Total Question: 130 QAs

1. While an answering service takes calls during the night, numerous patients have complained that telephone calls during working hours are often unanswered. The best solution for the office is likely to

A. hire another staff person to answer the telephone.

B. ask the answering service to answer after a specified number of rings. Correct

C. set a voice mail to answer the phone and instruct callers to call back.

D. have all calls go first to a voicemail system so people can leave messages.

If, while answering service takes calls during the night, numerous patients have complained that telephone calls during working hours are often unanswered, the best solution for the office is likely to ask the answering service to answer calls after a specified number of rings (usually 3 to 4). If an office has limited staff, the person who answers the call may need to assist the physician or may be on another line and unable to take a call.

2. If a patient in the waiting room is coughing and no examining rooms are available, the CMAA should

A. ask the patient to wait outside.

B. cancel and reschedule the appointment.

C. ask the patient to cover her mouth when coughing.

D. provide the patient with a face mask. Correct

If a patient in the waiting room is coughing, the CMAA should provide the patient with a face mask, explaining that the office policy is to ask all patients with a cough to wear one to prevent spread of infection. Droplets from cough can remain suspended for up to 10 minutes in the air. The patient should be moved to an examining room as soon as one is available to reduce the risk of exposure to others but should not be asked to wait outside.

3. OSHA's form 301 is used to

A. describe each workplace death/injury, what actually happened. Correct

B. list each workplace death/injury.

C. summarize the number of annual workplace deaths/injuries.

D. apply for waivers of responsibility.

OSHA's **form 301** is used to describe each workplace death/injury (what actually happened) in detail, including the date and time, the type of injury, the cause, the individuals involved, and a description of what the person was doing immediately before the incident. This form must be submitted to OSHA with one week of being notified of the death/injury. **Form 300** is a log used to list each workplace death/injury that occurs at a workplace. Form **300A** is an annual summary of all workplace deaths/injuries that have occurred.

4. An example of protected health information (PHI) includes

A. de-identified data regarding types of patients seen by a practice.

B. a patient's diagnosis. Correct

C. age range of patients seen by a physician.

D. sexual abuse of a child.

An example of protected health information includes a patient's diagnosis and any information regarding the patient's health condition or treatment, any identifying information, and any information regarding payment for healthcare that can identify the patient. The sexual abuse of a child must be reported to the appropriate authorities, such as Child Protective Services. Information that is shared, such as for research, must first be de-identified so that the information cannot be traced back to specific individuals.

5. If the physician has indicated on the patient's encounter form that the patient should return for a followup exam in one week but there are no appointment times available for one month, the CMAA should

A. double-book the patient.

B. make the appointment in one month.

C. ask the physician if the patient can wait one month. Correct

D. schedule the patient by phone after a cancellation.

If the physician has indicated on the patient's encounter form that the patient should return for a follow-up exam in one week but there are no appointment times available for one month, the CMA should ask the physician if the patient can wait one month. If not, then the patient should be double-booked but informed there might be a short wait at the visit. If a cancellation occurs, the patient can be rescheduled.

6. A commonly-used analgesic is

A. acetaminophen. Correct

B. furosemide.

C. penicillin.

D. atenolol.

A commonly-used analgesic is acetaminophen (Tylenol). Analgesics are medications used to control pain and may include over-the-counter drugs, such as acetaminophen and ibuprofen, and prescription drugs, such as codeine and morphine. Acetaminophen is often advised for mild to moderate pain and to control fever. It is generally a safe drug for both children and adults if dosage recommendations are followed. An overdose of acetaminophen can result in damage to the liver.

7. **The distal part of the arm is the part near the**

- A. shoulder area.
- B. upper arm
- C. elbow
- D. wrist and hand. Correct

The distal part of the arm is the part near the wrist and hand. Distal refers to furthest from the point of reference. With limbs, the distal part is toward the hand and foot and the proximal, which is closest to the point of reference, is toward the shoulder and hip. *Proximal* and *distal* are terms often used to describe the location of an injury or abnormality.

8. **When using a copier or scanner for medical records, it is essential to**

- A. place a basket near the machine to hold records waiting to be copied or scanned.
- B. make only a single copy of a record at a time.
- C. remove stored information from memory to prevent unauthorized access. Correct
- D. check the printer for equipment for ink when finished.

When using a copier or scanner for medical records, it is essential to remove stored information from memory to prevent unauthorized access. Most current equipment stores copies of documents scanned or copied. Records should never be left in a basket near the equipment for later scanning or copying. If possible, the equipment should require a password as this helps to trace use and determine who was copying or scanning and when.

9. If a new patient calls for an appointment and states that she has been experiencing heavier than usual periods with cramping for the past 3 months, the type of appointment would be categorized as

- A. urgent, acute problem/illness.
- B. new, non-urgent problem/illness. Correct
- C. routine.
- D. physical exam.

If a new patient calls for an appointment and states that she has been experiencing heavier than usual periods with cramping for the past 3 months, the type of appointment would be categorized as new, non-urgent problem/illness. Since this is an ongoing problem and the patient is unlikely at risk if the appointment is delayed, the patient can wait for an appointment time if necessary although the patient should be scheduled as soon as possible because "heavy period" can have different meanings to different people.

10. The ethical principles that states that actions should be carried out for the good of the patient is

- A. beneficence. Correct
- B. maleficence.
- C. justice.
- D. autonomy.

Beneficence is the principle that requires that actions should be carried out for the good (benefit) of the patient. **Maleficence** is the principle that requires that care should be provided in such a way as to avoid intentional harm. **Justice** requires that limited healthcare benefits be distributed fairly. **Autonomy** refers to the right that the individual has to make decisions about his or her own care, including the right to consent and to refuse care.

11. If three patients cancel appointments for the same morning, the best solution is to

A. leave the times free in case other patients call for appointments.

B. block out free time for the physician and staff.

C. reschedule afternoon patients to the free times so staff finishes early.

D. call those on the list for wanting an earlier appointment. Correct

If three patients cancel appointments for the same morning, the best solution is to call those on the list for wanting an earlier appointment and to reschedule three of them for the empty time periods. Most busy practices have patients who wanted earlier appointments but no earlier time periods were available at that time, so practices should keep a list of these patients and contact them when cancellations occur because cancelled result in wasted time and less income.

12. The type of healthcare insurance that pays in the form of predetermined payments for loss or damages rather than for healthcare services is

A. liability insurance.

B. no-fault auto insurance.

C. indemnity insurance. Correct

D. accident and health insurance.

Indemnity insurance pays in the form of predetermined payments for loss or damages rather than for healthcare service. **Liability insurance** pays damages for bodily injury or loss of property, such as from injury resulting from unsafe conditions. **No-fault auto insurance** pays for injury/damages resulting from driving a car with coverage varying according to state regulations. **Accident and health insurance** pays for healthcare costs and may or may not include disability payments, depending on the type of policy.

13. The vertical plane that separates anterior from posterior is the

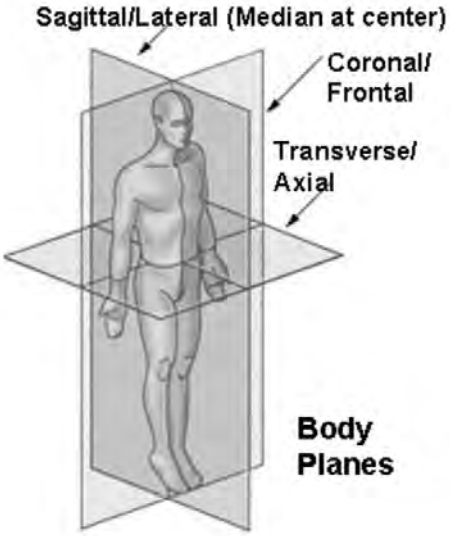
A. coronal/frontal. Correct

B. sagittal/lateral plane.

C. median/midsagittal plane.

D. axial/transverse.

The vertical plane that separates anterior (front) from posterior (back) is the coronal/frontal plane.



14. If the appointment matrix shows the following, what is the best time to schedule a new patient who calls at 8:00 AM on June 6 for an appointment to assess increasing edema (swelling) of the feet and mild shortness of breath?

Dr. Jones		
Hr.	June 6	June 7
8:00	Mrs. Smith—BP check	Staff meeting
8:10		" "
8:20	Miss Black--UTI	
8:30	" " " "	Mrs. Smythe--arthritis
8:40		" " " "
8:50	T. Bates—Med. followup	
9:00		S. Brown—post-op check
9:10		
9:20	B. Wood—Pap smear	

A. 8:10 June 6.

B. 8:20 June 7.

C. 8:50 June 7.

D. 9:00 June 6. Correct

If a new patient being scheduled is complaining of increasing edema (swelling) of the feet and shortness of breath, then the patient should be scheduled for longer than 10 minutes because the physician will need time to take a history and physical and to examine the patient to determine the likely diagnosis and best course of treatment. The first longer time period available begins at 9:00 AM on June 6. Because the patient is complaining of shortness of breath, the appointment should not be delayed until June 7.

15. If a physician informs the CMAA that she would like to have a conference call with three other physicians at 8:30 AM on the following Monday, the first thing the CMAA should do is to

A. gather all the telephone numbers for the physician.

B. contact all participants to confirm telephone numbers, date, and time. Correct

C. offer to take notes during the conference call.

D. inform other staff members the physician has scheduled a conference call.

If a physician informs the CMAA that she would like to have a conference call with three other physicians at 8:30 AM on the following Monday, the first thing the CMAA should do is to contact all participants to verify the correct telephone numbers, the data, and time to ensure that the others will be available and expecting the call. The CMAA should be sure to block out the time on the appointment matrix so that no patients are scheduled for the physician during the call.

16. The percentage of costs that the patient must pay is the

A. deductible.

B. copayment.

C. co-insurance. Correct

D. cap.

The percentage of costs that a patient must pay is the **co-insurance**. For example, if the insurance company pays 80%, then the co-insurance is 20%. In some cases, such as Medicare, the patient may carry a supplementary/secondary insurance that covers the co-insurance amount although the patient may still be required to pay a **deductible** (a dollar amount rather than a percentage amount). **Cap** refers to the maximum amount that an insurance carrier will pay. **Co-payment** is the specific dollar amount required for each visit or service.

17. The most effective method of decreasing no shows is to

- A. charge a fee for missed appointments.
- B. admonish the patients for missing appointments.
- C. remind the patients of appointments a day or two before. Correct
- D. avoid extended wait times.

The most effective method of decreasing no shows is to remind the patients of appointments a day or two before. Studies show giving reminders (usually by telephone or text message) often reduces the number of no shows by half. If, however, some patients still are no shows, many practices charge a set fee, such as $25 for a missed visit, but patients must be notified in advance (generally at the time the appointment is made) that a fee is charged for missed appointments.

18. A patient has come for a blood pressure check but states, "I think this is a waste of time!" When using the SOAP format, this statement would be documented in which section?

- A. Subjective. Correct
- B. Objective
- C. Assessment.
- D. Plan.

Subjective notes usually quote what the client states directly:" I think this is a waste of time!" **Objective** notes record what is observed, clinical facts: "Patient sitting with face flushed." **Assessment** relates to evaluation of subjective and objective notes: "Patient appears anxious and complains of being very busy at work. BP 132.86, P. 18." **Plan** is based on assessment: "Review medication list and instruct patient in self-monitoring of blood pressure."

19. If the physician has given the patient directions that state "Eye drops--gtt ii OD TID" and the patient asks what it means, the CMAA would reply,

A. "Administer eye drops with two drops in the left eye two times a day."

B. "Administer eye drops with two drops in the left eye three times a day."

C. "Administer eye drops with two drops in the right eye three times a day." Correct

D. "Administer eye drops with two drops in the right eye two times a day."

If the physician has given the patient directions that state "Eye drops--gtt ii OD TID" and the patient asks what it means, the CMAA would reply: ""Administer eye drops with two drops in the right eye three times a day." Roman numerals are often used in medical prescriptions, but sometimes in lower case—ii instead of II—because the dots help to reinforce the number.

Roman numerals (often used in prescriptions)	I = 1, V = 5, X = 10, L = 50, C = 100, D = 500, and M = 1000	IV = 4, V = 5, VII = 7, IX =9, XII = 12 XLII = 42

20. Which of the following is a legal document that must be retained for at least 5 years?

A. Appointment matrix.

B. Daily appointment schedule. Correct

C. Telephone message form.

D. Diagnostic procedure tracking log.

The daily appointment schedule is a legal document that must be retained for at least 5 years. The daily appointment

Jones Medical Practice

Daily appointment schedule for 2-8-19

Time	Name	Telephone #	Purpose	Notes
8:00	Telephone calls			
8:15	Review lab reports			
8:30	Simms, Sarah	866-4302	Recheck--BP	10 minutes late
8:45	Jackson, James	722-6685	PE--1 yr.	Fx'd rt. hip 8-18
9:00	" " " "	" " "		

schedule is a list of patients who are to be seen that day including contact information (telephone number) and the purpose of the visit. If created in a word processing program, it should be printed and any additions, deletions, or corrections made in permanent ink. The appointment schedule is used to pull medical records if the practice utilizes paper records or to access electronic records.

21. When a patient has two (or more) health plans, the CMAA should initially

- A. determine which plan provides best coverage.
- B. determine which plans provide primary and secondary (tertiary, etc.) coverage. Correct
- C. ask the patient to choose which plan to use.
- D. assume both plans will pay for coverage.

When patients have two or more health plans, the CMAA should initially determine which plan provides primary coverage and which secondary coverage and so on. Rules vary widely regarding the order of payment, so the CMAA may need to contact the health plans and determine the order of insurance responsibility on an individual basis. Double coverage is usually precluded, and the patient is often not able to choose. Medicare is primary over supplementary insurances, and private insurances are primary over Medicaid.

22. "H & P" in a medical record refers to

- A. healthcare provider.
- B. help and provisions.
- C. health priorities.
- D. history and physical. Correct

"H & P" in the medical record refers to history and physical. Other commonly used abbreviations include:

- Hx = history.
- Dx = diagnosis.
- Tx = Treatment
- I & O = intake and output.
- DOI = date of injury.
- DOB = date of birth.
- AMA = against medical advice.
- NKA = no known allergies.

23. Pre-testing instructions should be provided to the patient

- A. in printed form.
- B. verbally (in person or over the telephone).
- C. verbally (in person or over the telephone) and in printed form. Correct
- D. verbally and in printed form at the request of the patient.

Pre-testing instructions should be provided to the patient verbally in person or over the telephone and in printed form (paper or electronic). The CMAA must not assume that patients can read and understand printed instructions or will take the time to do so, but should always review instructions verbally with a patient and ask for feedback to ensure the patient understands. The instructions (verbal and printed) should be noted in the patient's medical record.

24. If a practice schedules 3 to 4 patients every hour so that they all arrive at the same time and are seen in the order in which they arrive, the type of scheduling utilized is

- A. fixed scheduled appointments.
- B. tidal wave/open hour booking.
- C. clustering.
- D. wave booking. Correct

Wave booking occurs if a practice schedules 3 to 4 patients every hour so that they all arrive at the same time and are seen in the order in which they arrive. With **fixed scheduled appointments**, each patient is generally scheduled to see the health provider at a specific time, such as at 9 AM, and no other patient is scheduled at the same time. With **tidal wave/open hour booking**, anyone can come during a specified time period and be seen on a first-come, first-served basis or according to acuity. With **clustering**, only one type of patient or those having similar procedures are scheduled during a block of time.

25. If a practice that carries out HIV/AIDS testing uses an alphanumeric code instead of the patient's name for testing, this code is referred to as a(n)

- A. secret code.
- B. unique identifier. Correct
- C. alternate name.
- D. confidential identifier.

If a practice that carries out HIV/AIDS testing uses an alphanumeric code instead of the patient's name for testing, this code is referred to as a unique identifier because each patient is given a different code and uses that rather than the patient's name. Unique identifiers are often used to encourage members of key populations, such as sex-workers and drug abusers, to have testing when their concerns about confidentiality may otherwise prevent them from doing so.

26. Which of the following terms refers to a physician who specializes in care, treatment and surgery of musculoskeletal problems?

- A. Orthopedist. Correct
- B. Radiologist.
- C. Rheumatologist.
- D. Physiatrist.

Orthopedist refers to a physician who specializes in care, treatment and surgery of musculoskeletal problems, such as bone fractures and skeletal abnormalities. A **radiologist** is a physician who specializes in imaging, such as x-rays, CTs, and MRIs, used to detect diseases and abnormalities. A **rheumatologist** is a physician who specializes in the care and treatment of those with rheumatic diseases or conditions with generalized inflammation and pain and stiffness of muscles and joints. A **physiatrist** is a physician who specialized in physical medicine and rehabilitation.

27. The protective strategy for insurance companies that involves limiting the maximum dollar benefits for a policy is a

A. reinsurance.

B. deferred liability.

C. cap. Correct

D. third-party liability.

The protective strategy for insurance companies that involves limiting the maximum dollar benefits for a policy is a cap. Caps may vary depending on the type of insurance. A routine accident and health benefits plan for one person may set a specific dollar maximum for that person, but a family plan may set a plan cap for the entire family and individual caps. Automobile insurance that covers bodily injury also usually has a category cap (such as $1 million for bodily injury) and per person caps (such as $250,000 per person), so one injured person cannot receive the entire amount.

28. If a patient cancels an appointment, this cancellation must be documented in

A. the appointment matrix.

B. the appointment matrix, the daily appointment schedule, and the patient's medical record. Correct

C. the medical record.

D. the appointment matrix and the patient's medical record.

If a patient cancels an appointment, it should be noted in the appointment matrix and the daily appointment record by crossing the appointment time out in red and writing "cancelled" or "C" and signing. The cancellation should also be reported in the patient's medical record along with the reason if known. This is especially important if the patient develops complications because of the missed appointment. However, if the patient simply reschedules, this information does not need to be noted in the medical record.

29. A patient with autism becomes very distressed and disruptive if made to wait for extended times for an appointment but dislikes getting up early in the morning. If appointments are scheduled in 15-minute increments between 8:00 and 4:00 PM with an hour break from noon to 1:00 PM, what is the best time to schedule the patient?

A. 8:00 AM.

B. 11:45 AM.

C. 1:00 PM. Correct

D. 3:45 PM.

The two best times to schedule a patient to avoid extended wait times is the first appointment of the day (8:00 AM) and first appointment after lunch (1:00 PM). Because this patient does not like to get up early in the morning, the early AM appointment should be avoided and the patient scheduled for 1:00 PM. If wait time is inevitable, the patient may cope better if placed in an examining room rather than left in the waiting area.

30. A fee schedule generally contains

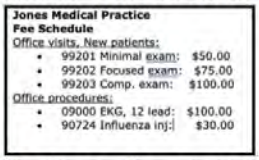
A. names of procedures and charges.

B. names of procedures, charges, and ICD-10-CM codes.

C. ICD-10-CM codes, CPT codes, names of procedures, and charges.

D. names of procedures, charges, and CPT codes. Correct

A fee schedule should contain a list of procedures, the providers charges, and the appropriate CPT codes. The fee schedule should mirror the charges listed on the encounter form.



Jones Medical Practice
Fee Schedule

Office visits, New patients:
- 99201 Minimal exam: $50.00
- 99202 Focused exam: $75.00
- 99203 Comp. exam: $100.00

Office procedures:
- 09000 EKG, 12 lead: $100.00
- 90724 Influenza inj: $30.00

A practice may, in fact, collect different fees depending on the insurance carrier. Medicare, for example, may only pay a percentage of the fee and many insurance companies negotiate discounts. This means that, effectively, a practice may have many actual fee schedules when discounts and contractual agreements are considered.

31. When an insurance plan negotiates a specific fee for a procedure (including all charges) and pays one bill, this is referred to as

A. unbundling.

B. bundling. Correct

C. fee-for-service.

D. discounted fee-for-service.

Bundling occurs when an insurance plan negotiates a specific fee for a procedure, including all associated costs, and pays one bill. **Unbundling** occurs when a bundled agreement is dissolved, and the insurance plan pays separate bills (hospital, anesthesiologist, surgeon, etc.). **Fee-for-service** is the traditional billing method in which services are billed for separately. **Discounted fee-for-service** is similar to fee-for-service except that reimbursements are discounted.

32. Because a patient has missed two appointments, the physician instructs the CMAA to tell the patient no appointment times are available the next time the patient calls for an appointment. This is an example of

A. abandonment. Correct

B. negligence.

C. termination.

D. malpractice.

If, because a patient has missed two appointments, the physician instructs the CMAA to tell the patient no appointment times are available the next time the patient calls for an appointment, this is an example of abandonment. If a patient is to be terminated from a practice, the patient must be sent written notice explaining the reason and allowing the patient to make other arrangements for care.

33. The type of managed care plan that allows a patient to see physicians and care providers within a network but to seek outside treatment in some circumstances is

A. health maintenance organization (HMO).

B. exclusive provider organization (EPO).

C. point of service plan (POS). Correct

D. preferred provider organization (PPO).

A point of service plan (POS) is a structure that combines aspects of an HMO with a PPO. Patients are able to receive care from healthcare providers within the network or may seek treatment outside the network in some circumstances. This type of plan offers more flexibility to the patient, but usually there are additional costs when a patient chooses to seek treatment outside of the network. Co-payments may increase and the percentage of costs covered by the plan may decrease.

34. If appointments must be cancelled because the physician is having surgery for removal of a tumor, patients should be advised that

A. the physician is having surgery to remove a tumor.

B. the physician is unavailable. Correct

C. the physician is ill.

D. the office must cancel appointments.

If appointments must be cancelled because the physician is having surgery for removal of a tumor, patients should be advised that the physician is unavailable. Giving no reason is frustrating to patients, but giving details about the physician's illness, or even the fact that the physician is ill, is a violation of the physician's right to privacy under HIPAA regulations. If patients have acute problems or the physician will be unavailable for a prolonged period, then recommendations for obtaining medical care elsewhere should be provided.

35. The Centers for Disease Control and Prevention is commonly referred to as the

- A. CDCP
- B. DCP.
- C. CCP.
- D. CDC. Correct

The Centers for Disease Control and Prevention, a federal agency under the Department of Health and Human Services, is commonly referred to as the CDC. The CDC leads the government efforts at prevention of illness and health promotion. The CDC collects data regarding infectious diseases and investigates and helps to develop methods to control outbreaks and promote public health. The CDC provides information about infectious disease for the public and for healthcare practitioners.

36. If a physician states that she wants a procedure carried out "STAT," this means

- A. immediately. Correct
- B. after a meal.
- C. as needed.
- D. per injection.

If a physician states that she wants a procedure carried out "stat," this mean immediately. For example, the physician may want diagnostic tests to be carried out stat or medications administered stat. Other commonly-used abbreviations include:

- prn = as needed
- ac = before meals
- pc =after meals
- PO = by mouth
- ASAP = as soon as possible.

37. **The government entity that requires that personal protective equipment be readily available at the worksite and in appropriate sizes is the**

A. CDC.

B. FDA.

C. OSHA. Correct

D. CMS.

OSHA sets and enforces regulations related to workplace safety. In healthcare, this encompasses bloodborne pathogens, hazardous materials and hazardous wastes, and compressed gases and air equipment. OSHA also establishes lifting limits and ergonomic guidelines to minimize the risk of injury. Compliance officers can take complaints and issue citations for those out of compliance.

38. **If a patient needs preauthorization for an MRI, the CMAA should generally**

A. telephone the insurance company and request preauthorization.

B. fill out the preauthorization form and fax it to the insurance company. Correct

C. ask the patient to contact the insurance company regarding preauthorization.

D. ask the physician to call the insurance company for preauthorization.

If a patient needs preauthorization for an MRI, the CMAA should generally fill out the preauthorization form and fax it to the insurance company. This is more efficient than telephoning because the insurance company needs the information on the form, which usually contains the patient's name and demographic information, information about the healthcare provider, patient preliminary diagnosis and diagnostic code, information about the insurance plan, planned procedure and appropriate codes, amount of patient's copayment and/or deductible, hospital benefits, and contact information.