Revenue cycle management

Deadline: Postmarked no later than January 1, 2016
Credit: 1 AAMA CEU (gen/adm) #128916

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Continuing education test

Directions: Determine whether each of the following statements is true (T) or false (F) based on information derived from the article.

1. The revenue cycle for health care providers is defined as the timing and amount of revenue received, whether from third-party payers or directly from patients. T F
2. Fee-for-service reimbursement is based on quantity of care, and value-based reimbursement is based on quality and cost of care. T F
3. Medicare reimbursements are determined by Congress, and therefore value-based reimbursement principles cannot be incorporated into the Medicare system. T F
4. Patient satisfaction is an important goal for all health care providers, but it is not a factor in value-based reimbursement. T F
5. The terms of the contracts with third-party payers, and the practice’s technological capabilities, are major elements of predicting and managing revenue flows. T F
6. A deductible is the amount the health insurer pays before the patient becomes responsible for payment. T F
7. For high-deductible policies, the health care provider must put more emphasis on collecting patient balances at the back end of the transaction. T F
8. Because of the possibility of a breach of database security, a medical office should not keep credit card information on file. T F
9. Patients’ credit card and other financial information is much different from patients’ medical information, and therefore is not “protected health information” under the Health Information Portability and Accountability Act (HIPAA). T F
10. ICD-10 is a high-level system that puts less emphasis on detailed information, and more emphasis on general information and trends, compared with ICD-9. T F
11. Crosswalk charts linking ICD-9 to ICD-10 codes should be readily available to all staff, and not just to personnel who have coding and billing responsibilities. T F
12. State licensing laws forbid a medical office staff member from offering financial advice to patients about how to best pay for their medical care. T F
13. Providers should resubmit denied claims to find out why they were denied, even if they do not prevail in getting the denial reversed. T F
14. In a concierge practice model, patients pay a fixed fee each year, quarter, or month, and are not charged for individual office visits and some tests and services. T F
15. Maximizing revenue and minimizing costs are not ultimate goals of a medical practice, but rather means to the ultimate goal, which is providing excellent patient care. T F
16. Combination codes under ICD-10 are limited to one diagnosis, but can express many elements of the one diagnosis. T F

Continuing education application

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