1. Answer each scenario independently:
   Ms. Smith is an established patient with Dr. Jones. Dr. Jones leaves his current practice to join another practice. Is Ms. Smith an established or a new patient, if she elects to see Dr. Jones at his new practice?
   Ms. Smith sees Dr. Jones with a new complaint of knee pain. Dr. Jones refers her to Dr. Doe, an orthopedic specialist within the group practice. Is Ms. Smith new or established with Dr. Doe?
   a. New, new
   b. Established, established
   c. New, established
   d. Established, new

2. Within the context of determining a patient’s “new or established” status, professional services may include:
   a. Face-to-face services, only
   b. Face-to-face and non-face-to-face services
   c. E/M services, only
   d. Surgical services, only

3. In general, who is permitted to supervise the technical component of a diagnostic test performed on a Medicare patient?
   a. Physician assistants
   b. Advanced registered nurse practitioners
   c. Physicians
   d. All of the above

4. In addition to performing and documenting a substantive portion of an E/M service, what else must a physician do to bill Medicare for a shared service with an NPP?
   a. The physician must document that he or she performed a face-to-face service with the patient.
   b. The physician must be in the building when the NPP performs his or her portion of the service.
   c. The physician must verify that the NPP saw the patient face-to-face.
   d. The physician must see the patient and establish a treatment plan before the NPP sees the patient.

5. In which of the following scenarios is it appropriate for the NPP to bill Medicare Part B for a service incident-to the physician?
   a. The physician is in the clinic but the patient is new.
   b. The clinic is a hospital-based location (POS 22).
   c. The NPP decides an additional treatment is needed for an established patient but the physician has not weighed in on this decision.
   d. The NPP is following the course of treatment established by the physician, the physician is in the clinic, and the clinic is a physician-based setting (POS 11).

6. Which service cannot be billed to Medicare as a shared service?
   a. 99231
   b. 99291
   c. 99219
   d. 99214

7. What is the difference between the Medicare reimbursement rate for an office visit billed incident-to the physician and an office visit billed under the NPP’s individual NPI?
   a. There is no difference in the rates.
   b. 10 percent
   c. 15 percent
   d. 20 percent

8. If a breach of PHI affects more than 500 individuals, within how many days must HHS be notified?
   a. 30 days
   b. 60 days
   c. 90 days
   d. On an annual basis

9. What is the largest HIPAA settlement to date?
   a. $650,000
   b. $3.5 million
   c. $5.55 million
   d. $6.5 million

10. Corrective action plans resulting from HIPAA violations typically include which of the following?
    a. Risk analysis
    b. Updated policies and procedures for handling PHI
    c. Employee training
    d. All of the above

11. A patient is discharged from the hospital and admitted to a nursing facility by the same provider on the same day. What is the appropriate coding for this scenario?
    a. Bill only the nursing facility admission
    b. Bill only the hospital discharge
    c. Bill both the hospital discharge and the nursing facility admission
    d. Bill the hospital visit as a subsequent visit and the nursing facility admission

12. What is the correct place of service code for a nursing home visit on a non-skilled patient?
    a. 11
    b. 31
    c. 22
    d. 32
13. When a PTP edit indicates a modifier status of 1, which code is reported with the appropriate modifier? 
   a. The column 2 code 
   b. Both the column 1 and column 2 codes 
   c. The column 1 code 
   d. Neither code; a status of 1 indicates modifiers are not allowed

14. On the medical unlikely edits (MUE) table, what does the Practitioner Services MUE Values column indicate about a HCPCS Level II/CPT® code? 
   a. The maximum number of units the code can be billed for a patient during a hospital admission 
   b. The maximum number of units the code can be billed for a patient for a single date of service 
   c. The maximum number of units the code can be billed by the same practitioner for a single date of service 
   d. The minimum number of units the code may be billed for a patient for a single date of service

15. When counseling and coordination of care make up at least percentage of the visit, CPT® allows you to report many types of E/M services based on time. 
   a. 25 percent 
   b. 50 percent 
   c. 100 percent 
   d. There is no specific requirement

16. True or False: When reporting a significant, separately identifiable E/M service with another procedure or service, there must be different diagnoses for the procedure or service and the E/M. 
   a. True 
   b. False

17. An E/M service leads to the decision to perform a major surgical procedure later that same day. When reporting the E/M service, you must append which modifier? 
   a. 25 
   b. 57 
   c. 79 
   d. No modifier is necessary.

18. According to CMS, which E/M categories should NOT have modifier 25 appended? 
   a. 99201-99205 (new patient visits) 
   b. 99211-99215 (established patient visits) 
   c. 99241-99245 (office/outpatient consultations) 
   d. 99304-99306 (nursing facility care)

19. Which is the proper coding to report a threaded bone dowel? 
   a. 20931 
   b. 22851 
   c. 22853 
   d. 22859

20. Which CPT® codes are appropriate for initial nursing facility visits? 
   a. 99304-99306 
   b. 99307-99310 
   c. 99315-99316 
   d. 99318