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Question: 1

The key factors that have contributed to the higher cost of health care include:

- A. Technology, aging population, chronic disease and litigation
- B. Aging population, chronic disease, performance payment and litigation
- C. Technology, performance payment and litigation
- D. All of the above

Answer: A

Question: 2

What change the basis of payment for hospital outpatient services from a flat fee for individual services to fixed reimbursement for bundled services?

- A. Cost payment system
- B. Ambulatory payment classifications
- C. Cost compliance and litigation
- D. None of the above

Answer: B

Question: 3

when providers try to get one payor to pay for costs that have not been covered by another payor, this refers to:

- A. Cost Capacity
- B. Cost capitalization
- C. Cost-shifting
- D. Prospective cost

Answer: C

Question: 4

The combination of age and technology has increased cost with the passage of time.

- A. True
- B. False

Answer: A

Question: 5

Prescription drug coverage for Medicare enrollees, which offsets some of the out-of-pocket costs for medications, this covers:

- A. Medicare Part A
- B. Medicare Part B
- C. Medicare Part D
- D. Medicare Part F

Answer: C

Question: 6

The need to abide by governmental regulations, whether they are for the provision of care, billing, privacy accounting standards, security or the like refers to:

- A. Compliance
- B. Chronic Medicare
- C. Health proactive standards
- D. None of the above

Answer: A

Question: 7

_____ that providers have to pay insurers to cover the cost of defending against the lawsuits and paying large jury awards.

- A. Ambulatory payment classifications
- B. Reimbursement Insurance cost plan
- C. Health proactive Insurance standard act
- D. Increased insurance premiums

Answer: D

Question: 8

A set of federal compliance regulations to ensure standardization of billing, privacy and reporting as institutions convert to electronic systems is called:

- A. Health Insurance standard Act
- B. Reimbursement Insurance Act
- C. Medicare Reporting Act

D. Health Insurance portability and Accountability Act

Answer: D

Question: 9

_____ is the tendency health care practitioners to do more testing and to provide more care for patients than might otherwise be necessary to protect themselves against potential litigation.

Answer: Defensive medicine

Question: 10

In which act, federal legislation designed to tighten accounting standards in financial reporting and that holds top executives personally liable as to the accuracy and fairness of their financial statements?

- A. Sarbanes-Oxley Act
- B. Insurance accountability Act
- C. Financial statement Act
- D. Portability and Accountability Standardized Act

Answer: A

Question: 11

Stark law states that:

- A. Legislation enacted by HIPAA to guard against providers' ordering self-referrals for Medicare or Medicaid patients directly to any settings in which they have a vested financial interest.
- B. Legislation enacted by CMS to guard against providers' ordering self-referrals for Medicare or Medicaid patients directly to any settings in which they have a vested financial interest.
- C. Legislation enacted by CMS to guard against providers' ordering self-referrals for Medicare or Medicaid patients indirectly to any settings in which they have a vested financial interest.
- D. Legislation enacted by HIPAA to guard against providers' ordering self-referrals for Medicare or Medicaid patients indirectly to any settings in which they have a vested financial interest.

Answer: B

Question: 12

Which one of the following is NOT the factor of Uninsured?

- A. Health insurance premiums becoming too costly

- B. Requiring patients to pay for the part of their own care-up
- C. Individuals being screened out of insurance policies
- D. Employers feeling they cannot afford to continue to provide health insurance as a Benefit

Answer: B

Question: 13

Concurrent review states that:

- A. Planning appropriateness and medical necessity of a hospital stay while the patient is in the hospital and implementing discharge planning.
- B. Monitoring appropriateness and medical necessity of a hospital stay while the patient is not in the hospital and try to implement discharge planning.
- C. Planning appropriateness and medical necessity of a hospital stay while the patient is not in the hospital and try to implement preadmission planning.
- D. Monitoring appropriateness and medical necessity of a hospital stay while the patient is in the hospital and implementing discharge planning.

Answer: D

Question: 14

Gatekeepers requiring a patient to obtain a referral from his or her primary care physician, the gatekeeper, before assign a specialist.

- A. True
- B. False

Answer: A

Question: 15

Requiring providers to have their capital expenditures preapproved by an independent state agency to avoid unnecessary duplication of services is referred to as:

- A. Preapproval certifications and opinions
- B. Preapproved payments
- C. Certificate of need
- D. State service reviews

Answer: C

Question: 16

Which one of the following systems is used to classify inpatients based on their diagnoses, used by both Medicare and private insurers?

- A. Diagnosis-related groups
- B. Proactive payments system
- C. Payment insurance group
- D. None of the above

Answer: A

Question: 17

A system that pays providers a specific amount in advance to care for defined health care needs of a population over a specific period is called:

- A. Health care system
- B. Prospective payments system
- C. Global payment system
- D. Capitation

Answer: D

Question: 18

Risk pool is:

- A. A generally small population of individuals who are all uninsured under the same arrangement, regardless of working status
- B. A generally large population of individuals who are all insured under the same arrangement, regardless of working status
- C. A generally large population of groups who are all uninsured under the different arrangement, regardless of working status
- D. A generally small population of individuals who are all insured under different arrangement, regardless of working status

Answer: B

Question: 19

A system to pay providers whereby the fees for all providers are included in a single negotiated amount is called:

- A. Single member per month payment

- B. Global payment
- C. Revolutionary payment
- D. Ambulatory payment

Answer: B

Question: 20

Which organizations are the third party entities that contract with multiple hospitals to offer cost savings in the purchase of supplies and equipment by negotiating large-volume discounted contract with vendors?

- A. Cost saving organizations
- B. Global payment organizations
- C. Group purchasing organizations
- D. Cost-accounting organizations

Answer: C



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