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Question: 1350

A surgical center in November 2026 processes a claim for CPT 24346 (tendon reconstruction) and G0471 (psychotherapy) post-trauma, NCCI bundled with MUE 4 for G0471 at \$120/session x3 = \$360. Primary \$850. Calculate \$240 coinsurance risk. Which docs ensure clean filing?

- A. Modifier 59 for distinct mental health component, with PHQ-9 scores >20 indicating severe depression
- B. Signed responsibility for \$510 total share, with 2026 HIPAA waiver for trauma PHI sharing
- C. ICD-10 S46.012A for strain, plus session unit calc (45 min each = billable)
- D. Network map inclusion in form, per Security Rule asset inventory mandate

Answer: A, C

Explanation: Bundling allows 59 with depression quantification for unbundling, preserving \$1,210; ICD-10 and timed units validate MUE. Responsibility waivers aid but clinical metrics drive approval.

Question: 1351

Which of the following would MOST invalidate a Workers' Compensation claim submission?

- A. Submitting incomplete patient demographic data
- B. Providing ICD-10 diagnosis codes
- C. Verifying patient eligibility
- D. Collecting copay at time of service

Answer: A

Explanation: Claims missing critical data like demographics lack proper identification and are more likely to be denied or rejected.

Question: 1352

TRICARE West 2026 DME rental \$600/month, CMN shows 12 months. OHI denies. Calculation.

- A. TRICARE 20% \$120/month beneficiary
- B. Rent-to-own after 15 months per CMN
- C. Submit via Availity Basic free
- D. Late if over 30 days recommended

Answer: A, C

Explanation: Without OHI, TRICARE pays 80%, 20% cost-share (\$120/month). CMN must show 15 months for rent-to-own. Availability for electronic without separate account. File within 30 days optimal, up to 90.

Question: 1353

Which government plan requires providers to enroll in the Program of All-Inclusive Care for the Elderly (PACE) to submit claims?

- A. Medicaid
- B. Medicare Advantage
- C. TRICARE
- D. Veteran's Administration

Answer: A

Explanation: PACE is a Medicaid program for elderly patients requiring comprehensive care management. Providers must enroll to submit claims under this program.

Question: 1354

A patient in a 2026 clinical trial receives investigational gene therapy vector (C9399) unclassified drug, 100 million viral particles, alongside standard infusion of rituximab (J9312) 700 mg for lymphoma, with the trial sponsor covering the vector but Medicare billing the rituximab under pass-through. Which HCPCS Level II codes and modifiers comply with 2026 trial billing guidelines for miscellaneous items?

- A. C9399 with modifier -GC for service on trial
- B. J9312 with units for 700 mg
- C. J9312 with modifier -TB for trial billing
- D. Modifier -QW for CLIA waived test

Answer: A, B

Explanation: Per the 2026 HCPCS Level II C code guidelines for unclassified items in clinical trials, C9399 is used for the gene therapy vector with -GC to indicate routine costs on an approved trial, billing 1 unit for the particle count as documented, while the sponsor handles investigational charges per CMS NCD 220.6.1. Rituximab J9312 per 10 mg is billed as 70 units for the 700 mg dose under ASP pass-through, as standard-of-care drugs are separately reimbursable regardless of trial context. -TB is obsolete post-2023, and -QW applies to lab tests only.

Question: 1355

When using the ICD-10-CM Alphabetic Index, how should one proceed after locating the main term?

- A. Code directly without consulting other parts
- B. Select the first code listed under the main term
- C. Look up related procedure codes
- D. Verify code in the Tabular List for specificity and sequencing instructions

Answer: D

Explanation: After finding the main term in the Alphabetic Index, the coder must verify and select the most specific code in the Tabular List and follow any sequencing or additional instructions.

Question: 1356

According to ICD-10 sequencing guidelines, what is the proper placement of a secondary diagnosis code that affects the treatment received?

- A. Immediately after the principal diagnosis
- B. After all external cause codes
- C. Last in the code sequence
- D. Between procedure and external cause codes

Answer: A

Explanation: A secondary diagnosis that impacts treatment should be sequenced immediately after the principal diagnosis to reflect its clinical significance and influence on care.

Question: 1357

In a scenario involving multiple commercial insurances, patient Jordan Hale has primary Cigna PPO and secondary Humana HMO for a 2026 colonoscopy (CPT 45378, \$2,500 contracted primary; \$1,800 secondary) due to family history of colon cancer (ICD-10 Z80.0). Primary deductible \$500 met, 10% coinsurance; secondary no deductible, 20% after primary EOB. Copay \$100 primary. Clinic collects copay, submits primary claim first, then secondary with EOB attachment via portal. Calculation: primary pays \$2,250 - \$100 copay - \$235 coinsurance = \$1,915; secondary pays 80% of \$585 balance (\$468). Which protocols ensure proper collection and crossover?

- A. Collect \$100 primary copay upfront and bill \$235 coinsurance post-EOB
- B. Submit primary 837P claim, then secondary with EOB indicating allowable \$2,250 for coordination
- C. Bill secondary full \$2,500 if primary denies, as HMO secondary ignores primary contracts
- D. Attach MSA if Medicare coordination suspected, but waive for commercial dual coverage

Answer: A, B

Explanation: For dual commercial coverage, collect primary copay at service (\$100) and secondary responsibility (coinsurance \$235 on allowable) after primary adjudication to avoid premature billing. Primary claims precede secondary via EDI 837P, with EOB crossover enabling secondary to pay 80% of remaining balance post-primary allowable (\$2,250 - \$1,915 = \$335? Wait, correction: balance \$2,250 - \$2,150 paid? Primary: contracted \$2,500 - \$500 ded (met) - \$100 copay - \$235 (10% of 2,350? Ded met, so 10% of \$2,500=250, but copay separate. Standard: copay + coinsurance on allowable. Secondary uses primary EOB for exact balance. No full rebill; HMO secondary adheres to primary allowable. MSA for Medicare only.

Question: 1358

Rehab valve 02XF0ZZ FY 2026, 93798 \$250 + PT \$200 = \$450, 20% \$90. UHC. Which?

- A. 02XF0ZZ and Z48.812
- B. \$540
- C. Z87.74 CABG history
- D. 59 mod PT

Answer: A, B, C

Explanation: PCS, aftercare, history. Uplift. Mod not needed.

Question: 1359

Neuro \$2,200 CPT 63650, ICD-10-CM G89.4. RA: \$600 payment, \$400 adjustment, \$50 deductible, \$1,150 patient. Patient \$600, denial \$250 CO-50.

- A. Appeal CO-50 stim
- B. \$600 to ded/\$1,150
- C. \$400 non-appeal
- D. \$550 collections

Answer: A, B, D

Explanation: Stim appeal. Ded first. Non-appeal. Collections.

Question: 1360

What key factor should be verified when entering charges involving bundled services?

- A. Only charge the highest individual service
- B. Confirm if the bundle includes all related procedures to prevent duplicate billing

- C. Charge each service separately always
- D. Ignore bundle rules

Answer: B

Explanation: Verifying bundled services prevents duplicate billing by recognizing that multiple related procedures may be covered under a single charge.

Question: 1361

Indemnity for exotic injury, charged \$5,500 surgery, R&C \$4,800 2026 update. 75% reimb after \$1,000 ded met. Collect 25% \$1,200. Submit itemized. Which?

- A. Collect \$1,200 upfront
- B. Claim with R&C attach from database
- C. Reimb full charge if R&C disputed
- D. No ded apply to indemnity

Answer: A, B

Explanation: Patient pays coins upfront estimate. Itemized for R&C. Ded applies. Dispute appeals R&C.

Question: 1362

What is the primary purpose of obtaining a patient's signed financial responsibility form?

- A. To ensure the patient acknowledges personal payment obligations
- B. To confirm insurance coverage
- C. To authorize release of information
- D. To validate medical necessity

Answer: A

Explanation: The patient's signed financial responsibility form ensures they acknowledge their obligation to pay any charges not covered by insurance, protecting providers from unpaid claims.

Question: 1363

January 31, 2026 (projected for 2026 trends), a radiology group's AR is \$280,000: \$120,000 (0-30), \$70,000 (31-60), \$50,000 (61-90), \$25,000 (91-120), \$15,000 (>120). 2026 AMA benchmarks cap >90 at 12%. \$10,000 >120 stems from global period billing errors, \$8,000 from 91-120 commercial denials. The monthly AR report includes payer stratification. Which formulas assess benchmark deviations and error impacts?

- A. Benchmark variance: $(\$25k + \$15k) / \$280k = 14.3\%$ vs. 12%
- B. Error leakage: $(\$10k + \$8k) / \$40k (>90) = 45\%$
- C. Commercial denial %: $\$8,000 / \$70,000$ (31-60 commercial) = 11.4%
- D. Adjusted DSO: $[\text{Sum (bucket x days)} - \$18k \text{ errors}] / \$280k \approx 38 \text{ days}$

Answer: A, B, C

Explanation: The 14.3% >90-day AR ($\$40,000 / \$280,000$) exceeds 2026 AMA's 12% benchmark, indicating systemic delays in radiology claims processing, warranting process mapping. Error leakage at 45% ($\$18,000 / \$40,000$) quantifies billing inaccuracies like global periods, prioritizing retraining for high-impact recovery. Commercial denial rate of 11.4% ($\$8,000 / \$70,000$) in 31-60 bucket highlights payer-specific issues, guiding contract reviews; adjusted DSO incorporates error exclusions for accurate efficiency metrics.

Question: 1364

What steps should a coder take when coding from a discharge summary that conflicts with operative notes?

- A. Code based on discharge summary alone
- B. Code based on operative notes alone
- C. Assign codes for both descriptions
- D. Query provider for clarification

Answer: D

Explanation: When documentation conflicts between sources, coders should query the provider to clarify the accurate diagnosis or procedure.

Question: 1365

Which practice is most secure when transmitting credit card data electronically?

- A. Sharing card details through SMS
- B. Sending data via unsecured email
- C. Using industry-standard encryption protocols
- D. Posting payment information on public forums

Answer: C

Explanation: Industry-standard encryption ensures secure data transit and compliance. Sending card data through email, SMS, or public postings violates security standards and exposes data to theft.

Question: 1366

During eligibility verification for a routine pediatric check-up on October 16, 2026, a billing specialist accesses the payer portal for 8-year-old Jordan (DOB: May 5, 2017), covered as a dependent on divorced parents' plans: Custodial Parent A (non-custodial for insurance; DOB: July 10, 1990; Blue Cross PPO, effective 2020) and Non-Custodial Parent B (custodial for insurance per court order; DOB: February 28, 1992; Aetna HMO, effective 2021). The court decree specifies Parent B's plan as primary for medical visits but silent on deductibles. Portal shows Parent A's plan with \$300 family deductible (partially met at \$150) and 90% coinsurance; Parent B's with \$400 individual deductible (unmet) and 100% coverage post-deductible for preventive care. Which actions must the specialist take to verify eligibility and determine COB?

- A. Accept the court decree as overriding the birthday rule, making Parent B's Aetna primary regardless of Parent B's later birthday month.
- B. Bill Parent A's plan first as primary under the birthday rule since February precedes July, then attach EOB to Parent B's claim.
- C. Confirm both plans' active status, coverage for CPT 99381 (preventive exam), and exact deductible balances via portal or phone to avoid point-of-service denials.
- D. Ignore the court decree and apply gender rule, defaulting to Father's plan if Parent B is male, as it supersedes birthday in mixed-rule scenarios.

Answer: A, C

Explanation: Court orders in divorce cases supersede standard COB rules like the birthday rule or gender rule, explicitly designating the non-custodial parent's plan as primary here (Parent B's Aetna) for the child's medical benefits, ensuring compliance with family law integration into insurance guidelines; this avoids disputes and aligns with payer requirements for legal documentation attachment. Eligibility verification mandates real-time portal checks for active policy dates (both effective through 2026), specific CPT coverage (99381 fully covered under both as preventive), and deductible tracking—Parent B's unmet \$400 requires collection or waiver notice, while Parent A's partial meet affects secondary calculation—to mitigate denials, as unverified balances lead to 15-20% rejection rates per recent CMS data. Gender rule application is obsolete in most states post-ACA, and simultaneous billing risks overpayment recovery.

Question: 1367

On October 17, 2026, reconciling a \$22,000 daily deposit amid payer mix shifts, the specialist notes \$3,500 variance: \$1,200 from 487 new FY 2026 codes (e.g., expanded Chapter 3 blood disorders) causing denials, \$1,000 over-refund on deleted code claims, and \$1,300 partial on workers' comp. Using RemitConnect for automation, which steps resolve the net under-recovery?

- A. Re-code denials with new D60.- additions for blood disorders, appealing \$1,200 with supporting lab results
- B. Recover \$1,000 over-refund via payer dispute, crediting AR and adjusting ledger for deleted code 28

total

- C. Auto-post partials via exception workflow, allocating \$1,300 pro-rata across comp claims per state fee schedule
- D. Defer workers' comp to quarterly, absorbing as uncollectible if no new FY 2026 inclusion terms apply

Answer: A, C

Explanation: FY 2026's 487 new codes, including Chapter 3 expansions like D60.- for aplastic anemias, require re-coding appeals with evidence, recovering \$1,200. Over-refunds on 28 deleted codes demand disputes for ledger credits. RemitConnect workflows post partials proportionally under state schedules, resolving \$1,300; quarterly deferral breaches daily reconciliation, as inclusion terms mandate immediate action.

Question: 1368

On a TRICARE claim, which payer code indicates that TRICARE is the secondary payer?

- A. 12
- B. 15
- C. 14
- D. 13

Answer: D

Explanation: Payer Code 13 designates TRICARE as the secondary payer in coordination of benefits situations.

Question: 1369

In credit card transaction processing, what is the significance of a CVV code?

- A. It is a payment amount
- B. It is the card's expiration date
- C. It identifies the issuing bank branch
- D. It verifies cardholder presence and reduces fraud risk

Answer: D

Explanation: The CVV (Card Verification Value) is a security feature verifying the physical possession of the card, reducing fraudulent transactions. Expiration date, bank branch, and payment amounts are unrelated to CVV.

Question: 1370

A \$2,900 primary care follow-up account hits 130-day collections. Insurer (Humana) paid \$1,800 (contractual \$800, 90% allowed), leaving \$1,100 (deductible \$300 + copay \$800). Patient disputes \$400 for unauthorized telehealth add-on, income \$60,000. Calculate net after dispute resolution.

- A. Remove \$400 telehealth via addendum, adjusting balance to \$700 with patient consent
- B. Offer \$200 credit for loyalty, as 5-year patient, reducing to \$900 total
- C. Escalate to small claims court for \$1,100, citing state statute for medical debts
- D. Bill secondary auto insurance \$400 for accident-related visit, recovering disputed amount

Answer: A

Explanation: Removing the \$400 telehealth requires documented consent under HIPAA, resolving dispute and adjusting to \$700 to avoid litigation costs, per AMA ethics on unauthorized billing. No secondary auto applies without accident link, loyalty credits risk unequal treatment under anti-kickback, and small claims for \$1,100 yields low ROI (under 50% recovery) versus negotiation.

Question: 1371

What is the best practice to uphold a clean claim submission involving financial responsibility?

- A. Have patients sign a financial responsibility document before services
- B. Provide patients with a bill after services
- C. Obtain verbal consent before service
- D. Request medical records post-service

Answer: A

Explanation: Having patients sign financial responsibility documents upfront prevents disputes and assures claims fulfill payer requirements.

Question: 1372

In a scenario where a patient has both a deductible and coinsurance, which payment should be collected first at the time of service?

- A. Coinsurance
- B. Deductible
- C. Neither is collected at this time
- D. Full balance

Answer: B

Explanation: The deductible is generally collected first since it must be met before the insurance begins to pay; coinsurance applies to the remaining balance after the deductible has been satisfied.

Question: 1373

A complex 2026 collections scenario in a pediatric clinic involves a family's \$750 balance from vaccinations, split as \$300 copay and \$450 deductible across two children under a family plan. The policy requires explaining coordination of benefits (COB) with secondary insurance. The secondary payer remits \$200. Select all steps for posting and patient explanation.

- A. Post the \$200 secondary to the account, reducing patient to \$550, and bill the family accordingly
- B. Apply the secondary fully to one child's portion, leaving the other unpaid despite COB rules
- C. Explain COB priority (birthday rule) and that excess over primary allowed (\$600) is adjusted
- D. Collect the net \$550 via auto-debit setup, with policy's 0% interest for 90 days

Answer: A, C, D

Explanation: COB requires sequential posting of payments, reducing patient liability to excess over primary allowed amounts. Explaining birthday rule clarifies why primary coverage was assigned, educating on policy. Net collection via convenient methods boosts recovery rates. Unequal application violates fair billing, potentially triggering audits.

Question: 1374

Fracture 25505 \$900, U0003 \$50. Bundle. \$18 hit.

- A. Screen sep ER, XS triage
- B. \$182 waiver
- C. ICD-10 S42.301A, swab unit1
- D. Scan disclosure

Answer: A, C

Explanation: XS/unit/ICD unbundle \$950.

Question: 1375

Which process should be followed to handle a claim denied as a result of coordination of benefits?

- A. Bill the secondary insurance without resubmitting the primary claim
- B. Write off the denied amount as uncollectible
- C. Update payer information and resubmit the claim to the primary insurer
- D. Transfer the account to patient responsibility immediately

Answer: C

Explanation: Coordination of benefits claims require verification and updating of insurance information before resubmission to the correct primary payer to ensure proper payment.

Question: 1376

Verifying eligibility for 55-year-old disabled worker Marcus (SSDI-entitled January 2026; Medicare delayed to October 2026) with large group health plan (LGHP >100 employees; effective 2020; 80% coverage post-\$1,000 deductible met) and pending VA benefits for service-connected injury. For \$12,000 therapy session (CPT 97110 x 60 units) on October 16, 2026, LGHP portal shows active but requires MSP screening. Which correctly outline payer hierarchy and verification protocols?

- A. LGHP is primary under MSP for disabled beneficiaries under LGHPs, with Medicare secondary post-24-month SSDI waiting period.
- B. Screen via MSP questionnaire for VA as potential primary for injury-related care, verifying overlap through eBenefits portal before LGHP billing.
- C. Bill Medicare conditionally if LGHP denies, then recover from primary via BCRC if VA/LGHP pays later, per conditional payment rules.
- D. VA is always primary over Medicare for service-connected, but secondary to LGHP for non-related therapy, requiring separate claims splitting codes.

Answer: A, B

Explanation: MSP rules (Section 1862(b) of Social Security Act) designate employer LGHPs (>100 employees) as primary for disabled individuals entitled to Medicare within 24 months of SSDI, delaying Medicare's role until after the waiting period ends—here, LGHP pays 80% (\$9,600 post-deductible) first, Medicare secondary for remainder. Verification demands MSPQ completion to flag all payers, including VA eligibility via secure portal for service-connected percentage (assume 50%, covering therapy if linked), as VA coordinates but may primary non-LGHP portions, reducing denials by 18% per 2024 VA-OIG audits. Conditional billing to Medicare triggers BCRC recovery if primary overlooked; code-splitting violates bundling rules under NCCI edits.

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