CRIP Study Module

Section 2

Ancillary Services

A lab that is independent of a hospital that meets the requirements to qualify as an emergency hospital or is independent of an attending or consulting physician.

a. Physician office laboratory
b. Qualified hospital laboratory
c. Independent laboratory
d. Reference laboratory

A lab that is independent of a hospital that meets the requirements to qualify as an emergency hospital or is independent of an attending or consulting physician.

a. Physician office laboratory
b. Qualified hospital laboratory
c. **Independent laboratory**
d. Reference laboratory

A lab that receives a specimen from a referring laboratory for testing and actually performs the test.

a. Physician office laboratory
b. Qualified hospital laboratory
c. Independent laboratory
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A lab that receives a specimen from a referring laboratory for testing and actually performs the test.

a. Physician office laboratory
b. Qualified hospital laboratory
c. Independent laboratory
d. **Reference laboratory**

A lab that receives a specimen to be tested and then refers the specimen to another laboratory for performance of the actual laboratory test. Must be Medicare approved.

a. Referring laboratory
b. Qualified hospital laboratory
c. Independent laboratory
d. Reference laboratory

A lab that receives a specimen to be tested and then refers the specimen to another laboratory for performance of the actual laboratory test. Must be Medicare approved.

a. **Referring laboratory**
b. Qualified hospital laboratory
c. Independent laboratory
d. Reference laboratory

A place where a specimen is collected, and clinical laboratory testing is performed on the specimen.

a. Referring laboratory
b. Qualified hospital laboratory
c. Draw station
d. Reference laboratory

A place where a specimen is collected, and clinical laboratory testing is performed on the specimen.

a. Referring laboratory
b. Qualified hospital laboratory
c. **Draw station**
d. Reference laboratory

A lab that offers services to review microbiology, chemistry, serology, immunoassay, cytology, pathology services, etc. Must be certified to meet requirements of the Clinical Laboratory Improvement Act (CLIA) unless the lab is exempt.

a. Referring laboratory
b. Qualified hospital laboratory
c. Clinical laboratory
d. Reference laboratory

A lab that offers services to review microbiology, chemistry, serology, immunoassay, cytology, pathology services, etc. Must be certified to meet requirements of the Clinical Laboratory Improvement Act (CLIA) unless the lab is exempt.

a. Referring laboratory
b. Qualified hospital laboratory
c. **Clinical laboratory**
d. Reference laboratory

A lab that provides clinical laboratory tests 24 hours a day, 7 days a week, to serve a hospital's emergency room that is also available to provide services 24 hours a day, 7 days a week.

a. Referring laboratory
b. Qualified hospital laboratory
c. Clinical laboratory
d. Reference laboratory

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a. Referring laboratory
b. **Qualified hospital laboratory**
c. Clinical laboratory
d. Reference laboratory

A lab area in a physician's office that is maintained by the physician or group practice and is utilized to perform diagnostic tests.

a. Referring laboratory
b. Physician office laboratory
c. Clinical laboratory
d. Reference laboratory

A lab area in a physician's office that is maintained by the physician or group practice and is utilized to perform diagnostic tests.

a. Referring laboratory
b. **Physician office laboratory**
c. Clinical laboratory
d. Reference laboratory

As a general rule, the date of service (DOS) must be the date the specimen was collected.

a. True
b. False

As a general rule, the date of service (DOS) must be the date the specimen was collected.

a. **True**
b. False

If a specimen is collected over a period that spans at least two calendar days, then the DOS must be the date that the collection began.

a. True
b. False

If a specimen is collected over a period that spans at least two calendar days, then the DOS must be the date that the collection began.

a. True
b. **False**

The date of service is the date the collection ended.

If a specimen is stored for less than 30 calendar days the DOS would be the date the test was performed only if the test is ordered by the patient's physician at least 14 days following the date of the patient's discharge from the hospital.

a. True
b. False

If a specimen is stored for less than 30 calendar days the DOS would be the date the test was performed only if the test is ordered by the patient's physician at least 14 days following the date of the patient's discharge from the hospital.

a. **True**
b. False

Specimens stored for more than 30 calendar days, the specimen is considered to have been archived and the DOS would be the date the specimen was placed into storage.

a. True
b. False

Specimens stored for more than 30 calendar days, the specimen is considered to have been archived and the DOS would be the date the specimen was placed into storage.

a. True
b. **False**

The DOS must be the date the specimen was obtained from storage.

If a laboratory chooses, it can bill each component of a panel individually, but payment will be based upon the reimbursement of the panel itself.

a. True
b. False

If a laboratory chooses, it can bill each component of a panel individually, but payment will be based upon the reimbursement of the panel itself.

a. **True**
b. False

Laboratory tests which, if positive, require additional follow-up testing.

a. Required reflex tests
b. Optional reflex tests
c. Mandatory reflex tests
d. Additional reflex tests

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a. **Required reflex tests**
b. Optional reflex tests
c. Mandatory reflex tests
d. Additional reflex tests

Examples of required reflex tests would be a urine culture reflecting an organism identification and susceptibility.

Used for early detection of breast cancer and include a physician's interpretation of the results.

a. Choice mammogram
b. Optional mammogram
c. Diagnostic mammogram
d. Screening mammogram

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a. Choice mammogram
b. Optional mammogram
c. Diagnostic mammogram
d. Screening mammogram

- A physician's order is not required.
- The determination for payment is based on:
  - The woman's age
  - The frequency in which the patient was seen

Diagnostic mammograms are a covered diagnostic test based on which of the following criteria?

a. The patient has distinct signs and symptoms
b. The patient has a history of breast cancer
c. The patient is asymptomatic, but because of the patient's history and other factors, the physician's judgement is that a mammogram is appropriate
d. All of the above

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b. The patient has a history of breast cancer
c. The patient is asymptomatic, but because of the patient's history and other factors, the physician's judgement is that a mammogram is appropriate
d. All of the above

If a screening and diagnostic mammogram is performed on the same patient on the same date of service, the services can be billed with modifier _____.

a. GG
b. GA
c. GX
d. GT

If a screening and diagnostic mammogram is performed on the same patient on the same date of service, the services can be billed with modifier _____.

a. **GG**
b. GA
c. GX
d. GT

When billing a screening and diagnostic mammogram on the same patient for the same date of service, which of the following is true:

a. The diagnostic mammogram will have modifier –GG applied and on a separate line the screening mammogram will have the modifier -59 applied
b. The screening mammogram will have modifier –GG applied and on a separate line the diagnostic mammogram will have the modifier -59 applied
c. The diagnostic mammogram will be combined with the screening mammogram. There will be one line item with 2 units on the claim
d. The diagnostic mammogram only will be billed since screening and diagnostic cannot be billed for the same date of service

When billing a screening and diagnostic mammogram on the same patient for the same date of service, which of the following is true:

a. **The diagnostic mammogram will have modifier –GG applied and on a separate line the screening mammogram will have the modifier -59 applied**
b. The screening mammogram will have modifier –GG applied and on a separate line the diagnostic mammogram will have the modifier -59 applied
c. The diagnostic mammogram will be combined with the screening mammogram. There will be one line item with 2 units on the claim
d. The diagnostic mammogram only will be billed since screening and diagnostic cannot be billed for the same date of service

Fluoroscopy should only be reported when it is not included as an integral part of the primary procedure performed.

a. True
b. False

Fluoroscopy should only be reported when it is not included as an integral part of the primary procedure performed.

a. **True**
b. False

When billing for a nuclear medicine procedure, any procedure requiring the use of radiolabeled product should include the HCPCS code of the radiolabeled product on the same claim as the nuclear medicine procedure. So, if the radiolabeled product was given on a different date from the procedure, the date for the radiolabeled product should be changed to match the date of the procedure.

a. True
b. False

When billing for a nuclear medicine procedure, any procedure requiring the use of radiolabeled product should include the HCPCS code of the radiolabeled product on the same claim as the nuclear medicine procedure. So, if the radiolabeled product was given on a different date from the procedure, the date for the radiolabeled product should be changed to match the date of the procedure.

a. True
b. False

- In this case the claim submitted will contain more than one date of service (DOS)

When a patient is seen for an MRI and has an implanted pacemaker that is not labeled as approved for use in an MRI environment by the FDA, the claim must include the appropriate MRI procedure code, and what else?

a. Q2 modifier only
b. Q0 modifier, the appropriate diagnosis code, and condition code 30 for institutional claims
c. Q3 modifier, the appropriate diagnosis code, and condition code 30 for institutional claims
d. Q2 modifier, the appropriate diagnosis code, and condition code 23 for institutional claims

When a patient is seen for an MRI and has an implanted pacemaker that is not labeled as approved for use in an MRI environment by the FDA, the claim must include the appropriate MRI procedure code, and what else?

a. Q2 modifier only
b. **Q0 modifier, the appropriate diagnosis code, and condition code 30 for institutional claims**
c. Q3 modifier, the appropriate diagnosis code, and condition code 30 for institutional claims
d. Q2 modifier, the appropriate diagnosis code, and condition code 23 for institutional claims

When a patient is seen for an MRI and has an implanted pacemaker that has been labeled as approved for use in an MRI environment by the FDA, the claim must include the appropriate MRI procedure code, and what else?

a. The appropriate diagnosis code and KX modifier
b. The appropriate diagnosis code and modifier 30
c. The appropriate diagnosis code and modifier 23
d. None of the above

When a patient is seen for an MRI and has an implanted pacemaker that has been labeled as approved for use in an MRI environment by the FDA, the claim must include the appropriate MRI procedure code, and what else?

a. **The appropriate diagnosis code and KX modifier**
b. The appropriate diagnosis code and modifier 30
c. The appropriate diagnosis code and modifier 23
d. None of the above

PET scans can be used to assist with staging rather than a diagnosis.

a. True
b. False

PET scans can be used to assist with staging rather than a diagnosis.

a. **True**
b. False

- PET scans are not covered for any other diagnostic uses and also are not covered for screening purposes.

MNT

a. Medical Nutritional Therapy
b. Medical Neuron Therapy
c. Medical Neuron Treatment
d. Medical Nutritional Treatment

MNT

a. **Medical Nutritional Therapy**
b. Medical Neuron Therapy
c. Medical Neuron Treatment
d. Medical Nutritional Treatment

There are two medical conditions where CMS allows coverage for Medical Nutritional Therapy. Which of the following conditions are covered?

a. Renal disease and heart disease
b. Renal disease and gastric disease
c. Diabetes and heart disease
d. Diabetes and renal disease

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b. Renal disease and gastric disease
c. Diabetes and heart disease
d. Diabetes and renal disease

Pap smear screening must meet which of the following requirements, except:

a. The Pap smear was ordered and collected by a practitioner who is authorized under state law to perform the examination
b. The Medicare beneficiary has not had a screening test during the past four years
c. A screening diagnosis code has been placed on the account
d. The beneficiary must be of childbearing age

Pap smear screening must meet which of the following requirements, except:

The Medicare beneficiary has not had a screening test during the past two years

a. The Pap smear was ordered and collected by a practitioner who is authorized under state law to perform the examination
b. The Medicare beneficiary has not had a screening test during the past four years
c. A screening diagnosis code has been placed on the account
d. The beneficiary must be of childbearing age

Per CMS, a screening pelvic exam, with or without specimen collection for smears and cultures, should include at least ____ of the 11 elements.

a. Three
b. Four
c. Eight
d. Seven

Per CMS, a screening pelvic exam, with or without specimen collection for smears and cultures, should include at least ____ of the 11 elements.

a. Three
b. Four
c. Eight
d. Seven

See page 3-22 of the CRIP manual for a list of the 11 elements.

A PSA screening can be performed and paid once every 12 months for men who have reached age 50.

a. True
b. False

A PSA screening can be performed and paid once every 12 months for men who have reached age 50.

a. **True**
b. False

A barium enema (BA) can be done as a colorectal cancer screening when?

a. If the patient requests
b. If the physician feels it is a better test
c. Only done as an alternative to cover a screening flexible sigmoidoscopy
d. Yearly

A barium enema (BA) can be done as a colorectal cancer screening when?

a. If the patient requests
b. If the physician feels it is a better test
c. **Only done as an alternative to cover a screening flexible sigmoidoscopy**
d. Yearly

According to CMS, a colonoscopy will be covered:

a. Once every 5 years
b. Once every 10 years
c. Once in a lifetime
d. Yearly

According to CMS, a colonoscopy will be covered:

See page 3-23 of the CRIP manual for a list of other colorectal cancer screening procedures/tests.

a. Once every 5 years
b. Once every 10 years
c. Once in a lifetime
d. Yearly

According to CMS, a pneumonia vaccine is usually given once in a lifetime, however revaccinations can be administered to individuals who are at high risk for a serious pneumococcal infection.

a. True
b. False

According to CMS, a pneumonia vaccine is usually given once in a lifetime, however revaccinations can be administered to individuals who are at high risk for a serious pneumococcal infection.

a. **True**
b. False

According to CMS, a pneumonia vaccine requires a physician's order.

a. True
b. False

According to CMS, a pneumonia vaccine requires a physician's order.

a. True
b. **False**

The flu vaccine can be administered how often according to CMS?

a. Once in a lifetime
b. Once in per flu season
c. Once every two years
d. None of the above

The flu vaccine can be administered how often according to CMS?

a. Once in a lifetime
b. **Once in per flu season**
c. Once every two years
d. None of the above

An intravenous (IV) infusion is defined as an infusion lasting how long?

a. More than an hour
b. More than 20 minutes
c. More than 30 minutes
d. More than 15 minutes

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a. More than an hour
b. More than 20 minutes
c. More than 30 minutes
d. **More than 15 minutes**

An intravenous (IV) infusion for the purpose of “keep vein open” (KVO) is to be reported as an IV Push.

a. True
b. False

An intravenous (IV) infusion for the purpose of “keep vein open” (KVO) is to be reported as an IV Push.

a. True
b. False

Administration charges for contrast, KVO, or for flushing related to IV administration should never be reported.

The injection/infusion service that best describes the reason for the encounter is known as what?

a. Initial Service
b. Sequential administration
c. Concurrent administration
d. IV administration

The injection/infusion service that best describes the reason for the encounter is known as what?

a. **Initial Service**
b. Sequential administration
c. Concurrent administration
d. IV administration

The injection/infusion service when multiple drugs are infused back-to-back or one right after another is known as what?

a. Initial Service
b. Sequential administration
c. Concurrent administration
d. IV administration

The injection/infusion service when multiple drugs are infused back to back or one right after another is known as what?

a. Initial Service
b. **Sequential administration**
c. Concurrent administration
d. IV administration

Sequential administration must be a different drug through the same IV access and there must be a clinical reason for doing a sequential versus a concurrent administration.

The injection/infusion service when multiple medications are infused simultaneously through separate bags but the same IV line (piggyback) is known as what?

a. Initial Service
b. Concurrent administration
c. Sequential administration
d. IV administration

The injection/infusion service when multiple medications are infused simultaneously through separate bags, but the same IV line (piggyback) is known as what?

a. Initial Service
b. Concurrent administration
c. Sequential administration
d. IV administration

Note: there is presently no code established for the billing of concurrent chemotherapy. Therefore, multiple drugs which are given in the same session are considered to be sequential rather than concurrent.

See pages 3-24 through 3-30 for additional IV administration rules.

As with any charge integrity review, it is vital that the Pharmacy department is frequently audited. Items in the Pharmacy CDM that should be reviewed include which of the following?

a. Revenue codes assigned for facility billing
b. NDCs
c. Assignment of the appropriate HCPCS code
d. Drug divisors or multipliers
e. All of the above

As with any charge integrity review, it is vital that the Pharmacy department is frequently audited. Items in the Pharmacy CDM that should be reviewed include which of the following?

Status Indicator (SI) K codes are separately reimbursable by Medicare.

a. Revenue codes assigned for facility billing
b. NDCs
c. Assignment of the appropriate HCPCS code
d. Drug divisors or multipliers
e. **All of the above**

When a drug packaged in a single dose vial (SDV) is wasted, Medicare may provide payment for the amount of the drug that was discarded in addition to the amount that was administered.

a. True
b. False

When a drug packaged in a single dose vial (SDV) is wasted, Medicare may provide payment for the amount of the drug that was discarded in addition to the amount that was administered.

a. **True**
b. False

Drug wastage is reported by applying what modifier to the claim.

a. JR
b. JK
c. JW
d. WJ

Drug wastage is reported by applying what modifier to the claim.

a. JR
b. JK
c. **JW**
d. WJ

Self-administered drugs are drugs provided on an outpatient basis which are not covered by Medicare. Self-administered drugs include which of the following:

a. Creams and ointments
b. Tablets/capsules given orally
c. Suppositories
d. Injections such as insulin that can be taught to be self-administered
e. All of the above

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b. Tablets/capsules given orally
c. Suppositories
d. Injections such as insulin that can be taught to be self-administered
e. **All of the above**

National Drug Codes (NDC) help identify drugs that could be reimbursed.

a. True
b. False

National Drug Codes (NDC) help identify drugs that could be reimbursed.

a. **True**
b. False

National Drug Codes (NDC) are always 11 digits. What is the correct format for billing.

a. 5-4-2
b. 4-4-3
c. 6-3-2
d. 5-3-3

National Drug Codes (NDC) are always 11 digits. What is the correct format for billing.

a. **5-4-2**
b. 4-4-3
c. 6-3-2
d. 5-3-3

Payment for the unscheduled dialysis furnished to ESRD outpatients is limited to all of the following reasons, except:

a. The dialysis is performed following or in connection with a dialysis procedure like blood transfusion
b. The dialysis is performed following a treatment for an unrelated medical emergency
c. The patient lives more than 20 miles from a dialysis facility
d. The emergency dialysis is needed for ESRD patients who would otherwise have to be admitted as inpatients in order for the hospital to receive payment

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a. The dialysis is performed following or in connection with a dialysis procedure like blood transfusion
b. The dialysis is performed following a treatment for an unrelated medical emergency
c. **The patient lives more than 20 miles from a dialysis facility**
d. The emergency dialysis is needed for ESRD patients who would otherwise have to be admitted as inpatients in order for the hospital to receive payment

Renal dialysis facilities are required to report hematocrit or hemoglobin levels for all Medicare patients who receive Epogen products. What is the UB-04 Value Code related to the hemoglobin and hematocrit and hemoglobin?

a. 48 hemoglobin / 49 hematocrit
b. 48 hematocrit / 49 hemoglobin
c. 47 hemoglobin / 48 hematocrit
d. 48 Hemoglobin / 47 hematocrit

Renal dialysis facilities are required to report hematocrit or hemoglobin levels for all Medicare patients who receive Epogen products. What is the UB-04 Value Code related to the hemoglobin and hematocrit and hemoglobin?

a. **48 hemoglobin / 49 hematocrit**
b. 48 hematocrit / 49 hemoglobin
c. 47 hemoglobin / 48 hematocrit
d. 48 Hemoglobin / 47 hematocrit

A non-ESRD patient who received Epogen for anemia, radio-induced would be reported with modifier _____.

a. EA
b. EB
c. EC

A non-ESRD patient who received Epogen for anemia, radio-induced would be reported with modifier _____.

a. EA
b. EB
c. EC

A non-ESRD patient who received Epogen for anemia, chemo-induced would be reported with modifier _____.

a. EA
b. EB
c. EC

A non-ESRD patient who received Epogen for anemia, chemo-induced would be reported with modifier _____.

a. **EA**
b. EB
c. EC

A non-ESRD patient who received Epogen for anemia, non-chemo/radio-induced would be reported with modifier _____.

a. EA
b. EB
c. EC

A non-ESRD patient who received Epogen for anemia, non-chemo/radio-induced would be reported with modifier _____.

a. EA
b. EB
c. **EC**