Test Bank for Essentials of Health Care Finance 9th Edition by Cleverley

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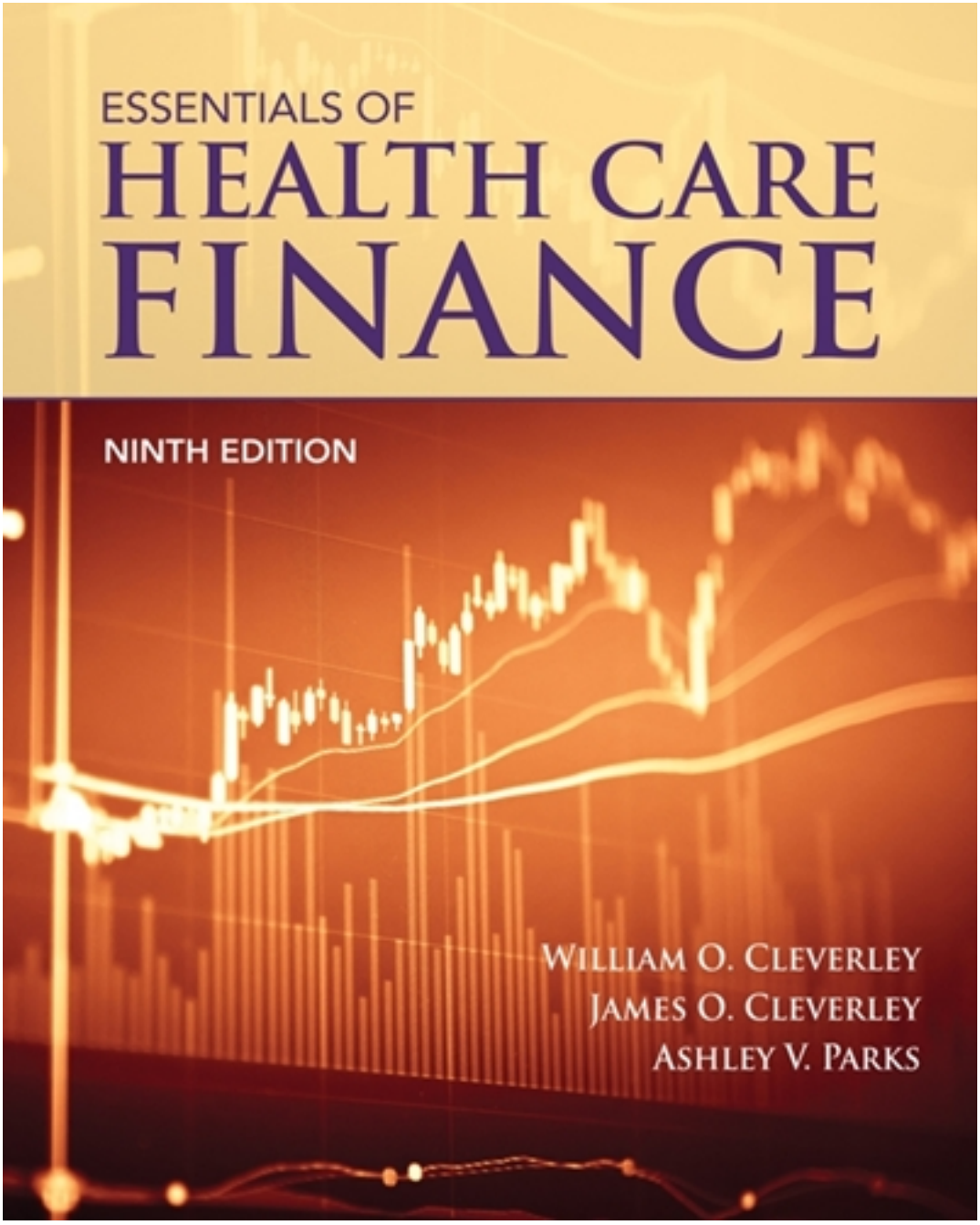

Test Bank

Chapter 2: Billing and Coding for Health Services

Essay

1. What is meant by the term, “the revenue cycle”?
Ans: The revenue cycle describes how a firm turns its goods or services into payment. It begins with the point of contact of the patient with the provider setting and ends when a complete payment is received by the provider for those services.
Complexity: Difficult
Ahead: Generating Healthcare Claims
Subject: Chapter 2

2. What factors contribute to the complexity of the revenue cycle in health care?
Ans: Students’ answers might vary somewhat, but they should focus around at least a few of the following themes:
- Nature and importance of services provided
- Size of the industry (amount of money involved)
- Regulations and policies regarding provision for and billing of services
- Cost of care
- Third-party payer system (most of the payments for services are not directly from the recipient of those goods and services)
- Diversity and complexity of patients, providers, payers, payment methods, and care settings
- Nonstandardization of care

Complexity: Difficult
Ahead: Generating Healthcare Claims
Subject: Chapter 2

3. What are the six stages of the revenue cycle?
Ans: In health care, the critical stages of the revenue cycle are the provision of services to the patient, the documentation of those services, the generation of charges for those services, the preparation of a bill or claim, the submission of the bill or claim to the respective payer, and the collection of payment.
Complexity: Difficult
Ahead: Generating Healthcare Claims
Subject: Chapter 2

4. What is the registration process, including the activities that comprise it?
Ans: In most cases, a patient or their representative will provide a basic set of information regarding the patient prior to the actual delivery of services. Three activities are especially important in the billing and collection process. The first is insurance verification. The second activity in registration is often related to the computation of copayment or deductible provisions that may be applicable for the patient. The third activity in this registration process relates to financial counseling. Patients who have no coverage may be eligible for some discount through the healthcare firm’s charity care policy.
Complexity: Difficult
Ahead: Scheduling and Registration
Subject: Chapter 2

5. What are the two types of forms used for health services billing?
Ans: There are two primary forms for billing purposes:
- CMS-1500
- CMS-1450 (aka UB-04)

Complexity: Easy
Ahead: Medical Documentation and HIM/Medical Records
Subject: Chapter 2

6. What is a charge master, also known as a charge description master (CDM), and what purpose does it serve?
Ans: The CDM is a healthcare organization's price list, and includes a list of all items for which the firm has established specific prices. The CDM provides the gross charge for any product or service, and in the hospital setting the CDM serves as well as an electronic file where all charge codes and CPT/HCPCS codes are masked to appropriate revenue codes for inpatient billing.
Complexity: Easy
Ahead: Charge Entry and Charge Master
Subject: Chapter 2

7. What are the six elements that should be present, at a minimum, in all chargemasters?
Ans: The six elements are as follows:
- Charge code
- Item description
- Department number
- Charge (price)
- Revenue code
- CPT/HCPCS code

Complexity: Moderate
Ahead: Charge Entry and Charge Master
Subject: Chapter 2

8. What is charge explosion?
Ans: Charge explosion can be used when a uniform set of supplies is used for a services or procedure. For example, a specific type of surgery may routinely require a standardized set of supplies. Rather than entering all these supplies, one code may be used that then explodes into the list of supply codes used for that surgery.
Complexity: Easy
Ahead: Charge Entry and Charge Master
Subject: Chapter 2

9. What are the differences between ICD-9-CM and ICD-10-CM? Why have healthcare facilities and health insurance plans in the U.S. adopted ICD-10?

Ans: ICD-10-CM reflects a significant improvement over ICD-9-CM in that ICD-10-CM codes include far more detail and information than was available with ICD-9-CM. ICD-10-CM is an expanded code set to include health-related conditions and offer a higher level of detail by including separate codes for the specific location of the injury or condition. The number of available diagnosis codes expanded from over 13,000 to nearly 70,000 available codes with the 10th version. The ICD-10-CM code set can be three to seven characters in length, compared to ICD-9 diagnosis codes, which comprise three digits that may be followed by a decimal point with up to two additional digits. Therefore, the ICD-10-CM coding system also has more room for updated codes and added information in the future.
Complexity: Moderate
Ahead: Medical Documentation and HIM/Medical Records
Subject: Chapter 2

Multiple Choice

1. What coding system would a physician use to bill for a procedure that occurred in an outpatient environment?
A) ICD-10 CM
B) ICD-10 PCS
C) CPT/HCPCS
D) DRG
E) None of these is correct.
Ans: C
Complexity: Easy
Ahead: Medical Documentation and HIM/Medical Records
Subject: Chapter 2

2. What coding system would a physician use to document a patient's diagnosis in an outpatient environment?
A) ICD-10 CM
B) ICD-10 PCS
C) CPT/HCPCS
D) DRG
E) None of these is correct.
Ans: A
Complexity: Easy
Ahead: Generating Healthcare Claims
Subject: Chapter 2

3. What coding system would an institutional facility (e.g., a hospital) use to document a patient's procedure in an inpatient environment?
A) ICD-10 CM
B) ICD-10 PCS
C) CPT/HCPCS
D) APC
E) None of these is correct.

Ans: B
Complexity: Easy
Ahead: Generating Healthcare Claims
Subject: Chapter 2

True/False

1. Data in the medical record are the primary source for documenting the provision of services.
Ans: True
Complexity: Easy
Ahead: Generating Healthcare Claims
Subject: Chapter 2

2. Since most hospitals are not-for-profit, they are not generally business oriented.
Ans: False
Complexity: Easy
Ahead: Chapter 2 Introduction
Subject: Chapter 2

3. Claims editing is initiated once the claim has been submitted to the payer for payment.
Ans: False
Complexity: Easy
Ahead: Generating Healthcare Claims
Subject: Chapter 2

4. Charge codes are universal codes specific to each product or service created by the Centers for Medicare and Medicaid Services (CMS) for healthcare organizations.
Ans: False
Complexity: Easy
Ahead: Charge Entry and Charge Master
Subject: Chapter 2

5. Prior approval for elective services, known as precertification, is required by many health plans before a claim can be submitted.
Ans: True
Complexity: Easy
Ahead: Scheduling and Registration
Subject: Chapter 2

6. While more up to date, ICD-10-CM codes contain far fewer code options and less detail than ICD-9-CM codes.
Ans: False
Complexity: Easy
Ahead: Medical Documentation and HIM/Medical Records
Subject: Chapter 2

7. HCPCS codes are the billing codes used only for physician office visit charges.
Ans: False
Complexity: Easy
Ahead: Medical Documentation and HIM/Medical Records
Subject: Chapter 2