
 Network: Choice / DIMCOMP
 Jurisdiction: Florida
 Employer:

| | |
|---|--------------------------------------|
| Summary: From Feb 12 2003 To Feb 12 2003 | Total Reimbursement: \$138.00 |
|---|--------------------------------------|

| FROM DOS | TO DOS | POS | CODE | MOD | REV | DIAG | UNITS | CHARGE | SCHEDULE | REDUCTION | PROVIDER | | REASON(S)* | |
|-----------|-----------|-----|------------------------------------|-----|-----|------|-------|--------|----------|-----------|-----------------------------|-----------------|------------|------|
| | | | | | | | | | | | PPO | REIMBURSEMENT | | |
| 2/12/2003 | 2/12/2003 | 5 | 99282 | | | | 1 | 212.00 | 28.00 | \$184.00 | 0.00 | 28.00 | 0066 | 0073 |
| | | | Emergency dept visit, low-moderate | | | | | | | | | | | |
| 2/12/2003 | 2/12/2003 | 5 | 12032 | | | | 1 | 380.00 | 110.00 | \$270.00 | 0.00 | 110.00 | 0066 | 0073 |
| | | | Layer closure of wounds, trunk | | | | | | | | | | | |
| | | | | | | | | | | | TOTAL CHARGES: | \$592.00 | | |
| | | | | | | | | | | | SCHEDULE REDUCTIONS: | \$454.00 | | |
| | | | | | | | | | | | PPO ADJUSTMENTS: | \$0.00 | | |
| | | | | | | | | | | | TOTAL REIMBURSEMENT: | \$138.00 | | |

38. Reason Codes:
 0066 - Repriced in accordance with State Workers' Compensation Fee Schedule
 0073 - Reimbursement in accordance with Choice contract

The workers compensation fee schedule for 99282 is \$49
 The workers compensation fee schedule for 12032 is \$180
 How much should the insurance company have paid this claim?

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- 39.

| FINANCIAL CLASS | CURRENT | 31-60 | 61-90 | 91-120 | 120+ | TOTAL |
|-----------------|---------|-------|-------|--------|------|-------|
|-----------------|---------|-------|-------|--------|------|-------|

| | | | | | | |
|-------------------------|-------------|-------------|------------|------------|------------|-------------|
| ACCORDIA | \$0.00 | \$65.24 | \$0.00 | \$0.00 | \$0.00 | \$65.24 |
| ADVANTRA (CARE) | \$608.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$608.00 |
| AETNA/US HEALTHCARE (CO | \$22,412.00 | \$3,810.00 | \$180.32 | \$0.00 | \$394.37 | \$26,796.69 |
| ANTHEM BCBS OF OH (MEDI | \$228.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$228.00 |
| ANTHEM HEALTHY START(MC | \$6,249.00 | \$3,948.00 | \$1,413.88 | \$100.00 | \$1,186.00 | \$12,896.88 |
| ANTHEM OHIO TRADITIONAL | \$59,355.00 | \$26,819.59 | \$2,917.99 | \$565.87 | \$1,877.55 | \$91,536.00 |
| AUTO INSURANCE | \$0.00 | \$0.00 | \$1,469.00 | \$1,071.00 | \$228.00 | \$2,768.00 |
| BEECHSTREET PPO | \$1,115.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$1,115.00 |
| BS FEDERAL EMPLOYEE | \$0.00 | \$44.57 | \$268.00 | \$0.00 | \$0.00 | \$312.57 |
| BUDGET PLAN | \$0.00 | \$280.50 | \$506.36 | \$1,903.00 | \$1,782.65 | \$4,472.51 |
| CARESOURCE (CAID HMO) | \$0.00 | \$0.00 | \$228.00 | \$0.00 | \$0.00 | \$228.00 |
| CHAMPUS-TRICARE | \$2,986.00 | \$0.00 | \$267.00 | \$147.18 | \$16.21 | \$3,416.39 |
| CHAMPVA | \$0.00 | \$11.95 | \$0.00 | \$21.78 | \$0.00 | \$33.73 |
| CIGNA COMMERCIAL | \$0.00 | \$462.00 | \$0.00 | \$769.00 | \$0.00 | \$1,231.00 |
| CIGNA HMO | \$1,063.00 | \$70.95 | \$0.00 | \$0.00 | \$50.92 | \$1,184.87 |

The above aging report is a true report from a provider's practice. You are hired to work the provider's accounts receivables. Which insurance company will you work first to recoup the provider's money?

40.

| FINANCIAL CLASS | CURRENT | 31-60 | 61-90 | 91-120 | 120+ | TOTAL |
|-------------------------|-------------|-------------|------------|------------|------------|-------------|
| ACCORDIA | \$0.00 | \$65.24 | \$0.00 | \$0.00 | \$0.00 | \$65.24 |
| ADVANTRA (CARE) | \$608.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$608.00 |
| AETNA/US HEALTHCARE (CO | \$22,412.00 | \$3,810.00 | \$180.32 | \$0.00 | \$394.37 | \$26,796.69 |
| ANTHEM BCBS OF OH (MEDI | \$228.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$228.00 |
| ANTHEM HEALTHY START(MC | \$6,249.00 | \$3,948.00 | \$1,413.88 | \$100.00 | \$1,186.00 | \$12,896.88 |
| ANTHEM OHIO TRADITIONAL | \$59,355.00 | \$26,819.59 | \$2,917.99 | \$565.87 | \$1,877.55 | \$91,536.00 |
| AUTO INSURANCE | \$0.00 | \$0.00 | \$1,469.00 | \$1,071.00 | \$228.00 | \$2,768.00 |
| BEECHSTREET PPO | \$1,115.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$1,115.00 |
| BS FEDERAL EMPLOYEE | \$0.00 | \$44.57 | \$268.00 | \$0.00 | \$0.00 | \$312.57 |
| BUDGET PLAN | \$0.00 | \$280.50 | \$506.36 | \$1,903.00 | \$1,782.65 | \$4,472.51 |
| CARESOURCE (CAID HMO) | \$0.00 | \$0.00 | \$228.00 | \$0.00 | \$0.00 | \$228.00 |
| CHAMPUS-TRICARE | \$2,986.00 | \$0.00 | \$267.00 | \$147.18 | \$16.21 | \$3,416.39 |
| CHAMPVA | \$0.00 | \$11.95 | \$0.00 | \$21.78 | \$0.00 | \$33.73 |
| CIGNA COMMERCIAL | \$0.00 | \$462.00 | \$0.00 | \$769.00 | \$0.00 | \$1,231.00 |
| CIGNA HMO | \$1,063.00 | \$70.95 | \$0.00 | \$0.00 | \$50.92 | \$1,184.87 |

The above aging report is a true report from a provider's practice. You are hired to work the provider's accounts receivables. Which insurance company will you work second to recoup the provider's money?

41. You are reviewing a CMS 1500 form and in Block 17a, you see the following: 1D
Per the NUCC, what does this mean?

42 Mrs. Smith works for ABC Electronics. The date is today. Mrs. Smith was injured while lifting boxes in the warehouse. How long does Mrs. Smith have to report her injury to her employer?

43

Jane Smith was seen today, by Dr. Jones at the hospital urgent care center located at 1500 Hospital Way, Anywhere, FL 12345. Mrs. Smith has an Aetna HMO through her employer, Bubba Burgers. The policy number is 578690452 and the group number is GND41123. The address is 6754 Aetna Way, Hartford, CT 78563. Bubba Burgers is located at 123 Main Street, Anywhere, FL 12345. Mrs. Smith resides at 893B Homestead Ave, Anyplace, FL 12346. Her birthday is January 12, 1953. Mrs. Smith sustained a 1.5 incision on her right index finger. Bubba Burgers carries workers compensation insurance through Gnopay Insurance. The policy number is 90011234. The address for Gnopay is 555 Gnopay Lane, Gnowhere, FL 12349. The adjustor is Gina N. Payer. The claim number is GNP062307. Mrs. Smith has signed an Assignment of Benefit form, which is in her medical record.

Using the above information, fill out the required fields in the CMS 1500 form below:

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/05

| | | | |
|---|--|---|--|
| PICA <input type="checkbox"/> | | PICA <input type="checkbox"/> | |
| 1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID) | | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | 3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | |
| 5. PATIENT'S ADDRESS (No., Street) | | 6. PATIENT RELATIONSHIP TO INSURED Sell <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | |
| CITY STATE | | 7. INSURED'S ADDRESS (No., Street) | |
| ZIP CODE TELEPHONE (Include Area Code) () | | 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/> | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | | b. EMPLOYER'S NAME OR SCHOOL NAME | |
| c. EMPLOYER'S NAME OR SCHOOL NAME | | c. INSURANCE PLAN NAME OR PROGRAM NAME | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | 10d. RESERVED FOR LOCAL USE | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. | |
| SIGNED _____ DATE _____ | | SIGNED _____ | |

44. Today, Mary Smith was treated at Mercy Urgent Care Center, 975 Urgent Way, Johnson City, NY 13901 for an injury she sustained on June 23, 2007. Her account number is Q144354. The NPI number for this facility is U77553311. The doctor that treated her was Ima Goodguy, MD. His medical license is ME567890. His NPI number is N9064431. His Tax ID number is 591220345. The ICD-9 numbers are (1) 786.50, (2) 995.39 (3) E865.59. The first CPT is 99213 with modifier 25. The charge is \$255.00. All three diagnoses codes support the CPT code. This was an emergency. The place of service code is 22. The second CPT code is 12002. The charge is \$125.00 and the second ICD-9 supports this charge. Each CPT unit is 1. Dr. Goodguy does not accept assignment and he collected the \$25 copayment from Mrs. Smith. Dr. Goodguy's payment address is PO Box 99989, Anyplace, FL 13701 and his phone number is 407-555-1213. The insurance claim will go to Tricare, a government payer.

Using the above information, fill out the appropriate areas of the CMS 1500 below.

| | | | | | |
|--|--|---|--|---|--|
| 14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | 17a. _____ 17b. NPI _____ | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | |
| 19. RESERVED FOR LOCAL USE | | 20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO | | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____ | | 23. PRIOR AUTHORIZATION NUMBER | | 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. ICD-9 QUAL I. ID. QUAL J. RENDERING PROVIDER ID. # | |
| | | | | NPI _____ | |
| | | | | NPI _____ | |
| | | | | NPI _____ | |
| | | | | NPI _____ | |
| | | | | NPI _____ | |
| | | | | NPI _____ | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/> | | 26. PATIENT'S ACCOUNT NO. | | 27. ACCEPT ASSIGNMENT? (For gov. claims see back) <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28. TOTAL CHARGE \$ _____ | | 29. AMOUNT PAID \$ _____ | | 30. BALANCE DUE \$ _____ | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | 32. SERVICE FACILITY LOCATION INFORMATION | | 33. BILLING PROVIDER INFO & PH # () | |
| SIGNED _____ DATE _____ | | a. _____ b. _____ | | a. _____ b. _____ | |

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Matching

Match the term with its definition.

- | | |
|--------------------------------|-------------------------------|
| a. Advanced Beneficiary Notice | e. Balance Billing |
| b. Appeal | f. Contractual Adjustment |
| c. Explanation of Benefits | g. Remittance Advice |
| d. Adjustment | h. Correct Coding Initiatives |

- ___ 45. A document prepared by the payer to provide how the claim was paid. _____
- ___ 46. The process of reducing the original amount charged by a specific amount. _____
- ___ 47. Notice furnished to a Medicare patient that a service may be denied and the patient will have to pay for the medical care. _____
- ___ 48. A reduction made to the original charge in accordance with an agreement with a payer. _____
- ___ 49. Guidelines developed to prevent incorrect billing. _____
- ___ 50. A request to have a denial, rejection, or incorrect payment reconsidered. _____
- ___ 51. Having the patient pay their portion of the medical bill after their insurance paid it's contract requirement. _____
- ___ 52. A document prepared by the payer to explain how multiple claims were paid. _____

THIS CONCLUDES YOUR TEST. IF TIME ALLOWS, PLEASE ENSURE YOU GO OVER YOUR ANSWERS BEFORE TURNING IN YOUR TEST. ONCE YOU TURN IN YOUR TEST, THERE CAN BE NO CORRECTIONS.

YOU MUST SCORE AN 80% OR BETTER TO PASS. GOOD LUCK.

Medical Billing Pre-Employment Test Answer Section

TRUE/FALSE

1. ANS: F
Per CMS: If an ABN being given to you is witnessed, you may be held liable because you are on notice of the likelihood of a Medicare denial. That is what makes you liable under the law.
2. ANS: F
3. ANS: F
4. ANS: T

MULTIPLE CHOICE

5. ANS: D
The insurance company must provide foundation to their demands, therefore you have them send you proof this is workers comp such as a first report of injury, the name of the carrier and their number.
6. ANS: C
The patient owes the difference between the charges and payment because the doctor is not contracted with the patient's health insurance company. ($\$553 - 378.53 = \174.47)
7. ANS: B
Patient owes COINS amount.
8. ANS: B
The patient owes the difference between the charge and the payment. ($279 - 92.74$)
9. ANS: D
10. ANS: D
NUCC CMS 1500 Form Instruction Manual. Page 33
11. ANS: D

| Insurance | Current | 31-60 | 61-90 | 91-120 | 120+ | Totals |
|---------------|---------|---------|---------|---------|---------|---------|
| ABC Insurance | \$250 | \$175 | \$350 | \$725 | \$400 | \$1,900 |
| White Cross | \$175 | \$250 | \$725 | \$350 | \$100 | \$1,600 |
| XYZ Insurance | \$725 | \$350 | \$175 | \$250 | \$600 | \$2,100 |
| Green Cross | \$350 | \$725 | \$250 | \$175 | \$500 | \$2,000 |
| Totals | \$1,500 | \$1,500 | \$1,500 | \$1,500 | \$1,600 | \$7,600 |

ABC = \$1475 owed over 31-60 days old
 White = \$1,175
 XYZ = \$1025
 Green = \$925

12. ANS: A (ABC Insurance)
13. ANS: B (White Cross)
14. ANS: C
15. ANS: C ($120 \times 20\% = \$24$)
16. ANS: D
17. ANS: C

18. ANS: A
19. ANS: C (Per CMS, if a patient makes a freedom of choice decision to be self pay, the doctor can continue to treat the patient as self pay.)
20. ANS: A
21. ANS: B
22. ANS: B
23. ANS: B
The patient should decide which carrier to bill. If you sent to VA, you accept what they pay as payment in full. If you bill Medicare, patient is responsible for coinsurance and deductibles.
24. ANS: B
25. ANS: A
26. ANS: C
27. ANS: A
28. ANS: B
29. ANS: D
30. ANS: B
31. ANS: C
32. ANS: A
33. ANS: B
34. ANS: A
35. ANS: B
36. ANS: D
This would be a workers comp injury.
37. ANS: B

COMPLETION

38. ANS: \$229 (49+180 = 229)
39. ANS:

Anthem Ohio Traditional. They have the highest amount owed that is over 60 days of aging.

| FINANCIAL CLASS | CURRENT | 31-60 | 61-90 | 91-120 | 120+ | TOTAL |
|-------------------------|-------------|-------------|------------|------------|------------|------------|
| ACCORDIA | \$0.00 | \$65.24 | \$0.00 | \$0.00 | \$0.00 | \$0.00 |
| ADVANTRA (CARE) | \$608.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 |
| AETNA/US HEALTHCARE (CO | \$22,412.00 | \$3,810.00 | \$180.32 | \$0.00 | \$394.37 | \$574.69 |
| ANTHEM BCBS OF OH (MEDI | \$228.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 |
| ANTHEM HEALTHY START(MC | \$6,249.00 | \$3,948.00 | \$1,413.88 | \$100.00 | \$1,186.00 | \$2,699.88 |
| ANTHEM OHIO TRADITIONAL | \$59,355.00 | \$26,819.59 | \$2,917.99 | \$565.87 | \$1,877.55 | \$5,361.41 |
| AUTO INSURANCE | \$0.00 | \$0.00 | \$1,469.00 | \$1,071.00 | \$228.00 | \$2,768.00 |
| BEECHSTREET PPO | \$1,115.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 |
| BS FEDERAL EMPLOYEE | \$0.00 | \$44.57 | \$268.00 | \$0.00 | \$0.00 | \$268.00 |
| BUDGET PLAN | \$0.00 | \$280.50 | \$506.36 | \$1,903.00 | \$1,782.65 | \$4,192.01 |
| CARESOURCE (CAID HMO) | \$0.00 | \$0.00 | \$228.00 | \$0.00 | \$0.00 | \$228.00 |
| CHAMPUS-TRICARE | \$2,986.00 | \$0.00 | \$267.00 | \$147.18 | \$16.21 | \$430.39 |
| CHAMPVA | \$0.00 | \$11.95 | \$0.00 | \$21.78 | \$0.00 | \$21.78 |
| CIGNA COMMERCIAL | \$0.00 | \$462.00 | \$0.00 | \$769.00 | \$0.00 | \$769.00 |
| CIGNA HMO | \$1,063.00 | \$70.95 | \$0.00 | \$0.00 | \$50.92 | \$50.92 |

40. ANS:

Budget Plan. They have the second highest amount owed that is over 60 days of aging.

| FINANCIAL CLASS | CURRENT | 31-60 | 61-90 | 91-120 | 120+ | TOTAL |
|----------------------------|----------------|--------------|--------------|---------------|-------------|--------------|
| ACCORDIA | \$0.00 | \$65.24 | \$0.00 | \$0.00 | \$0.00 | \$0.00 |
| ADVANTRA (CARE) | \$608.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 |
| AETNA/US HEALTHCARE (CO | \$22,412.00 | \$3,810.00 | \$180.32 | \$0.00 | \$394.37 | \$574.69 |
| ANTHEM BCBS OF OH (MEDI | \$228.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 |
| ANTHEM HEALTHY START(MC | \$6,249.00 | \$3,948.00 | \$1,413.88 | \$100.00 | \$1,186.00 | \$2,699.88 |
| ANTHEM OHIO TRADITIONAL | \$59,355.00 | \$26,819.59 | \$2,917.99 | \$565.87 | \$1,877.55 | \$5,361.41 |
| AUTO INSURANCE | \$0.00 | \$0.00 | \$1,469.00 | \$1,071.00 | \$228.00 | \$2,768.00 |
| BEECHSTREET PPO | \$1,115.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 |
| BS FEDERAL EMPLOYEE | \$0.00 | \$44.57 | \$268.00 | \$0.00 | \$0.00 | \$268.00 |
| BUDGET PLAN | \$0.00 | \$280.50 | \$506.36 | \$1,903.00 | \$1,782.65 | \$4,192.01 |
| CARESOURCE (CAID HMO) | \$0.00 | \$0.00 | \$228.00 | \$0.00 | \$0.00 | \$228.00 |
| CHAMPUS-TRICARE | \$2,986.00 | \$0.00 | \$267.00 | \$147.18 | \$16.21 | \$430.39 |
| CHAMPVA | \$0.00 | \$11.95 | \$0.00 | \$21.78 | \$0.00 | \$21.78 |
| CIGNA COMMERCIAL | \$0.00 | \$462.00 | \$0.00 | \$769.00 | \$0.00 | \$769.00 |
| CIGNA HMO | \$1,063.00 | \$70.95 | \$0.00 | \$0.00 | \$50.92 | \$50.92 |

41. ANS:

1D = Medicaid Provider Number

Taken from the NUCC CLAIM MANUAL Page 24

42. ANS: Most states require the injury to be reported by the employee, 30 days from date of injury

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

GNOFAY INSURANCE COMPANY
555 GNOFAY LANE
GNOWHERE, FL 12349

| | | | |
|--|--|--|--|
| <input type="checkbox"/> PICA | | <input type="checkbox"/> PICA | |
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)</small> | | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) 90011234 | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) SMITH, JANE | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) BUBBA BURGERS | |
| 3. PATIENT'S BIRTH DATE MM DD YY 01 12 1953 M <input type="checkbox"/> F <input checked="" type="checkbox"/> | | 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/> | |
| 5. PATIENT'S ADDRESS (No., Street) 893B HOMESTEAD AVE | | 7. INSURED'S ADDRESS (No., Street) 123 MAIN STREET | |
| CITY ANYPLACE STATE FL | | 8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/> | |
| ZIP CODE 12346 TELEPHONE (Include Area Code) () | | CITY ANYWHERE STATE FL | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> | | a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> | |
| c. EMPLOYER'S NAME OR SCHOOL NAME | | b. EMPLOYER'S NAME OR SCHOOL NAME BUBBA BURGERS | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | c. INSURANCE PLAN NAME OR PROGRAM NAME GNOFAY INSURANCE COMPANY | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE SIGNED _____ DATE 7/20/2009 | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED _____ | |

43. ANS:

Note: There are 26 correct answers to this question.

| | | | | | | | | | | | |
|--|--|--|---|--|---|---|-------------------------------|-----------------------------|------------------------------|--------------------------------|-----------------------------|
| 14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 06 23 2009 | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | | | | | | | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | 17a. | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | | | | | | |
| 19. RESERVED FOR LOCAL USE | | | 17b. NPI | 20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. I 78659 2. I 99539 3. I E86579 4. I | | | | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER | | | | | | | |
| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | | E. DIAGNOSIS POINTER | F. \$ CHARGES | G. DAYS OR UNITS | H. SPOT Family Plan | I. ID. OUAL | J. RENDERING PROVIDER ID. # |
| 07 22 2009 07 22 2009 | | 22 | Y | 99213 25 | | 123 | 255 00 | 1 | | OB NPI ME567890 N9064431 | |
| 07 22 2009 07 22 2009 | | 22 | Y | 12002 | | 2 | 125 00 | 1 | | OB NPI ME567890 N9064431 | |
| | | | | | | | | | | NPI | |
| | | | | | | | | | | NPI | |
| | | | | | | | | | | NPI | |
| | | | | | | | | | | NPI | |
| 25. FEDERAL TAX I.D. NUMBER 591220345 | | SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/> | 26. PATIENT'S ACCOUNT NO. Q144354 | | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 28. TOTAL CHARGE \$ 380 00 | 29. AMOUNT PAID \$ 25 00 | 30. BALANCE DUE \$ 355 00 | | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Ima Goodguy, MD signature SIGNED 07 22 2009 DATE | | | 32. SERVICE FACILITY LOCATION INFORMATION MERCY URGENT CARE CENTER 375 URGENT CARE WAY JOHNSON CITY, NY 13901 a. b. U77553311 | | | 33. BILLING PROVIDER INFO & PH # (407) 555-1213 Ima Goodguy, MD PO Box 99989, Anyplace, FL 13701 a. b. N9064431 | | | | | |

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Note: There are 44 correct answers to this question.

When scoring the CMS 1500 form, the student receives one point for each form field filled in correctly. There are no points for filling in a field that is not required or has no data that was provided. Also, no points for filling out a required field but has the wrong info provided. No points for misspelling or incomplete information. The top half of the claim form has 26 points. The bottom half has 44 points. The standard for the claim form is the NUCC CMS 1500 Claim Form Instruction Manual.

MATCHING

- 45. ANS: C
- 46. ANS: D
- 47. ANS: A
- 48. ANS: F
- 49. ANS: H
- 50. ANS: B
- 51. ANS: E
- 52. ANS: G

Scoring The Test

Use the table below to determine the candidates final score.

| Questions OK | score |
|--------------|-------|--------------|-------|--------------|-------|--------------|-------|--------------|-------|
| 1 | 1 | 26 | 21 | 51 | 42 | 76 | 63 | 101 | 83 |
| 2 | 2 | 27 | 22 | 52 | 43 | 77 | 64 | 102 | 83 |
| 3 | 2 | 28 | 23 | 53 | 44 | 78 | 64 | 103 | 84 |
| 4 | 3 | 29 | 24 | 54 | 45 | 79 | 65 | 104 | 85 |
| 5 | 4 | 30 | 25 | 55 | 45 | 80 | 66 | 105 | 86 |
| 6 | 5 | 31 | 26 | 56 | 46 | 81 | 67 | 106 | 87 |
| 7 | 6 | 32 | 26 | 57 | 47 | 82 | 68 | 107 | 88 |
| 8 | 7 | 33 | 27 | 58 | 48 | 83 | 69 | 108 | 88 |
| 9 | 7 | 34 | 28 | 59 | 49 | 84 | 69 | 109 | 89 |
| 10 | 8 | 35 | 29 | 60 | 50 | 85 | 70 | 110 | 90 |
| 11 | 9 | 36 | 30 | 61 | 50 | 86 | 71 | 111 | 91 |
| 12 | 10 | 37 | 31 | 62 | 51 | 87 | 72 | 112 | 92 |
| 13 | 11 | 38 | 31 | 63 | 52 | 88 | 73 | 113 | 93 |
| 14 | 12 | 39 | 32 | 64 | 53 | 89 | 74 | 114 | 94 |
| 15 | 12 | 40 | 33 | 65 | 54 | 90 | 74 | 115 | 95 |
| 16 | 13 | 41 | 34 | 66 | 55 | 91 | 75 | 116 | 96 |
| 17 | 14 | 42 | 35 | 67 | 55 | 92 | 76 | 117 | 97 |
| 18 | 15 | 43 | 36 | 68 | 56 | 93 | 77 | 118 | 98 |
| 19 | 16 | 44 | 36 | 69 | 57 | 94 | 78 | 119 | 98 |
| 20 | 17 | 45 | 37 | 70 | 58 | 95 | 79 | 120 | 99 |
| 21 | 17 | 46 | 38 | 71 | 59 | 96 | 79 | 121 | 100 |
| 22 | 18 | 47 | 39 | 72 | 60 | 97 | 80 | | |
| 23 | 19 | 48 | 40 | 73 | 60 | 98 | 81 | | |
| 24 | 20 | 49 | 40 | 74 | 61 | 99 | 82 | | |
| 25 | 21 | 50 | 41 | 75 | 62 | 100 | 83 | | |

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