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1. In a ______________ system the health care provider charges and is paid for each item of service provided.
   a. prospective payment
   b. fee-for-service
   c. capitation
   d. per diem

   ANSWER: b

2. Which of the following is NOT one of the administrative simplification provisions of HIPAA?
   a. EDI
   b. Privacy
   c. Security
   d. PPS

   ANSWER: d

3. A(n) _________ links data provided by various health care providers.
   a. HIE organization/RHIO
   b. patient-focused record
   c. fee-for-service network
   d. prospective payment system

   ANSWER: a

4. A longitudinal patient record documents a patient’s health status, conditions, and treatments ______________________________.
   a. using electronic signals to transmit clinical information from one site to another
   b. throughout the patient’s life
   c. in a prospective payment system
   d. throughout the patient’s residence in a particular community

   ANSWER: b

5. The State Children’s Health Insurance Program (SCHIP or CHIP) is __________________.
   a. a private health insurance program with variable coverage from state-to-state
   b. a Medicare Part A program for uninsured children
   c. a Medicare Part D program for uninsured children
   d. a joint state-federal program providing insurance for lower income children not covered by Medicaid

   ANSWER: d

6. Under HIPAA, it is permissible to use or disclose PHI without a specific written authorization when it is necessary for _____________________.
   a. treatment
   b. payment
   c. health care operations
   d. all of the above
   e. none of the above

   ANSWER: d

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7. This part of Medicare is optional insurance coverage available to all Medicare beneficiaries designed to lower prescription drug costs.
   a. Part B
   b. Part A
   c. None of the above
   d. Part D
   e. Part C

   ANSWER: d

8. This part of Medicare is also known as Medicare Advantage.
   a. Part A
   b. Part B
   c. Part C
   d. Part D
   e. None of the above

   ANSWER: c

9. This law, passed in 2010, expanded Medicaid eligibility requirements.
   a. American Recovery and Reinvestment Act (ARRA)
   b. Children's Health Insurance Program (CHIP)
   c. Hill-Burton Act
   d. Health Information Technology for Economic and Clinical Health Act (HITECH)

   ANSWER: b

10. A program designed by CMS to recover improper Medicare payments is named ________________.
   a. Recovery Audit Contractor (RAC)
   b. Pay-for-performance (P4P)
   c. Quality improvement organization (QIO)
   d. Clinical documentation improvement (CDI)

   ANSWER: a

11. Under this type of program, reimbursement may be rewarded or penalized based upon the provider's ability to meet pre-established targets for delivery of health care services.
   a. Pay-for-performance (P4P)
   b. Zone Program Integrity Contractors (ZPICs)
   c. Quality improvement organization (QIO).
   d. Clinical documentation improvement (CDI)

   ANSWER: a

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12. This legislation amends the HIPAA privacy and security rules.
    a. Hill-Burton Act
    b. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
    c. Health Information Technology for Economic and Clinical Health Act (HITECH)
    d. Clinical documentation improvement (CDI)

    ANSWER: c

13. Under this care model, the primary care physician acts as a “gatekeeper” to coordinate the patient care across providers by addressing preventive, acute, and chronic care needs and by providing the patient with access to electronic tools.
    a. Health information exchange organization
    b. Patient-centered medical home model
    c. Pay-for-performance (P4P)
    d. Patient safety organization (PSO)

    ANSWER: b

14. This program was developed by The Joint Commission to help accredited health care institutions focus upon specific patient safety concerns.
    a. National Quality Forum (NQF)
    b. Quality Improvement Organization (QIO)
    c. National Patient Safety Goals (NPSG)
    d. Patient Safety Organization (PSO)

    ANSWER: c

15. This federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information was mandated in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009.
    a. Office of the National Coordinator for Health Information Technology (ONC)
    b. Nationwide Health Information Network (NHIN)
    c. Centers for Medicare and Medicaid Services (CMS)
    d. Institute of Medicine

    ANSWER: a

16. Americans have heavily depended on hospitals for lifesaving health care since the 1700s.
    a. True
    b. False

    ANSWER: False

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17. The American College of Surgeons was one of the first organizations to establish standards for hospitals.
    a. True
    b. False

    ANSWER: True

18. The purpose of the Hill-Burton program in the mid-twentieth century was to decrease the number of hospital beds in over served areas.
    a. True
    b. False

    ANSWER: False

19. Part A of Medicare pays for hospital inpatient care, home health care, skilled nursing care, and hospice care.
    a. True
    b. False

    ANSWER: True

20. Federal and state governments jointly fund the Medicaid program.
    a. True
    b. False

    ANSWER: True

21. In a prospective payment system, the health care provider charges and is paid for each item of service provided.
    a. True
    b. False

    ANSWER: False

22. The administrative simplification provisions of HIPAA deal with insurance portability, fraud and abuse, and medical liability reform.
    a. True
    b. False

    ANSWER: False

23. A per diem method of payment means that the provider is paid based on the number of persons the provider agrees to treat.
    a. True
    b. False

    ANSWER: False

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24. Medicare pays skilled nursing facilities, home health providers, inpatient rehabilitation hospitals, and long-term care hospitals under prospective payment systems.
    a. True
    b. False

    ANSWER: True

25. A Health Information Exchange links data provided by various health care providers.
    a. True
    b. False

    ANSWER: True

26. The patient-centered medical home unnecessarily fragments care among disconnected providers resulting in a lack of care coordination.
    a. True
    b. False

    ANSWER: False

27. Telemedicine involves transmitting medical information back and forth between patient and physician in separate locations by electronic means such as video, electronic mail, telephone, or satellite.
    a. True
    b. False

    ANSWER: True

28. A personal health record is a paper-based health record that is protected from disclosure to those outside the facility that created it.
    a. True
    b. False

    ANSWER: False

29. Changes in health care delivery have caused health information management professionals to focus more narrowly on acute inpatient settings.
    a. True
    b. False

    ANSWER: False

30. Under Part C, beneficiaries pay a monthly premium for the insurance plan, in addition to their Part B premium
    a. True
    b. False

    ANSWER: True

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31. Under the American Recovery and Reinvestment Act (ARRA), providers that fail to demonstrate meaningful use for health information technology will be financially penalized.
 a. True
 b. False

 ANSWER: True

32. ______ involves the use of robotic technology to assist with or perform procedures remotely.

 ANSWER: Telesurgery

33. The ____________________ program was implemented by CMS to identify and investigate malicious fraudulent claims activity within Medicare's seven geographic regions (zones).

 ANSWER: Zone Program Integrity Contractor
 ZPIC

34. _____________________________________ is the federal agency within the Department of Health and Human Services that administers the Medicare and Medicaid programs.

 ANSWER: Centers for Medicare and Medicaid Services
 CMS

35. The ____________________ program is designed to recover improper Medicare payments.

 ANSWER: Recovery Audit Contractor
 RAC

36. A(n) ____________________________ is a partner or contractor performing a job or service on behalf of a covered entity.

 ANSWER: business associate

37. A(n) ___________________________________ is a locally implemented program focused upon improving the quality of clinical documentation to facilitate an accurate representation of health care services through complete and accurate reporting of diagnoses and procedures.

 ANSWER: clinical documentation improvement program

38. A(n) ______________________________ system is one in which a health care provider maintains individual patient health records electronically

 ANSWER: electronic health record

39. _____________________________________ is the electronic movement of health-related information among organizations according to nationally recognized standards.

 ANSWER: Health information exchange
 HIE

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40. __________________________________ is a general term referring to electronic health records and related information systems to manage health care processes.

ANSWER: Health information technology
HIT

41. The Joint Commission created a ______ program to help accredited health care institutions focus upon specific patient safety concerns.

ANSWER: National Patient Safety Goals

42. Under ___________, providers are paid based on the number of patients they agree to treat, rather than on the number of services they provide. Therefore, it is more profitable to the provider if the patient requires fewer services.

ANSWER: capitation

43. ______ provides medical assistance to lower-income individuals and families. Federal and state governments jointly fund this program.

ANSWER: Medicaid

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Match each item with the description below.

a. Health Insurance Portability and Accountability Act (HIPAA)

b. American Recovery and Reinvestment Act (ARRA)

c. Hill-Burton Act

d. Medicare Prescription Drug, Improvement, and Modernization Act

e. Patient Protection and Affordable Care Act (PPACA)

f. Health Information Technology for Economic and Clinical Health Act (HITECH)

g. Medicaid Integrity Program (MIP)

h. Zone Program Integrity Contractors (ZPICs)

44. Enacted in 2009 and also known as the “Stimulus Act,” its main purpose was to create jobs and stimulate economic growth; however, it contained many provisions for health care, including billions of dollars for health information technology.

ANSWER: b

45. Enacted as part of the “Stimulus Act” in 2009 to promote the adoption and meaningful use of health information technology, this legislation amended the HIPAA privacy and security rules by introducing additional privacy regulations, breach notification rules, and stiffer civil and criminal penalties for security violations.

ANSWER: f

46. Also known as the “Hospital Survey and Construction Act,” enacted by Congress in 1946, this legislation provided federal money to determine the need for more hospitals and to pay for their construction.

ANSWER: c

47. This legislation made significant revisions to the Medicare program by calling for the creation of Part D, e-prescribing for prescription drug plans, revision of claims processing, and a Medicare payment recovery demonstration project.

ANSWER: d

48. Also known as “Health Reform,” this legislation contained a number of health care provisions, including an expansion of Medicaid eligibility requirements and increased quality reporting requirements for health care providers.

ANSWER: e

49. This program focuses on Medicaid overpayments.

ANSWER: g

50. This identifies and investigate malicious fraud within seven geographic zones.

ANSWER: h

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Match each item with the description below.

a. Patient safety organizations (PSO)

b. Office of the National Coordinator for Health Information Technology (ONC)

c. Health information exchange organizations

d. Regional extension centers (REC)

e. Recovery audit contractors (RAC)

f. Quality improvement organizations (QIO)

51. A third-party entity working under the direction of CMS to detect improper Medicare payments through review of providers' medical records and Medicare claims data.

ANSWER: e

52. Non-profit organizations called for by ARRA and initially funded by federal grants to provide health information technology support to providers to help them become meaningful users of certified electronic health record technology.

ANSWER: d

53. Private, mostly not-for-profit organizations staffed by professionals trained to review medical care and help beneficiaries with complaints about the quality of care and to implement improvements in the quality of care available throughout the spectrum of care.

ANSWER: f

54. Organizations that can work with clinicians and health care organizations to identify, analyze, and reduce the risks and hazards associated with patient care.

ANSWER: a

55. An entity that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards, often used synonymously with regional health information organization (RHIO).

ANSWER: c

56. How does a clinical documentation improvement program help health care facilities?

ANSWER: A clinical documentation improvement program is facilitates accurate documentation, coding, and reporting of quality data. Accurate clinical documentation can positively affect reimbursement, severity of illness and mortality risk assessment, and reporting of quality and pay-for-performance measures.

57. What is HITECH and how did it affect regulations regarding protected health information?

ANSWER: HITECH was passed in 2009 as Title XIII of the American Recovery and Reinvestment Act (ARRA). In addition to implementing the electronic health record incentive program, HITECH amended the HIPAA privacy and security rules by introducing additional privacy regulations, breach notification rules, and stiffer penalties for security violations. HITECH, along with the Genetic In-formation Nondiscrimination Act of 2008 (GINA), were intended to clarify the information protected under the HIPAA Privacy Rule and to prohibit most providers and health plans from inappropriately disclosing information for non-medical purposes. It required that entities utilizing EHRs to provide patients with an electronic copy of their protected health information upon request.

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58. Describe the difference between licensure and accreditation.

ANSWER: Licensure is a governmental process that requires that a facility meet certain regulations set by the state in order to provide care. Many government and private payers require licensure as a condition of enrollment in their program. Health care organizations also choose to pursue accreditation, which is a voluntary process in which facilities agree to follow a set of standards and receive recognition for having met those standards.

59. Describe what a Health Information Exchange (HIE) is and think critically based on your understanding of the technology to provide at least one example suggesting how such a system could benefit a patient.

ANSWER: Health information exchange (HIE) is a process that has been defined as “the electronic movement of health-related information among organizations according to nationally recognized standards.”An HIE organization “over-sees and governs the exchange of health-related information among organizations ac-cording to nationally recognized standards.” This term has often been used synonymously with regional health information organization (RHIO), which is a “health information organization that brings together health care stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving health and care in that community.”

60. Describe what a personal health record (PHR) is and three attributes that make them useful for patients.

ANSWER: It is “an Internet-based set of tools that allows people to access and coordinate their life-long health information and make appropriate parts of it available to those who need it.” The Markle Foundation goes on to describe the following attributes of a PHR:

- Each person controls his or her own PHR. Individuals decide which parts of their PHR can be accessed, by whom, and for how long.
- PHRs contain information from one’s entire lifetime.
- PHRs contain information from all health care providers.
- PHRs are accessible from any place at any time.
- PHRs are private and secure.
- PHRs are “transparent.” Individuals can see who entered each piece of data, where it was transferred from, and who has viewed it.
- PHRs permit easy exchange of information with other health information systems and health professionals

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61. What benefits does telemedicine provide for a patient?

ANSWER: With the advent of telemedicine, patients and clinicians separated by distance can interact with one another electronically. In a real-time telemedicine session, the patient is generally in a remote location from the physician and receives medical care via an audio-visual connection with a provider located off-site and directly by the provider at their location. Store-and-forward telemedicine is a term used to describe services in which medical information is captured electronically and transmitted to a remote site for a health care provider to review, analyze or report at a later time. Use of technologies and devices to remotely monitor a patient's condition is referred to as telehealth. Remote physiological monitoring and medication adherence remote monitoring are also examples of telehealth services.

Telemedicine provides patients with access to physicians and services that they might not have the ability to receive otherwise.

62. According to Chapter 1, list four key principles for Medicare/Medicaid standards:

ANSWER:

- Assuring that Medicare and Medicaid are properly administered by their contractors and state agencies
- Establishing policies for the reimbursement of health care providers
- Conducting research on the effectiveness of various methods of health care management, treatment, and financing
- Assessing the quality of health care facilities and services

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63. Describe the differences between Medicare Parts A, B, C and D.

ANSWER: Part A: Hospital Insurance
Part B: Medical Insurance
Part C: Medicare Advantage
Part D: Prescription Drug Coverage.

- Part A helps pay for hospital inpatient care, some home health care, skilled nursing care, and hospice care.
- Part B provides coverage for physician services, hospital outpatient services, some home health care, medical equipment and supplies, and other health services.
- With Part C, or Medicare Advantage, the beneficiary purchases a health insurance plan offered by one of the private companies approved by Medicare. These plans may offer coverage for services excluded by Parts A and B, but the premiums, out-of-pocket expenses, and rules for coverage vary by plan. Under Part C, beneficiaries pay a monthly premium for the insurance plan, in addition to their Part B premium.
- Part D, created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), is optional insurance coverage available to all Medicare beneficiaries that is designed to lower prescription drug costs. Medicare beneficiaries pay a monthly premium for the Parts B and D benefits, but not for Part A. Beneficiaries may opt to purchase a managed care plan to provide their health care services and prescription drugs.

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