C) e11.51, i96, z79.4
D) e11.51, z79.4 - ansd) e11.51, z79.4

By signing the assignment of benefits in item 13 of the cms-1500 claim form, the patient is:

A) directing the insurance company to send the reimbursement to the patient.
B) directing the insurance company to send the reimbursement to the provider.
C) agreeing that services were provided.
D) preventing the claim from being paid. - ansb) directing the insurance company to send the reimbursement to the provider.

Rationale: as stated on the cms-1500 claim form item 13. "insured's or authorized person's signature: i authorize payment of medical benefits to the undersigned physician or supplier for services described below."

Contacting debtors at a very early hour of the day or revealing to an employer that there is debt would be violations of which federal law?

A) hipaa
B) federal claims collection act
C) fair debt collection practices act
D) tax equity and fiscal responsibility act - ansc) fair debt collection practices act

Rationale: the fair debt collection practices act (fdcpa) outlines specific collection practices that are considered illegal.

Cpt codes 64418 and 19380 were reported together for the injection of the supra capsular nerve with anesthetic agent (64418) with reversion of a reconstructed breast (19380). The injection was denied as a bundled service. What would be the next step for the biller?

A) resubmit corrected claim adding modifier -59 to 64418
B) resubmit corrected claim adding modifier -51 to 64418.
C) move the charge for the bundled procedure to patient responsibility
D) write-off the charge for 64418 because it is a bundled procedure - ansd) write-off the charge for 64418 because it is a bundled procedure.

Rationale: services or procedures that are determined to be bundled as part of the payer's contract must be written off. Costs for the bundled procedure cannot be shifted to patient responsibility.

Do annual cpt code charges affect a physician's office superbill?

A) no, because the physician performs the same procedures year after year

Iii. Hospice organizations
Iv. Institution based ambulance companies
V. Outpatient rehabilitation facilities
Vi. Ambulatory surgery centers

A) iii-vi
B) iv, vi
C) i, iii, iv, vi
D) i-v - ansd) i-v

Rationale: providers that submit the ub-04 claim are community mental health centers (cmhcs), hospitals (emergency department, inpatient, and outpatient services), hospice organizations, institution based ambulance companies, outpatient rehabilitation facilities, home healthcare agencies, psychiatric drug/alcohol treatment facilities, skilled nursing facilities, subacute facilities

When a claim payment has been denied, the denial:

A) is always found to be in error and a prompt appeal should be made.
B) may be valid and should not be appealed.
C) should be analyzed and if it was denied in error, an appeal should be initiated.
D) both b & c - ansd) both b & c

Rationale: the denial should be analyzed prior to submitting an appeal to determine the reason for the denial. Some reasons for a denial could include billing for a procedure or service that was not medically necessary, or billing for a non covered benefit, or a pre-existing condition. Other possible reasons could be that the patient's coverage was terminated or the procedure required a pre-authorization that was not obtained.

When an account has been determined (by the practice's policy) to be delinquent, the account should:

A) be written off as a bad debt
B) be closed and no further visits scheduled for the patient.
C) be turned over to a collection agency.
D) continue to be worked by the practice's billing office staff as time allows. - ansc) be turned over to a collection
Agency.

Rationale: a medical practice should develop policies for handling delinquent accounts. The final step in delinquent account protocol would be to release the account to a collection agency who will continue the collection process until resolution.

When submitting a medigap policy, which option is an example of how the patient's id number should appear in item 9a of the cms-1500 claim form?