Council for Certification of Medical Auditors, Inc.

CMAS Exam Practice Exercises – Series 2

2015-2016 Edition

Practice Exercises Series 2

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 03: Audit Skill *03.02: Specific Knowledge and Skill Set*
Sub-domain:	03.02.02 Problem Solving
Suggested Reference Material(s):	This is simple mathematical item. Review any basic Finance book of your choice.

"A patient requested an audit of his hospital bill, which totaled $37,100.00. On review you find some errors as follows:"

Charge Description	Unsupported charges	Under/unbilled charges
Nasal Bone X-ray	$00.00	$150.00
Thyroid Scan	$180.00	$00.00
CT Scan of Head	$00.00	$00.00
Echocardiogram	$00.00	$00.00
Echo-Encephalogram	$00.00	$00.00
Total	$180.00	$150.00

The net result of this audit is:

A. $150.00 overcharged
B. $30.00 overcharged
C. $30.00 undercharged
D. $180.00 undercharged

Answer B

After the audit, the adjusted bill amount is:

A. $37,000.00
B. $37,110.00
C. $37,700.00
D. $37,070.00

Answer D

Core domain:	CMAS BOK 02: Medical Audit Process and Methodologyl *02.02: Audit Process, Work Flow and Audit Findings*
Sub-domain:	02.02.15 Use statistically generated audit samples
Suggested Reference Material(s):	Medicare Program Integrity Manual Chapter 8 – Administrative Actions and Statistical Sampling for Overpayment Estimates http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c08.pdf

What type of sampling method is described in the below sample?

A sample with size one-tenth of the frame size is desired, select a random number between one and ten, say that it is "6", and then select every tenth unit thereafter, i.e., "16, 26, 36, …etc." until the maximum unit number in the frame has been exceeded.

A. Cluster Sampling
B. Simple Random Sampling
C. Stratified Sampling
D. Systematic Sampling

Answer: D

Core domain:	CMAS BOK 03: Audit Skill *03.02: Specific Knowledge and Skill Set*
Sub-domain:	03.02.02 Problem Solving
Suggested Reference Material(s):	This is simple mathematical item. Review any basic Finance book of your choice.

A payor based auditor reviews a hospital inpatient account with a total amount billed out on the UB of $272,655.34. The following final adjustments are to be made to the account based on the auditor's findings:

Revenue Code	Overcharge	Undercharge	Unbilled
250Pharmacy	$2,543.65	$195.63	$45.12
301/Lab/Chemistry	$985.65		
390/Blood Storage & Process	$365.00		
410/Respiratory	$86.00		
636/Drugs/Detail Code	$13,265.97		
730/EKG/ECG	$175.00		
Totals	$17,421.27	$195.63	$45.12

Based on the above findings:

The net result of this audit is: A. $195.63 undercharged B. $17,180.52 overcharged C. $17,421.27 overcharged D. $17,662.02 overcharged	After the audit, the adjusted bill amount is: A. $290,314.36 B. $254,993.32 C. $255,234.07 D. $255,474.82
Answer: B	Answer: D

Core domain:	CMAS BOK 02: Medical Audit Process and Methodology *02.05: Compliance and Special Investigations*
Sub-domain:	02.05.09: Interpret/apply/disseminate laws and other mandates
Suggested Reference Material(s):	• Comprehensive Error Rate testing Program (CERT): open here • Overview of Improper Payment Reviews Conducted by Medicare & Medicaid Review Contractors: open here

According to the Improper Payment Elimination and Recovery Act (IPERA), "improper payment" is defined as payments that should not have been made, payment to an ineligible recipient, payment for an ineligible service, any duplicate payment, payment for services not received, and payment (one of the options below) ….

A. made to providers excluded in the National Practitioner Data Bank
B. made in an incorrect amount (including underpayments)
C. made in an incorrect amount (including overpayments)
D. made in an incorrect amount (including overpayments and underpayments)

Answer: D

Major causes of improper payment include the following EXCEPT:

A. National & local coverage policy requirements not met
B. Physician orders missing and/or records are Illegible/missing signatures
C. Claim not submitted using the appropriate claim form
D. The medical record submitted does not support medical necessity

Answer: C

Core domain:	CMAS BOK 04: Medical Audit Environment
Sub-domain:	04.01.15: Health Insurance Reimbursement Methodologies
Suggested Reference Material(s):	• Essentials of Managed Health Care, Peter R. Kongsrvedt, MD • A Study of Hospital Charge Setting Practices http://www.medpac.gov/documents/Dec05_Charge_setting.pdf

Choose the type of reimbursement agreement (contract) described in the following scenario.

A. Capitation
B. Flat Rate
C. Case rate
D. Straight per diem
E. Differential by service type
F. Physician services contract

1. Pay a set amount (single charge) per hospital admission regardless of the cost of the actual services the patient receives.
2. Cured Medical Center was paid $6250.00 for a five day medically necessary medical stay. Contract states: Pay $1250.00 per day for medical admission less non covered billed charges.
3. Reimburse at 150 percent of CMS Resource-based relative value scale (RBRVS)
4. The hospital receives a flat per-admission reimbursement for the service to which the patient is admitted. A prorated payment may be made (e.g., 50% for intensive care and 50% medicine) if serviced are mixed. The following services are included: medicine, surgery, intensive care, neonatal intensive care, psychiatry, and obstetrics.

Answer: 1) B; 2) D; 3) F; 4) E

Core domain:	CMAS BOK 02: Medical Audit Process and Methodology *02.02: Audit Process, Work Flow and Audit Findings*
Sub-domain:	02.02.08: Assign/validate E and M codes
Suggested Reference Material(s):	Medicare CERT/FFS Report, page 32

Billing for Evaluation and Management Services must be supported with appropriate documentation in the patient's medical record justifying the actual service rendered; in addition, the correct E and M must be selected and coded prior to billing. The following general documentation elements are required to be submitted to support the diagnosis and treatment codes reported on the claim.

1. Patient encounter information, including the reason for the encounter, relevant beneficiary history and physical exam findings, results of diagnostic tests, the clinical impression or diagnosis, the plan of care, and the date and identity of the provider
2. Appropriate health risk factors and the patient's progress, along with responses to and changes in treatment
3. Documentation showing that the encounter is pre authorized by the payor and evidence of the medical necessity for the encounter using national screening criteria
4. Past, present, and revised patient diagnoses and the documented or easily inferred rationale for ordering diagnostic and other ancillary services

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

Answer: C

Core domain:	CMAS BOK 03: Audit Skill *03.02: Specific Knowledge and Skill Set*
Sub-domain:	03.02.01: Accounting/Finance 03.02.02 Problem Solving
Suggested Reference Material(s):	Simple mathematical items. Review any basic Finance ro Accounting book of your choice.

The contracted rate states the following: Claim will be paid at DRG rate except when claim goes into stoploss amounting to $65, 000. Accounts over stoploss will be paid at 45% from 1st dollar.
The total billed charges for this claim was $82,000. The total payment due is:

A. $36,000
B. $36,900
C. $41,000
D. $65,000

($82k x 45%) Answer: B

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):	Simple mathematical items. Review any basic Finance ro Accounting book of your choice.

Sonia is the lead Auditor of LMN Hospital. She received a report from the external auditor of an incorrectly paid claim. The payment received was $40,000.00; according to the external auditor, payment is expected to be at $44,750.00. The total billed charges amounted to 97,000.00.
The contract between LMN Hospital and the Health Plan is written this way: *Stop loss amount $68,000.00. Accounts over stop loss will be paid at DRG rate up to stop loss; then 75% of dollars over stop loss.*

What is Sonia's next course of action?

A. Agree with the external auditor's report after confirming the accuracy of payment based on the terms of the contract
B. Disagree with the external auditor's findings because the three level quality control process in this department is always accurate
C. Request that the Health Plan write an official letter of appeal following the hospital's grievance and appeals policy
D. Seek advisement from the Hospital Legal Counsel for validation of their contract

Answer: A

Core domain Sub-domain::	CMAS BOK 04: Medical Audit Environment *04.01.09: Medicare/Medicaid Policies*
Suggested Reference Material(s):	• Fact Sheet: HAC • Medicare Hospital Acquired Condition website • Accuracy of Coding Pressure Ulcer: Medicare FFS

Carmen CMAS, Audit Manager met with her team to enforce the need to make sure claims are submitted to CMS following the Hospital-Acquired Conditions (HAC) ruling using the designated Present on Admission (POA) Indicator. Which of the following reason codes is NOT TRUE with regard to the payment implications in reporting HAC/POA rules?

A. Y: Diagnosis was present at time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as "Y" for the POA Indicator.
B. N: Diagnosis was not present at time of inpatient admission. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "N" for the POA Indicator.
C. U: Documentation insufficient to determine if the condition was present at the time of inpatient admission. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "U" for the POA Indicator.
D. W: Claim withheld. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "W" for the POA Indicator.

Answer: D