CRIP Study Module

Section 1

Overall Review of Charge Capture

About the CRIP exam

- 4 Sections
  - Overall Review of Charge Capture
  - Ancillary Services
  - Surgical Services and Procedures
  - Recurring Outpatient and Clinical Services
- 4 hour time limit – 1 hour per section
  - Multiple Choice
  - True or False
- Recertification
  - National Membership is required
  - Earn 30 CEUs within the 2-year certification period
    - 15 CEUs must be AAHAM sponsored

CDM

a. Claim Description Module
b. Charge Description Master
c. Claim Description Master
d. Common Description Master

CDM

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b. Charge Description Master
c. Claim Description Master
d. Common Description Master

Failure to maintain an accurate CDM can negatively impact the organization because it may result in which of the following:

a. Claim rejections from the payer
b. Over/Under payments
c. Potential fines and penalties
d. RAC take backs
e. All of the above

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b. Over/Under payments
c. Potential fines and penalties
d. RAC take backs
e. **All of the above**

Benefits of maintaining an accurate CDM include all of the following except:

a. It can minimize billing errors
b. It can help foster pricing transparency
c. It can help improve the operating margin of the facility
d. It drives more than 90% of the organization’s revenue cycle dollars

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a. It can minimize billing errors
b. It can help foster pricing transparency
c. It can help improve the operating margin of the facility
d. It drives more than 90% of the organization's revenue cycle dollars

* It drives more than 70% of rev cycle dollars

Because of the complexity of the CDM, it’s important that one or two people oversee any changes or updates.

a. True
b. False

Because of the complexity of the CDM, it's important that one or two people oversee any changes or updates.

a. True
b. False

* It's essential that the maintenance of the CDM occurs in a collaborative effort by the CDM department and the facility departments.

A charge request form can aid in the process of initiating, updating, and inactivating charges. A charge request form should which of the following items:

a. The department name and GL number
b. The charge type: room and board, ancillary services, time charges, etc.
c. Parent/child explosion links
d. Technical or pharmacy description
e. All of the above

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b. The charge type: room and board, ancillary services, time charges, etc.
c. Parent/child explosion links
d. Technical or pharmacy description
e. **All of the above**

A charge request form can aid in the process of initiating, updating, and inactivating charges. A charge request form should which of the following items:

a. Appropriate CPT/HCPCS code
b. Pharmacy charge that will be billed to the patient
c. Appropriate grouping for the UB-04
d. All of the above

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a. Appropriate CPT/HCPCS code
b. Pharmacy charge that will be billed to the patient
c. Appropriate grouping for the UB-04
d. **All of the above**

Once a request form has been received and reviewed, consider having a charge master committee review it before final input and approval.

a. True
b. False

Once a request form has been received and reviewed, consider having a charge master committee review it before final input and approval.

a. **True**
b. False

A charge master committee should include all the following except:

a. Health Information Management
b. Finance
c. Regulatory Affairs
d. Human Resources
e. Pharmacy
f. Supply Chain

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Medicare releases an Addendum B how often?

a. Yearly in October
b. Yearly in December
c. Quarterly
d. Bi-annually

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b. Yearly in December
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Click here to see the Medicare Addendum B:

According to the Medicare Addendum B, status indicator C means:

a. Inpatient only procedure
b. Outpatient only procedure
c. Non-covered code
d. Pass through code

According to the Medicare Addendum B, status indicator C means:

a. **Inpatient only procedure**
b. Outpatient only procedure
c. Non-covered code
d. Pass through code

Elimination of the Inpatient Only List

In this rule, we are finalizing our proposal to eliminate the Inpatient Only (IPO) list over a three-year transitional period, beginning with the removal of approximately 300 primarily musculoskeletal-related services, with the list completely phased out by CY 2024. This will make these procedures eligible to be paid by Medicare in the hospital outpatient setting when outpatient care is appropriate, as well as maintain our ability to pay for these services in the hospital inpatient setting when inpatient care is appropriate, as determined by the physician.

https://www.cms.gov/newsroom/fact-sheets/cy-2021-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0

According to the Medicare Addendum B, status indicator D means:

a. Inpatient only procedure
b. Outpatient only procedure
c. Deleted codes
d. Packaged under OPPS

According to the Medicare Addendum B, status indicator D means:

a. Inpatient only procedure
b. Outpatient only procedure
c. **Deleted codes**
d. Packaged under OPPS

According to the Medicare Addendum B, status indicator N means:

a. Inpatient only procedure
b. Outpatient only procedure
c. Deleted codes
d. Packaged under OPPS

According to the Medicare Addendum B, status indicator N means:

a. Inpatient only procedure
b. Outpatient only procedure
c. Deleted codes
d. Packaged under OPPS

According to the Medicare Addendum B, status indicator G or H means:

a. Pass through codes
b. Outpatient only procedure
c. Deleted codes
d. Packaged under OPPS

According to the Medicare Addendum B, status indicator G or H means:

a. **Pass through codes**
b. Outpatient only procedure
c. Deleted codes
d. Packaged under OPPS

According to the Medicare Addendum B, status indicator K means:

a. Pass through codes
b. Outpatient only procedure
c. Deleted codes
d. Non-pass through codes for drugs which are separately payable by Medicare

According to the Medicare Addendum B, status indicator K means:

a. Pass through codes
b. Outpatient only procedure
c. Deleted codes
d. **Non-pass through codes for drugs which are separately payable by Medicare**

According to the Medicare Addendum B, status indicator B, E, or M means:

a. Pass through codes
b. Outpatient only procedure
c. Noncovered codes that are not reimbursable (usually there is an alternative code)
d. Non-pass through codes for drugs which are separately payable by Medicare

According to the Medicare Addendum B, status indicator B, E, or M means:

a. Pass through codes
b. Outpatient only procedure
c. **Noncovered codes that are not reimbursable (usually there is an alternative code)**
d. Non-pass through codes for drugs which are separately payable by Medicare

Procedure charges include the cost of labor hours used when performing the procedure.

a. True
b. False

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a. **True**
b. False

The cost of equipment should not be included in procedure charges.

a. True
b. False

The cost of equipment should not be included in procedure charges.

a. True
b. **False**

Procedures are not usually set up in the nursing units as Medicare regards the billing of nursing services as inclusive.

a. True
b. False

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a. **True**
b. False

Most supply items are not billed separately since most are included in the procedure charge.

a. True
b. False

Most supply items are not billed separately since most are included in the procedure charge.

a. **True**
b. False

Medical record documentation is the key to proper payer reimbursement.

a. True
b. False

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a. **True**
b. False

Definitive LCDs or NCDs are:

a. Lists specific diagnosis codes
b. Lists potential coverage circumstances, but not specific diagnosis codes
c. Lists charge limits that can be charged by the hospital
d. Lists physician licensing requirements to perform specific procedures

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b. Lists potential coverage circumstances, but not specific diagnosis codes
c. Lists charge limits that can be charged by the hospital
d. Lists physician licensing requirements to perform specific procedures

Level I CPT codes:

a. Are system or descriptive terms
b. 5-digit numeric codes
c. Identify medical services and procedures furnished by physicians and other healthcare professionals
d. All of the above

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a. Are system or descriptive terms
b. 5-digit numeric codes
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d. All of the above

Level II HCPCS codes:

a. Include services such as ambulance, supplies and services not included in CPT codes
b. 5-digit numeric codes with an alpha prefix
c. Include DMEPOS items
d. All of the above

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a. Include services such as ambulance, supplies and services not included in CPT codes
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d. **All of the above**

The Omnibus Budget Reconciliation Act (OBRA) of 1989 provided for the RBRVS as a payment reform provision. RBRVS is comprised of which of the following?

a. Fee schedule for payment of physician services, based on the RVU
b. Medicare Volume Performance Standard (MVPS) for the rates of increase in Medicare expenditures for physician services
c. Limits the amount of non-participating physicians can charge to beneficiaries, referred to as the limiting charge to 115% of the fee schedule amount
d. All of the above

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c. Limits the amount of non-participating physicians can charge to beneficiaries, referred to as the limiting charge to 115% of the fee schedule amount
d. **All of the above**

What is know as the heart of the fee schedule?

a. RBRVS
b. HCPCS
c. RVU
d. UB-04

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a. RBRVS
b. HCPCS
c. **RVU**
d. UB-04

The RVU is the heart of the fee schedule. The RVU is comprised of all of the following except:

a. Work required
b. Practice expense
c. Physician salaries
d. Malpractice insurance expense

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a. Work required
b. Practice expense
c. **Physician salaries**
d. Malpractice insurance expense

The uniform bill known as the _______ is required for billing hospital inpatient and outpatient claims to Medicare

a. CMS 1500
b. UB-04
c. CMS-1450
d. A and C

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a. CMS-1500
b. UB-04
c. CMS-1450
d. A and C

When related outpatient services are provided 72 hours prior to an inpatient admission, the outpatient charges are bundled with the inpatient charges. This is known as what?

a. MS-DRG Payment Window
b. UB-04 Combination Rule
c. Inpatient 72-hour Rule
d. None of the above

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a. **MS-DRG Payment Window**
b. UB-04 Combination Rule
c. Inpatient 72-hour Rule
d. None of the above

MUE:

a. Medicare Unlikely Edit
b. Medically Unlikely Edit
c. Medical Unknown Edit
d. None of the above

MUE:

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b. Medically Unlikely Edit
c. Medical Unknown Edit
d. None of the above

CMS allows the use of an ABN to attempt to charge the patient for a service with an MUE edit.

a. True
b. False

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a. True

b. False

To bypass the MUE edit, the charge item should be broken into separate line items with a unit of service amount equal to or less than the MUE limit.

a. True
b. False

To bypass the MUE edit, the charge item should be broken into separate line items with a unit of service amount equal to or less than the MUE limit.

a. **True**
b. False

Which of the following is the correct way to report a service that hits the MUE edit, when all charges are appropriate and necessary?

A

42 REV CODE	43 DESCRIPTION	44 HCPCS	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES
730	EKG	93500	11/25/2020	1	100.00
730	EKG	9350076	11/25/2020	2	100.00
730	EKG	9350076GD	11/25/2020	2	100.00

B

42 REV CODE	43 DESCRIPTION	44 HCPCS	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES
730	EKG	93500GD	11/25/2020	5	100.00

Which of the following is the correct way to report a service that hits the MUE edit, when all charges are appropriate and necessary?

✓A

42 REV CODE	43 DESCRIPTION	44 HCPCS	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES
730	EKG	93500	11/25/2020	1	100.00
730	EKG	9350076	11/25/2020	2	100.00
730	EKG	9350076GD	11/25/2020	2	100.00

B

42 REV CODE	43 DESCRIPTION	44 HCPCS	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES
730	EKG	93500GD	11/25/2020	5	100.00

HCPCS and CPT codes can be defined to another level of specificity by appending a two-digit numeric or alphanumeric code known as a modifier.

a. True
b. False

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a. **True**
b. False

Which of the following modifiers do not increase or decrease payment for a procedure?

a. 25, 59, 91
b. 73, 74, 25
c. 91, 74, 26
d. 25, 59, 26

Which of the following modifiers do not increase or decrease payment for a procedure?

a. **25, 59, 91**
b. 73, 74, 25
c. 91, 74, 26
d. 25, 59, 26

* These modifiers indicate that the services were medically necessary and distinct from other services that were provided on the same day and therefore allow payment to be received for the distinct service.

-25 – significant, separately identifiable E&M, same day, same physician
-59 – distinct procedural service
-91 – repeat clinical lab test

Modifier -25

a. Repeat procedure by a different physician
b. Repeat procedure by the same physician
c. Significant, separately identifiable E&M
d. Distinct procedural service

Modifier -25

a. Repeat procedure by a different physician
b. Repeat procedure by the same physician
c. **Significant, separately identifiable E&M**
d. Distinct procedural service

Modifier -50

a. Repeat procedure by a different physician
b. Repeat procedure by the same physician
c. Significant, separately identifiable E&M
d. Bilateral procedure

Modifier -50

* Modifier -50 should not be used:

When the description for the procedure:

- Is nonspecific
- Applies to different body parts
- Includes the word “bilateral” or “unilateral” in the CPT code description
- On a procedure where the organ is considered to be midline
- To report the procedure with modifiers RT or LT on the same claim line

a. Repeat procedure by a different physician
b. Repeat procedure by the same physician
c. Significant, separately identifiable E&M
d. **Bilateral procedure**

Modifier -59

a. Repeat procedure by a different physician
b. Distinct procedural service
c. Significant, separately identifiable E&M
d. Bilateral procedure

Modifier -59

* The appropriate uses for modifier -59 are:
  Indicating that a procedure or service was distinct or independent from other services performed on the same day
  Representing a:
    Different procedure or surgery
    Different site or organ system
    Separate incision/excision
    Separate lesion
    Separate injury

a. Repeat procedure by a different physician
b. **Distinct procedural service**
c. Significant, separately identifiable E&M
d. Bilateral procedure

Four modifiers that were created to assist in reducing errors associated with overpayments under modifier -59 are known as X (epsu) modifiers. Which of the following is used for a service that is distinct because it occurred during a separate encounter?

a. XE
b. XS
c. XP
d. XU

Four modifiers that were created to assist in reducing errors associated with overpayments under modifier -59 are known as X (epsu) modifiers. Which of the following is used for a service that is distinct because it occurred during a separate encounter?

a. **XE**
b. XS
c. XP
d. XU

Four modifiers that were created to assist in reducing errors associated with overpayments under modifier -59 are known as X (epsu) modifiers. Which of the following is used for a service that is distinct because it was performed by a different practitioner?

a. XE
b. XS
c. XP
d. XU

Four modifiers that were created to assist in reducing errors associated with overpayments under modifier -59 are known as X (epsu) modifiers. Which of the following is used for a service that is distinct because it was performed by a different practitioner?

a. XE
b. XS
c. **XP**
d. XU

Four modifiers that were created to assist in reducing errors associated with overpayments under modifier -59 are known as X (epsu) modifiers. Which of the following is used for a service that is distinct because it was performed on a separate organ or structure?

a. XE
b. XS
c. XP
d. XU

Four modifiers that were created to assist in reducing errors associated with overpayments under modifier -59 are known as X (epsu) modifiers. Which of the following is used for a service that is distinct because it was performed on a separate organ or structure?

a. XE
b. XS
c. XP
d. XU

Four modifiers that were created to assist in reducing errors associated with overpayments under modifier -59 are known as X (epsu) modifiers. Which of the following is used for a service that is distinct because it does not overlap usual components of the main service?

a. XE
b. XS
c. XP
d. XU

Four modifiers that were created to assist in reducing errors associated with overpayments under modifier -59 are known as X (epsu) modifiers. Which of the following is used for a service that is distinct because it does not overlap usual components of the main service?

a. XE
b. XS
c. XP
d. XU

While the -59 modifier can still be used, it should not be used if there is a more descriptive modifier available.

a. True
b. False

While the -59 modifier can still be used, it should not be used if there is a more descriptive modifier available.

a. **True**
b. False

Modifier -59 can be appended to E&M services if a distinct service was provided.

a. True
b. False

Modifier -59 can be appended to E&M services if a distinct service was provided.

a. True
b. False

* Modifier -59 should never be appended to an E&M service as a modifier -25 should be reported instead.

Modifier -59 should be hard-coded in the CDM for procedures that are frequently performed in conjunction with other procedures.

a. True
b. False

Modifier -59 should be hard-coded in the CDM for procedures that are frequently performed in conjunction with other procedures.

a. True

b. False

Modifier -59 should never be hard-coded in the CDM and should be assigned by coding only after a review of the record is completed.

Modifier -73 is used when all the following is true except:

a. Used only for procedures requiring anesthesia
b. Used to report discounted procedures on an outpatient
c. After the patient has been prepared for the procedure and taken to the procedure room
d. After induction of anesthesia

Modifier -73 is used when all the following is true except:

a. Used only for procedures requiring anesthesia
b. Used to report discounted procedures on an outpatient
c. After the patient has been prepared for the procedure and taken to the procedure room
d. **After induction of anesthesia**

Modifier -74 is used when which of the following is true:

a. Used only for procedures requiring anesthesia
b. Used to report discounted procedures on an outpatient
c. After the patient has been prepared for the procedure and taken to the procedure room
d. After induction of anesthesia
e. All the above are true

Modifier -74 is used when which of the following is true:

a. Used only for procedures requiring anesthesia
b. Used to report discounted procedures on an outpatient
c. After the patient has been prepared for the procedure and taken to the procedure room
d. After induction of anesthesia
e. All the above are true

Modifier -76 – all the following is true except:

a. Defined as “Repeat procedure by the same physician”
b. A procedure or service was repeated in a separate session on the same day by the same physician
c. The first procedure would be listed once, then on a separate line, the repeated procedure code should be listed with modifier -76 appended
d. After induction of anesthesia

Modifier -76 – all the following is true except:

a. Defined as “Repeat procedure by the same physician”
b. A procedure or service was repeated in a separate session on the same day by the same physician
c. The first procedure would be listed once, then on a separate line, the repeated procedure code should be listed with modifier -76 appended
d. **After induction of anesthesia**

Modifier -77 is defined as:

a. Repeat procedure by another physician
b. Repeat procedure by the same physician
c. Discontinued outpatient procedure after anesthesia
d. Discontinued outpatient procedure before anesthesia

Modifier -77 is defined as:

a. **Repeat procedure by another physician**
b. Repeat procedure by the same physician
c. Discontinued outpatient procedure after anesthesia
d. Discontinued outpatient procedure before anesthesia

Modifier -91 is defined as:

a. Repeat procedure by another physician
b. Repeat procedure by the same physician
c. Repeat clinical diagnostic laboratory test
d. Discontinued outpatient procedure before anesthesia

Modifier -91 is defined as:

a. Repeat procedure by another physician
b. Repeat procedure by the same physician
c. **Repeat clinical diagnostic laboratory test**
d. Discontinued outpatient procedure before anesthesia

ABN

a. Advance Beneficiary Notice of Noncoverage
b. Advance Benefit Notification
c. Available Benefits Notification
d. Advance Beneficiary Note

ABN

a. **Advance Beneficiary Notice of Noncoverage**
b. Advance Benefit Notification
c. Available Benefits Notification
d. Advance Beneficiary Note

When is an ABN issued to a beneficiary?

a. When a service does not or is not expected to meet medical necessity
b. When a service is expected to be covered by Medicare
c. When a service is written off due to NCCI edits
d. When new services are covered under Medicare

When is an ABN issued to a beneficiary?

a. **When a service does not or is not expected to meet medical necessity**
b. When a service is expected to be covered by Medicare
c. When a service is written off due to NCCI edits
d. When new services are covered under Medicare

An ABN must be issued to a patient when it is expected that Medicare will deny payment for an item or service. Reasons why Medicare may deny the service include all the following except:

a. Service does not meet medical necessity criteria
b. Frequency exceeds limitations per the patient’s health benefits
c. Services are experimental or investigational
d. Services are not considered safe or effective for the care of the patient
e. Services cost more than Medicare allows

An ABN must be issued to a patient when it is expected that Medicare will deny payment for an item or service. Reasons why Medicare may deny the service include all the following except:

Can you name a service that may not be covered due to frequency?

a. Service does not meet medical necessity criteria
b. Frequency exceeds limitations per the patient's health benefits
c. Services are experimental or investigational
d. Services are not considered safe or effective for the care of the patient
e. **Services cost more than Medicare allows**

An ABN must be issued to a patient after the service is performed and it is determined that Medicare may not pay.

a. True
b. False

An ABN must be issued to a patient after the service is performed and it is determined that Medicare may not pay.

a. True

b. False

An ABN must be given prior to any service being performed and far enough in advance for the beneficiary to make an informed decision.

An ABN is an official denial of coverage by Medicare.

a. True
b. False

An ABN is an official denial of coverage by Medicare.

a. True

b. False

An ABN is not an official denial of coverage. The beneficiary has the right to file an appeal if they payment is denied when a claim is submitted.

ABN Triggering Events include all of the following except:

a. Initiation
b. Reduction
c. Continuation
d. Termination

ABN Triggering Events include all the following except:

a. Initiation
b. Reduction
c. **Continuation**
d. Termination

Per CMS, an ABN must be retained for how long?

a. One year
b. Five years
c. Ten years
d. Two years

Per CMS, an ABN must be retained for how long?

a. One year
b. **Five years**
c. Ten years
d. Two years

Hospitals use what notice to inform beneficiaries that all or part of the Part A inpatient care may not be covered by Medicare.

a. Hospital Issued Notice of Noncoverage (HINN)
b. Advance Beneficiary Notice of Noncoverage (ABN)
c. Important Message From Medicare (IMM)
d. None of the above

Hospitals use what notice to inform beneficiaries that all or part of the Part A inpatient care may not be covered by Medicare.

a. **Hospital Issued Notice of Noncoverage (HINN)**
b. Advance Beneficiary Notice of Noncoverage (ABN)
c. Important Message From Medicare (IMM)
d. None of the above