

Proper and Ethical Billing and Coding

Simply list your answers in an e-mail, write down **letter choice only**: a. b. c. d. e. T F

Please e-mail your answers to: marcusstrutzdc@gmail.com

- 1) Above all else, be
 - A) careful and deliberate
 - B) careful and meticulous
 - C) honest and ethical
 - D) reasonably accurate

- 2) Integrity is ...
 - A) doing things well while being on the right track with morals and ethics
 - B) getting things done most of the way correctly and with good intentions
 - C) adherence to moral and ethical principles, soundness of moral character, and honesty
 - D) being mostly sound with moral character and honesty

- 3) Shared risk in health insurance contracts is for the most part defined by ...
 - A) the best of intentions between the parties
 - B) the amount of the deductible and c-payment amounts
 - C) the degree of paperwork to be completed on the part of the treating doctor
 - D) the degree of paperwork to be completed on the part of the consumer/patient

- 4) Secondary insurance is ...
 - A) excess insurance that pays for most itemized procedure codes regardless of whether the primary insurance company approves or disapproves any given procedure code for payment
 - B) extra insurance that pays only for itemized procedure codes only if the primary insurance company approves a given procedure code for payment
 - C) excess insurance that pays only for itemized procedure codes only if the primary insurance company approves a given procedure code for payment
 - D) extra insurance that generally is not worth the effort to bill

- 5) Insurance fraud is ...
 - A) accidental misrepresentation of at least one material fact, justifiably relied upon by another, so as to obtain the property of another.
 - B) good faith misrepresentation of at least one material fact, justifiably relied upon by another, so as to obtain the property of another.
 - C) the intentional misrepresentation of at least one material fact, justifiably relied upon by another, so as to obtain the property of another.
 - D) unconscious misrepresentation of at least one material fact, justifiably relied upon by another, so as to obtain the property of another.

- 6) One can commit insurance fraud by ...
 - A) doing insurance fraud by themselves
 - B) conspiring with another and committing at least one overt act to commit insurance fraud
 - C) aiding and abetting another in committing insurance fraud
 - D) all of the above

- 7) Which of the following will subject a doctor to being compliant with federal HIPAA law?
- A) sending a bill by a conventional facsimile (fax) machine over a telephone line
 - B) sending a bill by way of a computer facsimile (fax) machine
 - C) mailing a bill by way of first class mail with the United States Postal Service
 - D) having a cash only practice and requiring patients to pay promptly at the time of service by their personal check
- 8) The following is required for confidential patient health care information to be released by a doctor:
- A) signed, written consent by the patient
 - B) court order or subpoena
 - C) a California Board of Chiropractic Examiner who requests a patients information upon showing apparently appropriate identification as a Board employee
 - D) all of the above
- 9) Which of the following would definitely not constitute negligence?
- A) not taking x-rays of a new patient
 - B) billing an insurance company for more work than was actually performed on a patient
 - C) using SOT to adjust a patient when every other chiropractor in town uses diversified or Gonstead techniques
 - D) failing to detect the subtle beginnings of cancer on a radiograph
- 10) Which place on a billing form is the most appropriate place to indicate a "corrected claim?"
- A) Box 19
 - B) Box 17
 - C) Box 24D
 - D) Box 33B
- 11) Which of the following is not a traumatic injury diagnosis code?
- A) 739.1
 - B) E812.0
 - C) 839.01
 - D) 338.11
- 12) On a personal injury patient who has their own medical payments automobile insurance, and who is also a Medicare beneficiary, it would be illegal to accept as payment more than the amount allowed by Medicare for
- A) the initial exam
 - B) spinal adjustments
 - C) radiographs
 - D) any re-examination
- 13) One common reason for Medicare audits is
- A) forgetting to sign all billing forms
 - B) Medicare's mere allegation on their website that chiropractors tend to make many mistakes
 - C) forgetting to sign any non-billing page with a legible, authentic signature
 - D) forgetting to sign one billing page among a group of billing pages

- 14) Which of the following billing codes would be inappropriate to use with a simple two minute established patient visit in which the patient had their spine adjusted, a wrist bone adjusted, and some stretching performed on them?
- A) 98940
 - B) 99212
 - C) 98943
 - D) 97012
- 15) Which of the following could constitute insurance fraud?
- A) billing an x-ray code without the -26 modifier when reading another doctor's radiographs taken of your patient
 - B) not obtaining a signed, written statement of a Medicare beneficiary indicating they understand that Medicare is not expected to pay for any non-spinal adjustment procedures
 - C) using the modifier -GA without obtaining a signed, written statement of a Medicare beneficiary indicating they understand that Medicare is not expected to pay for any non-spinal adjustment procedures
 - D) all of the above
- 16) Which of the following is NOT true?
- A) Medicare will pay for maintenance care with sufficient documentation
 - B) Medicare has a \$100.00 deductible for all Medicare part B (health care including chiropractic) beneficiaries
 - C) Medicare will pay for acute care with sufficient documentation
 - D) only bill an insurance company work actually performed on a patient that is appropriately documented in the patient chart notes
- 17) Which of the following is NOT true?
- A) some supply codes begin with the letter L
 - B) some trauma codes begin with the letter A
 - C) some modifiers have letters
 - D) some modifiers have numbers
- 18) A doctor who is aware of another doctor who is fraudulently billing an insurance company could be convicted of insurance fraud on the following basis(-es):
- A) conspiracy
 - B) aiding and abetting
 - C) active assistance
 - D) all of the above
- 19) Which of the following is absolutely true?
- A) all physical therapy codes pertain only to modalities
 - B) therapeutic procedures have two subcategories
 - C) all physical therapy requires direct, supervised contact by a doctor with a patient
 - D) modalities may sometimes not require direct, supervised contact by a doctor with a patient
- 20) A re-examination performed on a patient that would normally constitute a 99212, but that required 21 minutes of face to face time with a patient, and which was properly documented including the time spent could AT MOST be billed as
- A) 99215
 - B) 99214
 - C) 99213
 - D) 99212