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Medical

OCS

Ophthalmic Coding Specialist

Question: 38
Which of the following is always the payer of last resort?

A. Medicare
B. Medicaid
C. Worker's Compensation Insurance
D. Commercial Insurance

Answer: B

Medicaid is always the payer of last resort. This means that if a patient has more than one type of insurance coverage, and one of the insurances is Medicaid, then the biller must bill the other insurance first and Medicaid second. Medicaid will never pay first, if the patient has more than one type of insurance coverage.

Question: 39
HCPCS J-Codes are used to represent:

A. Drugs administered by methods other than the oral method
B. Durable medical equipment
C. Dental procedures not found in the CPT manual
D. Temporary national codes for Medicare

Answer: A

HCPCS J-Codes are used to represent drugs administered by methods other than the oral method. The J-codes are used to bill drugs administered to the patient, while in the office. Other sections in the HCPCS manual represent durable medical equipment and temporary national codes. Dental procedures are not represented at all in the CPT manual, and are reported with D-codes.

Question: 40
What does HIPAA stand for?

A. Health Insurance Portability and Accountability Act
B. Health Insurance Protection and Accountability Association

C. Health Insurance Post-Payment Auditing Association
D. Health Insurance Accountability and Auditing Act

Answer: A

HIPAA stands for Health Insurance Portability and Accountability Act. HIPAA is an Act of Congress, not an association or organization. Those that do not follow HIPAA requirements can be prosecuted. HIPAA also joins with other organizations to ensure that everyone involved in patient healthcare follow its stipulations.

Question: 41
Appendix 1 in the HCPCS Level II manual contains:

A. An alphabetized list of HCPCS modifiers
B. A table of drugs
C. A list of changes, additions, and deletions
D. A short list of CPT codes to use with HCPCS codes

Answer: B

Appendix A in the HCPCS Level II manual contains a table of drugs. This table lists all of the drugs in alphabetical order and can be found in the HCPCS manual. The listings are also organized according to the drugs administration route and unit information.

Question: 42
In order for a physician to appropriately code for a consultation service, three things must be documented. What are those three things?

A. The referral or request from the PCP, the rendering of the opinion by the specialist or consultant, and the written report or findings sent from the specialist to the PCP
B. The rendering of the specialty service to the patient, the referral of the patient from the specialist to an additional specialist, and the written report of the findings provided to the specialist

C. The specialist request of a second opinion regarding the patient, the PCP's advice regarding which second specialist the patient should see, and the second specialist's report or findings
D. The referral from the PCP to the specialist, an additional referral from the specialist to another specialist, and the written report or findings sent from the specialist to the PCP

Answer: A

In order for a physician to appropriately code for a consultation service, three things must be documented. These three things are: the referral or request from the PCP, the rendering of the opinion by the specialist or consultant, and the written report or findings sent from the specialist to the PCP. These three things can be easily remembered by the "Three R's:" "Referral to Specialist," "Rendering of Service" and "Report to PCP."

Question: 43
When listing both CPT and HCPCS modifiers on a claim, you:

A. List the HCPCS modifier first
B. Do not list the HCPCS modifier at all
C. Only list the CPT modifier
D. List the CPT modifier first

Answer: D

When listing both CPT and HCPCS modifiers on a claim, you list the CPT modifier first. When you report a procedure code with more than one modifier, you must list the modifier that will affect the payment first on the claim. Typically, CPT modifiers will affect the payment of a claim, but HCPCS modifiers may not.

Question: 44
In the RBRVS calculation, the GPCI takes into account:

A. The geographic location of a practice or provider
B. The type of provider specialty

C. The malpractice risk of a procedure
D. The overhead cost of the practice

Answer: A

In the RBRVS calculation, the GPCI takes into account the geographic location of a practice or provider. GPCI stands for Geographic Practice Cost Index, and it takes into account the relative price differences in geographical location. The GPCI is a part of the RBRVS (Resource Based Relative Value Scale), which calculates a reasonable fee for procedures.

Question: 45
HIPAA was created to:

A. Protect patient privacy
B. Enact ways to uncover fraud and abuse
C. Create standards of electronic transactions
D. All of the above
E. Only options A and B

Answer: D

All of the above, HIPAA was created to protect patient privacy, enact ways to uncover fraud and abuse, and to create standards of electronic transactions. HIPAA protects patient privacy through its strict standards of confidentiality, allows organizations like the OIG to uncover fraud and abuse, and gives these organizations the power to investigate and prosecute suspected fraud and abuse cases. HIPAA also creates standards of electronic transactions, such as the ANSI 5010 update and requires encryption and passwords on websites that contain patient data.

SAMPLE QUESTIONS

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