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-ofpocket 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 sates 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 o 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