

CAVIT Medical Science Practice Exam (Sample)

Study Guide



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SAMPLE

Questions

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- 1. What information is essential to gather from the physician before requesting precertification?**
 - A. Patient's weight and height**
 - B. Details about the proposed service**
 - C. Patient's dietary preferences**
 - D. Family medical history**
- 2. What section of a claim details the specific amounts a provider expects payment for?**
 - A. Claim Notes**
 - B. Summary Plan Information**
 - C. Your Total Responsibility**
 - D. Amount Not Covered**
- 3. What should be done with patient consent for photocopying medical records?**
 - A. No consent is needed**
 - B. Patient must verbally agree**
 - C. Patient must sign consent**
 - D. Consent forms must be filed separately**
- 4. What occurs when there is a difference between the charge and payment?**
 - A. It becomes an additional co-pay**
 - B. It is recorded as an adjustment on the patient account**
 - C. It is paid directly to the physician**
 - D. It is erased from the patient's record**
- 5. What should you avoid in email writing?**
 - A. Using correct grammar**
 - B. Including a subject line**
 - C. Sending criticism or negative content**
 - D. Being polite**

- 6. What role does the state compensation board play in Workers' Compensation?**
- A. It evaluates patient medications**
 - B. It oversees employer practices**
 - C. It helps approve medical practitioners**
 - D. It maintains records of injury reports**
- 7. When did Medicare Part D take effect?**
- A. 2000**
 - B. 2004**
 - C. 2006**
 - D. 2008**
- 8. What is a common error on insurance forms related to the patient's diagnosis?**
- A. Diagnosis does not justify procedures performed**
 - B. Total amount of billing agrees with services provided**
 - C. Information matches codes**
 - D. Place of service consistent with procedure code**
- 9. What should you do if you're unsure about the spelling of a word?**
- A. Guess and move on**
 - B. Look it up to verify spelling**
 - C. Use spell check only**
 - D. Ignore it if it seems unfamiliar**
- 10. What might preauthorization be required for?**
- A. Routine check-ups only**
 - B. Emergency room visits**
 - C. Surgery and hospitalization**
 - D. Prescription medication**

Answers

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1. B
2. C
3. C
4. B
5. C
6. D
7. C
8. A
9. B
10. C

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Explanations

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1. What information is essential to gather from the physician before requesting precertification?

- A. Patient's weight and height**
- B. Details about the proposed service**
- C. Patient's dietary preferences**
- D. Family medical history**

Gathering details about the proposed service is essential before requesting precertification. This information provides the insurance company with the specifics of the treatment or procedure being requested, including the type of service, its medical necessity, and how it aligns with the patient's condition. The insurance provider needs this data to evaluate whether the proposed service meets their criteria for coverage, ensuring that the patient receives appropriate care while also managing costs within the healthcare system. While other information, such as a patient's weight and height, dietary preferences, or family medical history, may contribute to the overall clinical picture, they are not as directly relevant to the precertification process itself. The focus during precertification is primarily on understanding the medical service being proposed, rather than ancillary details that do not directly pertain to the service's approval. Hence, collecting detailed information about the proposed service is critical to facilitating the precertification request effectively.

2. What section of a claim details the specific amounts a provider expects payment for?

- A. Claim Notes**
- B. Summary Plan Information**
- C. Your Total Responsibility**
- D. Amount Not Covered**

The section of a claim that outlines the specific amounts a provider expects payment for is "Your Total Responsibility." This part of the claim clearly states the total amount that the insured party is expected to pay, including any deductibles, copayments, and coinsurance. It provides a comprehensive overview of the financial responsibilities the patient or insured individual will incur for the services received. Being able to see the total responsibility helps patients understand what they can expect to pay out of pocket, and it assists healthcare providers in managing billing and collections effectively. This clarity is crucial for both parties involved in the transaction, ensuring transparency about financial obligations related to healthcare services.

3. What should be done with patient consent for photocopying medical records?

- A. No consent is needed**
- B. Patient must verbally agree**
- C. Patient must sign consent**
- D. Consent forms must be filed separately**

Obtaining signed consent from a patient before photocopying their medical records is essential for maintaining compliance with privacy regulations, such as the Health Insurance Portability and Accountability Act (HIPAA) in the United States. This requirement ensures that patients are aware of and agree to the sharing or duplication of their sensitive health information. By having a signed consent, healthcare providers can safeguard patient rights and demonstrate that they respect the confidentiality and privacy of personal medical data. This process not only protects the patient's information but also establishes a documented agreement that can be referred to if questions about information sharing arise in the future. It also fosters trust in the patient-provider relationship, as patients feel more secure knowing they have control over who has access to their medical records. Following this protocol is crucial in a medical setting for legal protection as well as ethical responsibility.

4. What occurs when there is a difference between the charge and payment?

- A. It becomes an additional co-pay**
- B. It is recorded as an adjustment on the patient account**
- C. It is paid directly to the physician**
- D. It is erased from the patient's record**

When there is a difference between the charge and the payment made, it is recorded as an adjustment on the patient account. This adjustment reflects the difference resulting from factors such as insurance negotiations, discounts provided, or write-offs due to the patient's financial situation. Recording this adjustment ensures accurate bookkeeping and maintains transparency in the patient's financial record. The adjustment helps in tracking the amount that is actually owed by the patient or written off by the practice, providing a clear understanding of their account status. This practice is essential in medical billing and coding, making it crucial for the clarity and accuracy of patient records.

5. What should you avoid in email writing?

- A. Using correct grammar**
- B. Including a subject line**
- C. Sending criticism or negative content**
- D. Being polite**

In email writing, it is essential to maintain a professional tone, and sending criticism or negative content can undermine that. When communication involves negative feedback, it often leads to misunderstandings, creates defensiveness, and can damage relationships. Instead, emails should be constructive and focus on solutions rather than simply pointing out faults. This fosters a more positive interaction and enhances teamwork in professional environments. Therefore, avoiding criticism or negative content contributes to maintaining a respectful and effective communication style.

6. What role does the state compensation board play in Workers' Compensation?

- A. It evaluates patient medications**
- B. It oversees employer practices**
- C. It helps approve medical practitioners**
- D. It maintains records of injury reports**

The state compensation board plays a crucial role in Workers' Compensation by maintaining records of injury reports. This function is vital because it ensures that accurate data is kept regarding workplace injuries, which can help in monitoring trends, identifying hazardous conditions, and informing policy decisions. By documenting these injuries, the board can analyze the effectiveness of existing safety regulations and make recommendations for improvements to worker safety. Furthermore, having a comprehensive database allows for the efficient processing of claims and helps ensure that workers receive the compensations they are entitled to in a timely manner. The maintenance of injury reports is also important for accountability, as it provides a history that can be referenced in case of disputes or legal issues related to workers' compensation claims. This foundation of accurate, organized data supports the overall objective of the workers' compensation system to protect both employees and employers.

7. When did Medicare Part D take effect?

- A. 2000**
- B. 2004**
- C. 2006**
- D. 2008**

Medicare Part D took effect in 2006, which is significant as it introduced a prescription drug benefit for Medicare beneficiaries. This program was designed to help seniors and individuals with disabilities afford their medications, which was a critical step in expanding healthcare coverage for this population. Medicare Part D operates through private insurance plans that provide coverage for outpatient prescription drugs. The implementation of this program marked a major change in Medicare, as it was the first time that a federal program included a comprehensive drug benefit, aiming to reduce the overall costs of medications for participants and improve their access to necessary treatments. This development reflects broader trends in healthcare policy focusing on medication affordability and access.

8. What is a common error on insurance forms related to the patient's diagnosis?

- A. Diagnosis does not justify procedures performed**
- B. Total amount of billing agrees with services provided**
- C. Information matches codes**
- D. Place of service consistent with procedure code**

A common error on insurance forms concerning the patient's diagnosis is that the diagnosis does not justify the procedures performed. This means that when submitting insurance claims, the diagnosis must be clearly linked to the procedures or services provided to ensure that the insurance company will cover the costs. If there is a mismatch—such as a diagnosis that does not support the medical necessity of the procedures—this can lead to claim denial or delays in reimbursement. It's essential for practitioners to accurately document and submit the diagnosis codes that align with the treatments rendered. This connection underscores the importance of thorough clinical documentation, as insurers require detailed justification for the services billed. In contrast, total amount of billing agreeing with services provided indicates that the charges are accurately reflecting what was performed, but it does not speak to the justification aspect. Similarly, information matching codes and the place of service being consistent with the procedure code are critical for accuracy but are not typically the primary areas where justifiable diagnoses are concerned. These aspects can be topically incorrect but do not directly signify the appropriate relationship between diagnosis and the procedures, which is crucial for claim approval.

9. What should you do if you're unsure about the spelling of a word?

- A. Guess and move on**
- B. Look it up to verify spelling**
- C. Use spell check only**
- D. Ignore it if it seems unfamiliar**

When faced with uncertainty regarding the spelling of a word, verifying the spelling by looking it up is the most effective course of action. This ensures accuracy in communication, which is crucial in medical practice where precise language can affect understanding and outcomes. Utilizing reliable resources such as dictionaries or online reference tools allows for confirmation of spelling and usage in context, thereby enhancing the credibility of the written work. While guessing might seem like a quick solution, it can lead to misunderstandings or the propagation of incorrect information. Relying solely on spell check may not catch context-specific errors, as these tools may overlook homophones or suggest incorrect alternatives that are technically spelled correctly but are inappropriate for the intended meaning. Ignoring the spelling entirely when it feels unfamiliar could lead to missed opportunities for learning and improving one's vocabulary. By taking the time to look up the correct spelling, you not only ensure the professionalism of your written communication but also reinforce your own language skills, which is especially important in a field as detail-oriented as medicine.

10. What might preauthorization be required for?

- A. Routine check-ups only
- B. Emergency room visits
- C. Surgery and hospitalization**
- D. Prescription medication

Preauthorization is a process used by health insurance companies to determine if a treatment or procedure is medically necessary and to ensure that the service will be covered under the policy. This requirement is less common for routine or emergency services, as those situations are generally more urgent and critical, often necessitating immediate attention. Surgery and hospitalization typically involve significant costs and resources, leading insurers to request preauthorization to avoid unnecessary expenses. By requiring preauthorization for these procedures, insurance companies can review the proposed treatment or hospital stay in detail, assessing various factors such as medical necessity, appropriateness of the procedure, and alternative treatment options. This step helps prevent over-utilization of medical services and encourages cost-effective decision-making both for healthcare providers and patients. In contrast, routine check-ups usually do not require preauthorization since they are preventive visits aimed at maintaining health, while emergency room visits are often beyond prior approval requirements due to their urgent nature. Prescription medications might also require preauthorization, but it varies widely depending upon the specific medication and insurance policy. Therefore, surgeries and hospitalization stand out as the most common scenarios where preauthorization is explicitly necessary.