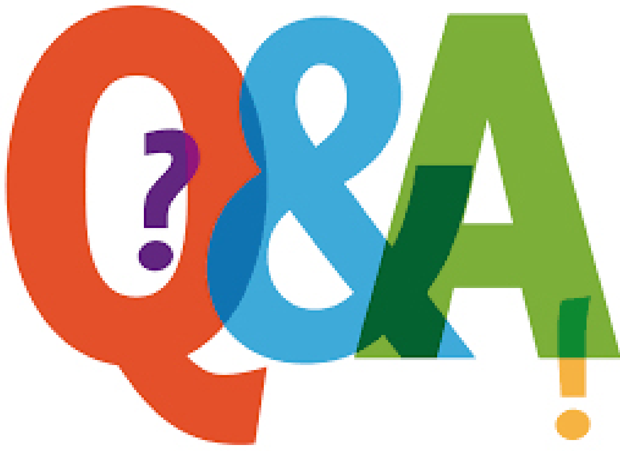

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Question: 823

Which of the following describes a "step-fixed" cost behavior in a healthcare setting?

A. A cost that decreases on a per-unit basis as volume increases.
B. A cost that increases linearly with every additional patient treated.
C. A cost that increases by a set amount once a specific volume threshold is reached, such as hiring an additional nurse for every six patients.
D. A cost that remains constant regardless of patient volume changes.

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Answer: C

Explanation: Step-fixed costs (or step-variable costs) remain constant over a small range of activity but "step up" to a higher level once an upper limit is exceeded. A common example is staffing ratios, where one nurse can handle a specific number of patients, and an additional nurse must be hired once that capacity is surpassed.

Question: 824

A physician performs an E/M service and a minor procedure on the same day. To receive payment for both, which CPT modifier must be used to indicate the E/M was a "significant, separately identifiable" service?

A. Modifier 51
B. Modifier 91
C. Modifier 59
D. Modifier 25

Answer: D

Explanation: Modifier 25 is used to report a significant, separately identifiable Evaluation and Management service by the same physician on the same day of a procedure or other service. This is a high-scrutiny area for auditors to prevent unbundling of services.

Question: 825

A fiscal intermediary processes claims for a hospital with a total value of $4 million. If the processing fee is 4%, what will be the total fee charged?

A. $120,000
B. $180,000
C. $160,000
D. $140,000

Answer: D

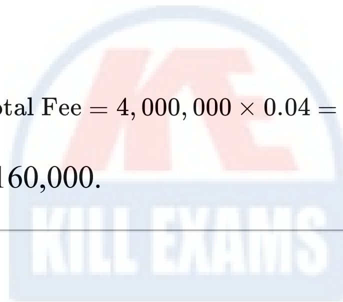
Explanation: The total fee charged is calculated as:

$$\text{Total Fee} = \text{Total Claims} \times \text{Processing Rate}$$

Substituting the values:

$$\text{Total Fee} = 4,000,000 \times 0.04 = 160,000$$

Thus, the total fee charged will be $160,000.



Question: 826

A hospital is evaluating its payer contracts and finds that one payer has a significantly higher reimbursement rate than others. If the hospital's average reimbursement rate is $300 per procedure with this payer providing $500 per procedure, how much additional revenue does the hospital generate for every 1,000 procedures performed under this contract?

A. $700,000
B. $500,000
C. $200,000
D. $300,000

Answer: C

Explanation: The additional revenue generated from the higher reimbursement rate is calculated as:

$$\text{Additional Revenue} = (\text{Higher Rate} - \text{Average Rate}) \times \text{Number of Procedures}$$

Substituting the values:

$$\text{Additional Revenue} = (500 - 300) \times 1,000 = 200 \times 1,000 = 200,000$$

Thus, the hospital generates an additional $200,000 for every 1,000 procedures performed under this contract.

Question: 827

A hospital's revenue cycle management team identifies that 30% of denied claims result from incorrect patient information. What is the most effective strategy to address this issue?

A. Reduce the number of insurance payers
B. Implement a patient verification system
C. Hire external auditors
D. Increase the number of staff in the billing department

Answer: B

Explanation: Implementing a patient verification system is the most effective strategy to ensure accurate patient information is collected at the time of service, thereby reducing the incidence of denials due to incorrect information.

Question: 828

A hospital's balance sheet shows total assets of $10 million, total liabilities of $3 million, and total net assets of $7 million. If the hospital's liabilities increase by $1 million, what will be the new total net assets?

A. $7 million

B. $6 million
C. $9 million
D. $8 million

Answer: A

Explanation: The total net assets will remain unchanged because the increase in liabilities does not affect net assets directly. Thus, the new total net assets will still be:

$$7,000,000$$

Thus, the new total net assets remain at $7 million.

Question: 829

On the Statement of Operations, "Other Operating Revenue" typically includes:

A. Investment income from the hospital's endowment fund
B. Realized gains on the sale of the hospital's main facility
C. Gross patient charges for emergency department visits
D. Cafeteria sales, parking fees, and medical record copy fees

Answer: D

Explanation: Other Operating Revenue consists of revenues generated from activities that are related to the hospital's daily operations but are not direct patient care services.

Question: 830

A physician documents a patient's visit using the CPT code 99214. What does this code indicate about the visit?

A. Established patient office visit, moderate complexity
B. New patient office visit, moderate complexity
C. New patient office visit, low complexity
D. Established patient office visit, high complexity

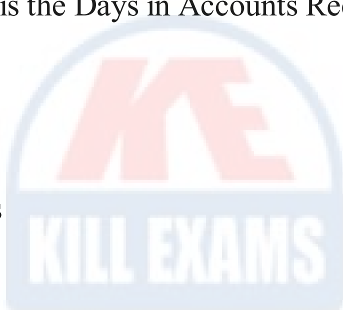
Answer: D

Explanation: The CPT code 99214 is used for an established patient office visit that involves high complexity. Proper coding is essential for accurate billing and reimbursement in healthcare.

Question: 831

A hospital has total accounts receivable of $1.5 million and total patient revenue of $6 million for the year. What is the Days in Accounts Receivable (DAR)?

A. 90 days
B. 100 days
C. 120 days
D. 75 days



Answer: A

Explanation: Days in Accounts Receivable is calculated using the formula:

$$\text{DAR} = \frac{\text{Accounts Receivable}}{\text{Average Daily Revenue}}$$

First, calculate the average daily revenue:

$$\text{Average Daily Revenue} = \frac{6,000,000}{365} \approx 16,438.36$$

Now, substituting the values:

$$\text{DAR} = \frac{1,500,000}{16,438.36} \approx 91.2 \text{ days}$$

Rounding gives approximately 90 days.

Question: 832

A hospital's financial statements report total revenues of $25 million and total expenses of $20 million. If the hospital has total assets of $100 million, what is the return on assets (ROA)?

A. 5%
B. 3%
C. 10%
D. 7%

Answer: A

Explanation: ROA is calculated as:

$$\text{ROA} = \frac{\text{Net Income}}{\text{Total Assets}}$$

First, calculate net income:

$$\text{Net Income} = \text{Total Revenues} - \text{Total Expenses} = 25,000,000 - 20,000,000 = 5,000,000$$

Now, calculate ROA:

$$\text{ROA} = \frac{5,000,000}{100,000,000} = 0.05 \text{ or } 5\%$$

Thus, the return on assets is 5%.

Question: 833

A physician group is paid $100 per patient per month under a capitation agreement. If the group has 400 patients, what is the total annual revenue from capitation payments?

A. $52,000
B. $50,000
C. $60,000
D. $48,000

Answer: A

Explanation: The total annual revenue from capitation payments is calculated as:

$$\text{Annual Revenue} = \text{Capitation Rate} \times \text{Number of Patients} \times 12$$

Thus, annual revenue = $100 × 400 × 12 = $480,000.

Question: 834

A hospital's financial manager is preparing the annual budget and expects a 10% increase in patient volume next year. If the current year's revenue is $12 million, what is the projected revenue for the next year, assuming the revenue per patient remains constant?

A. $10.5 million
B. $12 million
C. $11 million
D. $13.2 million

Answer: D

Explanation: Projected revenue is calculated by increasing the current revenue by 10%. Thus, projected revenue = $12,000,000 * 1.10 = $13,200,000. This calculation assumes that the revenue per patient does not change with the increase in volume.

Question: 835

A health insurance plan collects $500,000,000 in annual premiums. In the same year, it spends $380,000,000 on clinical services and $25,000,000 on activities that improve healthcare quality. According to the Affordable Care Act (ACA) standards for large group markets, what is the Medical Loss Ratio (MLR) and does the plan owe a rebate?

A. MLR is 85%; the plan does not owe any rebate to its members.
B. MLR is 76%; the plan must issue a rebate to reach the 85% requirement.
C. MLR is 81%; the plan must issue a rebate to reach the 85% requirement.
D. MLR is 81%; the plan does not owe a rebate as it exceeds 80%.

Answer: C

Explanation: The Medical Loss Ratio (MLR) is calculated as

$$\frac{\text{Clinical Service Expenses} + \text{Quality Improvement Expenses}}{\text{Premiums} - \text{Taxes/Fees}}$$

. Assuming negligible taxes for this scenario:

$$\frac{\$380,000,000 + \$25,000,000}{\$500,000,000} = 0.81$$

or 81%. For large group markets, the ACA requires an MLR of at least 85%. Since 81% is below the threshold, the plan must issue rebates.

Question: 836

A hospital is negotiating a managed care contract that includes a risk-sharing arrangement. What is a critical factor that the hospital must consider to ensure financial sustainability under this contract?

A. The types of services offered
B. The number of patients enrolled
C. The historical cost of care for the patient population
D. The geographic location of the hospital

Answer: C

Explanation: Understanding the historical cost of care for the patient population is crucial in a risk-sharing arrangement. It allows the hospital to predict potential losses or gains based on the expected utilization and cost patterns, ensuring financial sustainability under the contract.

Question: 837

A hospital has total assets of $22 million and total liabilities of $9 million. What are the total net assets?

A. $11 million
B. $10 million
C. $12 million
D. $13 million

Answer: A

Explanation: Total net assets can be calculated using the accounting equation:

$$\text{Net Assets} = \text{Assets} - \text{Liabilities}$$

Substituting the values:

$$\text{Net Assets} = 22,000,000 - 9,000,000 = 13,000,000$$

Thus, the total net assets are $13 million.

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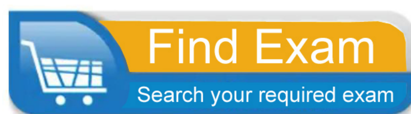

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