Council for Certification of Medical Auditors, Inc.

CMAS Exam Practice Exercises – Series 1

2015-2016 Edition

Practice Exercises Series 1

Suggested reference or reading materials posted here were current at the time this document was prepared.
To access the CMS Web-based Training Courses, open the link below, scroll down to the bottom of the page and look for the Web-Based Training (WBT) Courses. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html

Core domain:	**CMAS BOK 02:** Medical Audit Process and Methodology ***02.02: Audit Process, Work Flow and Audit Findings***
Sub-domain:	02.02.06 Assign/validate ICD-9-CM codes/ICD-10-CM codes 02.02.07 Assign/validate MS DRG codes 02.02.08 Assign/validate E and M codes 02.02.19 Assign/validate CPT codes 02.02.23 Assign/validate HCPCS II
Suggested Reference Material(s):	• Medicare site: http://www.cms.gov/Medicare/Medicare.html - look for coding • CDC Coding website: http://www.cdc.gov/nchs/icd.htm • CMS Web-based Training Courses: Diagnosis Coding Using the ICD-9-CM • CPT - Current Procedural Terminology: go to the ama.org website • Place of Service Codes for Professional Claims: http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

Test your **Coding Knowledge**. Which codes apply to the coding system noted below.

A. CDT: Current Dental Terminology
B. CPT: Current Procedural Terminology
C. E and M: Evaluation and Management Code
D. E and M: Evaluation and Management Code with Modifier
E. HCPCS: Healthcare Common Procedure Coding System
F. ICD-10-CM: International Classification of Diseases, 10th Revision, Clinical Modification
G. ICD-10-PCS: International Classification of Diseases, 10th Edition, Procedure Coding System
H. ICD-9-CM: International Classification of Diseases, 9th Revision, Clinical Modification, Diagnosis Code
I. ICD-9-CM: International Classification of Diseases, 9th Revision, Clinical Modification, Procedure Code
J. MS-DRG: Medicare Severity Diagnosis Related Group
K. Place of Service Codes for Professional Claims

	1. 047K0ZZ – Dilation of right femoral artery, open approach
	2. 248 - Percutaneous Cardiovascular Procedure with Non Drug-Eluting Stent with MCC or 4+ Vessels/Stents
	3. 43.5 – Partial gastrectomy with anastomosis to esophagus
	4. 745.3 - Bulbus cordis anomalies and anomalies of cardiac septal closure, common ventricle
	5. 78459 - Myocardial imaging, positron emission tomography (PET), metabolic evaluation
	6. 99217 - Hospital observation discharge management code
	7. 99283 (-25) - significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service
	8. L89.133 – Pressure ulcer of right lower back, stage III
	9. P9022 - Red blood cells, washed, each unit
	10. 22- Outpatient Hospital: A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

Answers: (1)G; (2) J; (3) I; (4)H; (5)B; (6) C; (7)D; (8)F; (9)E; (10)K

The transition from the decades-old Ninth Edition of the International Classification of Diseases (ICD-9) set of diagnosis and inpatient procedure codes to the Tenth Edition code sets—or ICD-10 will be implemented on:

A. October 1, 2013
B. January 1, 2014
C. October 1, 2014
D. January 1, 2015

Answer: C

Core domain:	CMAS BOK 04: Medical Audit Environment
Sub-domain:	04.01.01: National Healthcare Billing Audit Guidelines
Suggested Reference Material(s):	National Health Care Billing Audit Guidelines Website: http://www.aamas.org/news/natl-audits-guidelines.html

According to the National Healthcare Billing Audit Guidelines, a billing audit conducted before the issuance of an interim or final bill is referred to as:

A. Concurrent audit
B. Contract compliance audit
C. Pre-certification audit
D. Retrospective audit

Answer: A

In which condition would a State and/or contractual agreements supersede HIPAA regulations?

A. If the contractual agreement includes a provision that contractors representing the audit company require employees complete an annual 16 hour continuing education training on HIPAA
B. If the facility being audited is a Critical Access Hospital
C. If the State complies with the Healthcare Reform Act
D. If the State or contractual agreement with regard to confidentiality requirements are more stringent or limiting in disclosure than the HIPAA

Answer: D

Core domain:	CMAS BOK 02: Medical Audit Process and Methodology 02.02 Audit Process, Work Flow and Audit Findings
Sub-domain:	02.02.09: Apply official coding rules
Suggested Reference Material(s):	Medicare Claims Processing Manual Chapter 25 - Completing and Processing the Form CMS-1450 Data Set CMS Web-based Training Courses: • Diagnosis Coding Using the ICD-9-CM • Acute Inpatient Prospective Payment System (IPPS) Hospital • Uniform Billing (UB)-04

Principal inpatient diagnosis is defined as:

A. The diagnoses that the utilization nurses write in their concurrent review sheet
B. The diagnosis that has been optimized by the DRG grouper
C. The condition which utilized the most resources while inpatient
D. The condition established after study to be chiefly responsible for the admission of the patient to the hospital

Answer: D

Core domain:	CMAS BOK 02: Medical Audit Process and Methodology *02.02 Audit Process, Work Flow and Audit Findings*
Sub-domain:	02.02.04 Apply third party payment rules
Suggested Reference Material(s):	• Health Insurance Glossary: http://www.nccn.com/component/content/article/58/101-health-insurance-glossary.html; http://www.cigna.com/health-care-glossary • Medicare and You: http://www.medicare.gov/Pubs/pdf/10050.pdf

The portion of a covered medical expense an insured individual or family must pay before the Health Plan pays their share of the expense.

A. Coinsurance
B. Copayment
C. Deductible
D. Referral

Answer: C

Core domain:	CMAS BOK 02: Medical Audit Process and Methodology 02.02 Audit Process, Work Flow and Audit Findings
Sub-domain:	02.02.10: Assign/validate revenue codes
Suggested Reference Material(s):	• CMS Web-based Training Courses: Uniform Billing (UB)-04 • UB-04 Overview: http://www.cms.gov/Outreach-and-Education/Medicare-Learnir Network-MLN/MLNProducts/downloads/ub04_fact_sheet.pdf • Chapter 25 of the *Medicare Claims Processing Manual*, Internet-Only Manual Publication (IOM Pub) 100-04: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf

Charges for operating specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders would be reported using Revenue Code:

A. 073X Electrocardiogram
B. 074X Electroencephalogram
C. 090X Electroshock treatment
D. 092X Electromyelgram

Answer: B

Core domain:	CMAS BOK 02: Medical Audit Process and Methodology 02.01: Investigate and Verify Charges Against Medical Record Documentation
Sub-domain:	02.01.02: Physician
Suggested Reference Material(s):	Global Surgery Fact Sheet: http://www.cms.gov/Outreach-and-Education/Medicare-Le Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf

Which of the following statements is NOT an accurate description of the global surgical package (also called global surgery)?

A. Global surgery applies in any setting, including an inpatient hospital, outpatient hospital, Ambulatory Surgical Center, and physician's office.
B. Physicians who furnish the surgery and furnish all of the usual pre-and post-operative work may bill for the global package.
C. The global surgical package includes all necessary services normally furnished by a surgeon before, during, and after a procedure.
D. Visits to a patient in an intensive care or critical care unit are not included in the global surgical package if made by the surgeon.

Answer: D

Core domain:	CMAS BOK 02: Medical Audit Process and Methodology 02.02: Audit Process, Work Flow and Audit Findings
Sub-domain:	02.02. 05: Review/audit accuracy of UB-04
Suggested Reference Material(s):	• CMS Web-based Training Courses: Uniform Billing (UB)-04 • UB-04 Overview: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ub04_fact_sheet.pdf • Chapter 25. *Medicare Claims Processing Manual*, Internet-Only Manual Publication (IOM Pub) 100-04

Revenue codes are codes that identify the specific type of service being billed by line item (e.g., room and board, IV therapy/supplies, and ancillary service). Revenue codes are billed using which form:

A. Uniform Bill-04 (UB-04) or CMS-1450
B. Advanced Beneficiary Notice (ABN)
C. CMS Form 1500
D. Certificate of Medical Necessity (CMN)

Answer: A

Core domain:	CMAS BOK 02: Medical Audit Process and Methodology 02.03: Other Relevant Medical Audit Responsibilties
Sub-domain:	02.03.07: Apply regulatory and legislative policies in medical audit activity
Suggested Reference Material(s):	CMS Web-based Training Courses • Acute Inpatient Prospective Payment System (IPPS) Hospital: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AcutePaymtSysfctsht.pdf

The following services are covered and included in payment under Inpatient Prospective Payment System (IPPS) when deemed to be medically reasonable and necessary:

1. Bed and board, use of hospital facilities and medical social services
2. Drugs, biologicals, supplies, appliances, and equipment such as pacemakers, prosthetic devices, and artificial limbs
3. Physician services and outpatient hospital services furnished incident to physician's services
4. Routine nursing services and other related services

A. 1 only
B. 1 and 4
C. 1, 2 and 4
D. 2, 3, and 4

Answer: C

Core domain:	CMAS BOK 02: Medical Audit Process and Methodology 02.02: Audit Process, Work Flow and Audit Findings
Sub-domain:	02.02.21 Apply Correct Coding Initiative rules
Suggested Reference Material(s):	• Medicare Coding National Correct Coding Policy Manual Chapter V: Surgery • National Correct Coding Initiative Edits: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html • How to Use the National Correct Coding Initiative (NCCI) Tools: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools-.pdf • http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MCRP_Booklet.pdf

Patient Z presented with aspiration of a foreign body. A bronchoscopy was performed identifying lobar foreign body obstruction, and an attempt was made to remove this obstruction bronchoscopically. How should this be billed?

A. Bill using CPT code 31622: diagnostic bronchoscopy
B. Bill using CPT code 31635: surgical bronchoscopy with removal of foreign body
C. Bill using CPT code 92511: nasopharyngoscopy with endoscope
D. Bill using CPT codes 31622: diagnostic bronchoscopy and 31635: surgical bronchoscopy with removal of foreign body

Answer: B

Which type of edits for certain HCPCS/CPT code are the maximum units of service that a provider would report, under most circumstances, for a single beneficiary on a single date of service.

A. Beneficiary Billing Edits
B. Correct Coding Edits
C. Medically Unlikely Edits
D. Diagnosis to Procedure Edits

Answer: C

Core domain:	CMAS BOK 02: Medical Audit Process and Methodology 02.03: Other Relevant Medical Audit Responsibilities
Sub-domain:	02.03.04 Apply medical necessity rules in audit activity
Suggested Reference Material(s):	Medicare FFS 2011 CERT Report: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/2011-Medicare-FFS-Improper-Payment-Report-.pdf

Choose the best answer. Claims are placed into this category when medical reviewers receive adequate documentation from the medical records submitted and can make an informed decision that the services billed were not meeting medical or clinical coverage policies

A. Incorrect Coding
B. Insufficient Documentation
C. Medical Necessity
D. No Documentation

Answer: C

Core domain:	CMAS BOK 04: Medical Audit Environment
Sub-domain:	04.01.08: Health Insurance Portability and Accountability Act (HIPAA)
Suggested Reference Material(s):	HIPAA - General Information: http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/index.html CMS Web-based Training Courses • Health Insurance Portability and Accountability Act (HIPAA) EDI Standards

The HIPAA Health Insurance Reform under Title II, the Administrative Simplification provisions, requires the Department of Health and Human Services (HHS) to:

1. address the security and privacy of health data.
2. Investigates entities who knowingly submit a false or fraudulent claim.
3. establish national identifiers for providers, health plans, and employers.
4. establish national standards for electronic health care transactions and code sets.

A. 1 only
B. 2 and 3
C. 1, 3 and 4
D. 1, 2, 3 and 4

Answer: C

Covered under the HIPAA Health Insurance Reform is the term **Electronic Data Interchange EDI,** commonly described as

A. the adoption of social networking methods in communicating healthcare related information such as Facebook, Twitter and others.
B. the mandatory use of electronic health records between patients and healthcare insurers.
C. the provision for incentive payments for Medicare eligible professionals who are meaningful users of certified electronic health record technology.
D. the transfer of information such as health care claims and supplemental information in a standard format.

Answer: D

Core domain:	CMAS BOK 04: Medical Audit Environment
Sub-domain:	04.01.09: Medicare/Medicaid Policies 04.01.11 Medicare Integrity Program
Suggested Reference Material(s):	CMS Web-based Training Courses • World Of Medicare • Your Institution in the World of Medicare • Your Office in the World Of Medicare • Medicare Fraud & Abuse: Prevention, Detection, and Reporting

Find the best description of the following government programs listed in items A through F.

A. Comprehensive Error Rate Testing (CERT) Contractor
B. Office of Inspector General (OIG)
C. Qualified Independent Contractor (QIC)
D. Quality Improvement Organization (QIO)
E. Medicare Fee-For-Service Recovery Audit Program
F. Zone Program Integrity Contractors (ZPICs)

	1.	Perform functions to ensure the integrity of the Medicare Program. Their primary goal is to identify cases of suspected fraud.
	2.	Protects the integrity of Department of Health and Human Services (HHS) programs and the health and welfare of the beneficiaries of those programs through a nationwide network of audits, investigations, inspections, and other related functions.
	3.	Works with consumers, physicians, hospitals, and other caregivers to ensure that beneficiaries receive the right care at the right time. They also investigate beneficiary complaints about quality of care and safeguard the integrity of the Medicare Trust Fund by ensuring that payment is made only for medically necessary services.
	4.	Responsible for identifying improper Medicare payments made to health care providers that were not detected through existing program integrity efforts.
	5.	Measures and improves the quality and accuracy of Medicare Fee-For-Service (FFS) claims submission, processing, and payment by reviewing a random sample of submitted claims and medical records.

Answers: (1) F; (2) B; (3) D; (4) E; (5) A

Core domain:	CMAS BOK 01: Professional Standards and Audit Behavior
Sub-domain:	01.01.02 Integrate code/standards of conduct policies in performance of medical audit activity 01.01.05 Apply principles of objectivity in performance of medical audit activity 01.01.07 Apply principles of independence in performance of medical audit activity
Suggested Reference Material(s):	Government Auditing Standards: http://www.gao.gov/assets/590/587281.pdf

Which of following statements BEST describe the generally accepted government auditing standards (GAGAS)?

1. It provides a framework for conducting high quality audits with competence, integrity, objectivity, and independence.
2. It contains requirements and guidance to assist auditors in objectively acquiring and evaluating sufficient, appropriate evidence and reporting the results.
3. It contains requirements and guidance dealing with ethics, independence, auditors' professional judgment and competence, quality control, performance of the audit, and reporting.
4. It summarizes new/ongoing monitoring and audit activities the government plans to pursue with respect to preserving the Medicare Trust Fund and prevent fraud, waste and abuse.

A. 1 and 2
B. 2 and 4
C. 1, 2, and 3
D. 2, 3 and 4

Answer: C

Core domain:	**CMAS BOK 02: Medical Audit Process and Methodology** **02.05: Compliance and Special Investigations**
Sub-domain:	02.05.05: Investigate compliance reports and issue
Suggested Reference Material(s):	CMS Web-based Training Courses • Medicare Fraud & Abuse: Prevention, Detection, and Reporting • Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians • Medicare Parts C and D Fraud, Waste and Abuse Training • Medicare Parts C and D General Compliance Training

Which of the statements below is **NOT** an accurate description of the law or statute used to address Medicare fraud and abuse?

A. The Anti-Kickback Statute prohibits offering, paying, soliciting, or receiving any remuneration in exchange for referrals of Federal health care program business.
B. The Criminal Health Care Fraud Statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain any of the money or property owned by, or under the custody or control of, any health care benefit program.
C. The Exclusion Statute prohibits the excluded entity from participation in all Federal health care programs. No payment will be made for services provided by excluded parties except in very limited circumstances.
D. The Stark Law allows physicians to refer patients for certain designated health services to an entity in which the physician (or an immediate family member) has an ownership/investment interest or with which he or she has a compensation arrangement.

Answer: D

Core domain:	**CMAS BOK 02: Medical Audit Process and Methodology** **02.01: Investigate and verify charges against medical record documentation**
Sub-domain:	02.01.02: Physician; 02.01.03 Outpatient Hospital; 02.01.01: Inpatient Hospital

A provider was paid $500.00 for a transthoracic echocardiography with contrast, real time with exercise stress test. After receiving additional documentation, the auditor determined the diagnostic study was performed without using contrast material. Which of the following would the auditor choose in documenting his/her findings?

A. Incorrect Coding
B. Insufficient Documentation
C. Medically Unnecessary Services
D. No Documentation

Answer: A

An audit of a physical therapy provider revealed 25 visits for Patient M. On medical review, it was noted that the documentation did not include the order, plan of care signed by the ordering physician, or treatment notes on the last 10 visits. Which of the following would the auditor choose in documenting his/her findings?

A. Incorrect Coding
B. Insufficient Documentation
C. Medically Unnecessary Services
D. No Documentation

Answer: B

The auditor reviewed the NICU charges for Baby Jane with the following information shown below. Medical record review showed that Baby Jane roomed-in with the mother until discharge. Which of the following would the auditor choose in documenting his/her findings?

42 REV. CD.	43 DESCRIPTION
175	NEONATAL INTENSIVE CARE UNIT
250	GENERAL PHARMACY
270	MEDICAL/SURGICAL SUPPLIES
300	GENERAL LABORATORY
320	GENERAL RADIOLOGY
380	BLOOD GENERAL
410	RESPIRATORY SERVICES

A. Incorrect Coding
B. Insufficient Documentation
C. Medically Unnecessary Services
D. No Documentation

Answer: D