

**The Health Plan
Post Assessment Test
Medicare Fraud and Abuse Training**

You must score an 80% or better to pass the post assessment test.

1. The practice of billing for services not furnished and/or supplies not provided, including the billing of Medicare for appointments that the patient failed to keep is considered_____.

- A. Medicare Fraud
- B. Medicare Abuse

2. Medicare Fraud is:

- A. An unintentional act that results in unnecessary cost to Medicare or Medicaid
- B. Intentionally, or knowingly and willfully attempting to execute a scheme to falsely obtain money from any health care benefit program.
- C. An intentional act that results in unnecessary cost to Medicare or Medicaid
- D. Unintentionally or unknowingly attempting to falsely obtain money from any health care benefit program.
- E. B and C
- F. A and D

3. Which of the following are examples of fraud?

- A. Unbundling or “exploding” charges
- B. Billing based on “gang visits”
- C. Billing non-covered or non-chargeable services as covered items
- D. A and B
- E. All of the above

4. Which of the following are examples of abuse?

- A. Charging in excess for services or supplies
- B. Providing medically unnecessary services
- C. Providing services that do not meet professionally recognized standards
- D. Billing Medicare based on a higher fee schedule than used for patients not on Medicare
- E. Submitting bills to Medicare that are the responsibility of other insurers under the MSP provisions
- F. All of the above

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5. Medicare abuse is:

- A. An unintentional act that results in unnecessary cost to Medicare or Medicaid
- B. Intentionally, or knowingly and willfully attempting to execute a scheme to falsely obtain money from any health care benefit program
- C. An intentional act that results in unnecessary cost to Medicare or Medicaid
- D. Unintentionally or unknowingly attempting to falsely obtain money from any health care benefit program
- E. B and C
- F. A and D

6. CMS does not have the authority to deny or revoke an individual or organization application for a Medicare provider number if there is evidence of impropriety such as previous convictions or false information on the application, or if the provider does not meet state/federal licensure or certification requirements

- A. True
- B. False

7. The following examples listed:

- **Violation of the Medicare assignment provisions**
- **Violation of the Medicare physician, provider, or supplier agreement**
- **False or misleading information expected to influence a discharge decision**
- **Violation of assignment requirement for certain diagnostic clinical laboratory tests**

Are examples of violations which may result in_____.

- A. Civil Monetary Penalties
- B. Revocation of provider number application
- C. Imposition of the Start Statute
- D. Medical Peer Review
- E. None of the above

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8. The _____ prohibits a physician from making a referral for certain designated health services to an entity which the physician (or member of his/her family) has ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.

- A. Anti-Kickback Statute
- B. Stark Statue

9. The _____ has the authority to exclude (sanction) providers or suppliers who have been convicted of health care-related offenses.

- A. Social Security Act
- B. Medicare Program
- C. Medicare Integrity Program
- D. Office of Inspector General (OIG)
- E. Federal Bureau of Investigation (FBI)

10. A _____ will be applied if there is a conviction for fraud.

- A. Mandatory Exclusion
- B. Permissive Exclusion

11. Medicare will not pay an excluded individual or entity that has accepted assignment of a Medicare claim.

- A. True
- B. False

12. The OIG's sanctioned List of Excluded Individuals/Entities (LEIE) identifies and entities that are excluded from Medicare reimbursement. But the LEIE does not identify individuals and entities that have been reinstated to the Medicare Program.

- A. True
- B. False

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13. Medical Review (MR) identifies and addresses billing errors through the following:

- A. Identifying potential billing errors concerning coverage and coding
- B. Profiling of providers, services and/or beneficiary utilization
- C. Evaluation of complaints, enrollment and/or cost report data
- D. Data Analysis
- E. A and D
- F. All of the above

14. The three basic components of data analysis are _____, _____, and _____.

- A. Prepayment review, post payment review, medical review
- B. Medical Record Documentation, probe review, corrective actions
- C. Probe review, prepayment review, benefit integrity
- D. Collecting data, identifying potential errors, ongoing monitoring and modification of data analysis components
- E. None of the above

15. The _____ pays an incentive reward to individuals who provide information on Medicare fraud and abuse or other sanctionable activities.

- A. Medicare Incentive Reward Program
- B. Medicare Trust Fund
- C. Social Security Act
- D. HIPAA Public Law

16. Reinstatement at the conclusion of an exclusion period is automatic after 180 days

- A. True
- B. False

17. Educating a provider about appropriate billing procedures may be part of _____.

- A. Data analysis
- B. National coverage review
- C. Corrective action
- D. Peer Review

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18. If a National Coverage Determination (NCD) and a Local Coverage Determination (LCD) exist concurrently regarding the same coverage policy, the _____

- A. The NCD takes precedence
- B. The Medicare Contractor may select to follow either the NCD or the LCD depending on the beneficiary needs.