Total Question: 50 QAs

Question No: 1
At which level of the Medicare Part A or Part B appeals process is the appeal reconsidered by a qualified independent contractor?
A. First level of appeal
B. Second level of appeal
C. Third level of appeal
D. Fourth level of appeal
Answer: B
Explanation: In the second level of the Medicare Part A or Part B appeals process, the appeal is reconsidered by a qualified independent contractor, otherwise known as a QIC. Suppliers, beneficiaries, and providers all have the right to appeal decisions related to Medicare coverage and payment after the initial claim determination. There are five levels to the appeal process. The first level of appeal entails a redetermination of the claim by a Medicare administrative contractor, fiscal intermediary, or Medicare carrier. The second level of appeal involves reconsideration by a qualified independent contractor. The third level of appeal includes a hearing overseen by an administrative law judge in the office of Medicare hearings and appeals. The fourth level of appeal is a review by the Medicare Appeals Council, and the fifth level of appeal is a judicial review in federal district court.

Question No: 2
If an at-risk patient is left unattended and has an adverse response to medication, this is known as a(n) ...
A. Sentinel event.
B. Initiator.
C. Latent outcome.
D. Slip.
Answer: A
Explanation: If an at-risk patient is left unattended and has an adverse response to medication, this is known as a sentinel event. A sentinel event is an adverse occurrence that is not in the normal progression of a patient's illness. As such, the death of a patient from terminal lung cancer would not be considered a sentinel event. However, an adverse drug event is considered a sentinel event, even if the patient is considered to be at risk. Whenever a sentinel event occurs, the health care facility should perform a root cause analysis.

Question No: 3
A behavioral health specialist notices a particularly high number of restraint deaths at a facility. An analysis of the root causes of these events is most likely to indicate problems with ...
A. Equipment.
B. Staff orientation and training.
C. Staffing levels.
D. Alarm systems.
Answer: B
Explanation: An analysis of the root causes of an abnormally high number of restraint deaths is most likely to indicate problems with staff orientation and training. Equipment, staffing levels, and alarm systems can also

be culpable in restraint deaths, but problems with orientation and training are much more likely. Restraint equipment has been designed to be very safe, so long as it is used correctly. When used improperly, restraint equipment can be deadly. It should be noted that most root cause analyses indicate problems in multiple areas.

Question No: 4
Which piece of legislation established a new set of standards for corporate responsibility?
A. Sarbanes -Oxley Act
B. United States Patriot Act
C. Foreign Corrupt Practices act
D. Stark Law
Answer: A
Explanation: The Sarbanes-Oxley Act of 2002 established a new set of standards for corporate responsibility. This act was passed after a series of corruption scandals, most notably the accounting improprieties at Enron. Sarbanes-Oxley requires chief executive officers and chief financial officers to certify financial reports. The United States' Patriot Act increased the abilities of federal officials to monitor communications and discover money-laundering operations. The Foreign Corrupt Practices Act changed the rules for international businesses, both by explicitly outlawing bribes to foreign officials, and by standardizing accounting practices for American businesses that operate overseas. The Stark Law prohibits physicians from referring Medicare and Medicaid patients to health care providers with which the physician has a financial relationship.

Question No: 5
According to the Federal Sentencing Guidelines, which of the following factors could increase the punishment of an organization?
A. Obstruction of justice
B. Violation of the direct court order
C. Prior history of violations
D. All of the above
Answer: D
Explanation: According to the Federal Sentencing Guidelines, an organization's punishment could be increased by obstruction of justice, the violation of a direct court order, or a prior history of violations. In addition, cooperation with or tolerance of criminal activity could also result in increased punishment. By contrast, there are certain factors that can diminish the punishment levied against an organization. The organization may receive decreased punishment if violations are self-reported, if the organization cooperates with investigation, or if the organization takes active steps to accept responsibility for violations. Moreover, an organization may minimize punishment by establishing and maintaining an effective compliance and ethics program.

Question No: 6
When a hospital official notes that most errors are occurring at the "sharp end," she means that ...
A. They involve surgical tools or knives.
B. They occur in clusters.
C. They occur during the interactions between caregivers and patients.
D. They are more likely to occur during busy periods.

Answer: C
Explanation: When a hospital official notes that most errors are occurring at the "sharp end," she means that they occur during the interactions between caregivers and patients. The phrases "sharp end" and "blunt end" are used by quality management professionals to describe areas of practice. The "sharp end" is all of the operations that involve direct contact with the patient, client, or customer.
The "blunt end" is all of the actions that take place outside of the awareness of the patient, client, or customer. Although patients are more likely to notice errors at the sharp end, there are significantly more errors committed at the blunt end.

Question No: 7
The majority of fraud and abuse violations relate to irregularities in ...
A. Treatment.
B. Diagnosis.
C. Billing.
D. Scheduling.
Answer: C
Explanation: The majority of fraud and abuse violations relate to irregularities in billing. Reimbursement for inpatient treatment through Medicare is based on the categories outlined in the International Classification of Diseases, Tenth Edition, Clinical Modifications (ICD-10-CM). This system of coding enables fraud and abuse by making billing inscrutable to most of the people who handle it. Two of the most common forms of billing fraud are unbundling, in which services that are normally grouped together at a discount are separated and billed individually, and upcoding, in which a billing code with a higher rate of reimbursement is used in place of the billing code representing the services actually performed.

Question No: 8
Which of the following words best describes the approach to punishment of the Federal Sentencing Guidelines?
A. Case-specific
B. Draconian
C. Consistent
D. Remedial
Answer: A
Explanation: The approach to punishment of the Federal Sentencing Guidelines (FSG) can best be described as case-specific. The FSG takes numerous factors into account when determining punishment; the range of penalties that may be applied to a given violation is broad. Organizations may affect the severity of their punishment with their actions subsequent to the violation.

Question No: 9
Which of the following groups may request information from the Healthcare Integrity and Protection Data Bank?
A. Professional societies with formal peer review
B. Quality improvement organizations
C. Plaintiffs attorneys
D. State agencies
Answer: D

Explanation: State agencies may request information from the Healthcare Integrity and Protection Data Bank. The other groups that may request information from this data bank are federal government agencies, health plans, health care practitioners, and researchers. However, researchers are only allowed to obtain statistical data from the data bank.

Question No: 10
Research suggests that the largest proportion of adverse events attributable to negligence occur in the ...
A. Post-trauma unit.
B. Surgery unit.
C. Maternity ward.
D. Emergency room.
Answer: D
Explanation: Research suggests that the largest proportion of adverse effects attributable to negligence occur in the emergency room. Of course, the volatile workload and elevated stress level of the emergency room is conducive to negligence. However, there are steps that can be taken to reduce these adverse events. Standardization and comprehensive training can diminish, though not eliminate, the incidence of adverse events related to negligence.

Question No: 11
According to Title II of the Health Insurance Portability and Accountability Act, disclosure of protected health information related to which of the following actions requires the patient's express written authorization?
A. State in which the treatment occurred
B. Health care operations
C. Treatment
D. Payment
Answer: A
Explanation: According to Title II of the Health Insurance Portability and Accountability Act, disclosure of protected health information related to the state in which the treatment occurred requires the patient's express written authorization. The Health Insurance Portability and Accountability Act declares that certain categories of information must be treated with special care. Besides the information listed in the other answer choices, HIP AA designates all names, geographic indicators smaller than a state, dates, phone numbers, email addresses, Social Security numbers, driver 's license numbers, IP addresses, biometric identifiers, photos, and other unique identifiers as protected health in formation.

Question No: 12
Which of the following groups is least likely to report errors?
A. Primary care physicians
B. Support staff
C. Independent contractors
D. Nurses
Answer: C
Explanation: Independent contractor s are the group least likely to report errors. In part, this is because they have the least personal interest in the success of the health care facility. Also, an independent contractor is more likely to view his or her employment as tenuous, and is therefore more nervous about admitting mistakes.

A system that explicitly avoids punishing those who report will improve the incidence of error reporting among independent contractors.

Question No: 13
Why does the Healthcare Quality Improvement Act provide confidentiality and legal immunity for health care peer review processes?
A. To prevent malpractice suits
B. To discourage complaints by patients
C. To encourage participation by physicians
D. To maintain a sterile work environment
Answer: C
Explanation: The Healthcare Quality Improvement Act provides confidentiality and legal immunity for health care peer review processes to encourage participation by physicians. When the law was being drafted, the American Medical Association argued that without these conditions, professionals would be reluctant to cooperate.

Question No: 14
Which type of subpoena calls for the delivery of certain documents to the court?
A. Subpoena habeas corpus
B. Subpoena ad testificandum
C. Subpoena ad infinitum
D. Subpoena duces tecum
Answer: D
Explanation: A subpoena duces tecum calls for the delivery of certain documents to the court. Health compliance officers are likely to field this sort of subpoena often. In a subpoena ad testiftcandum, the court demands that a specific person appear and give testimony. Any failure to comply with a subpoena may be defined as contempt of court, and may be punishable by fines or a prison sentence. Subpoena habeas corpus and subpoena ad infinitum are not legal terms. A writ of habeas corpus asserts that a person who has been arrested must be brought in front of a judge.

Question No: 15
Which of the following is generally NOT included in an explanation of benefits?
A. Date of service
B. Insurance code for services
C. Doctor's fee
D. Patient's medical history
Answer: D
Explanation: The patient's medical history is generally not included in an explanation of benefits. An explanation of benefits (EOB) form is typically sent to policyholders by an insurance company after the policyholder receives treatment. The explanation of benefits form will explain the elements of medical treatment that are covered by the health insurance policy. The form will usually include services performed, the date on which services were performed, the insurance code for services, the name of the service provider, the total cost of the medical service, and the proportion of the total fee covered by insurance. In many cases, an explanation of benefits will also describe any related insurance claims that have been denied.