

MCBC Medicare Practice Test (Sample)

Study Guide



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Questions

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- 1. Who is responsible for providing all Medicare-covered services except hospice care in exchange for a predetermined capitated payment?**
 - A. Private insurers**
 - B. Medicare Administrative Contractors**
 - C. Medicare Advantage Organizations**
 - D. Primary care physicians**
- 2. What does selecting OPTION 3 on the ABN signify?**
 - A. The patient agrees to the service**
 - B. The patient does not want the care in question**
 - C. The patient wants to appeal the decision**
 - D. The patient wants to change the provider**
- 3. Services that are deemed not to meet certain conditions for coverage are categorized as what?**
 - A. Medically unnecessary**
 - B. Experimental treatments**
 - C. Preventive care**
 - D. Routine services**
- 4. What is the maximum number of diagnosis codes that can be reported on the HIPAA 837P?**
 - A. 8**
 - B. 10**
 - C. 12**
 - D. 15**
- 5. What do ABN modifiers indicate?**
 - A. Type of service**
 - B. Whether services are considered medically necessary**
 - C. Billing errors**
 - D. Service quality ratings**

- 6. How does a recovery auditor approach claims when reviewing payments?**
- A. Using Medicare's payment policies**
 - B. Creating new guidelines**
 - C. Collaborating with patient representatives**
 - D. Reviewing only new claims**
- 7. Which of the following is considered cost sharing by the beneficiary?**
- A. Premiums**
 - B. Coinsurances**
 - C. Supplemental insurance**
 - D. Lifetime limits**
- 8. What type of services are classified as 'incident-to' under Medicare?**
- A. Services provided by independent contractors**
 - B. Services performed in emergency rooms**
 - C. Services provided under a physician's supervision**
 - D. Services outsourced to third-party vendors**
- 9. What is usually a requirement for a Medicare private fee-for-service plan?**
- A. Enrollment in Part B only**
 - B. Use of specific providers only**
 - C. Acceptance of all medical conditions**
 - D. Approval from previous insurance carriers**
- 10. Which of the following are types of plans offered under Medicare Advantage?**
- A. Medicare private fee-for-service plans**
 - B. Health Maintenance Organizations**
 - C. Medicare prescription drug plans**
 - D. Medicare coordinated care plans**

Answers

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

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Explanations

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1. Who is responsible for providing all Medicare-covered services except hospice care in exchange for a predetermined capitated payment?

A. Private insurers

B. Medicare Administrative Contractors

C. Medicare Advantage Organizations

D. Primary care physicians

The correct answer emphasizes the role of Medicare Advantage Organizations, which are also known as Medicare Part C plans. These organizations enter into arrangements with Medicare to provide a variety of services to eligible beneficiaries. In this model, they receive a fixed, predetermined capitated payment from Medicare for each member enrolled in their plan, allowing them to manage costs and services effectively. Medicare Advantage Organizations are responsible for covering all Medicare services except for hospice care, which remains under Original Medicare. This arrangement allows these organizations to offer additional benefits and streamline the Medicare service delivery process. As a result, beneficiaries often find additional options for supplemental coverage or other services as part of their Advantage plans. Understanding this structure is vital because it highlights how the delivery of Medicare services can be managed outside of the traditional fee-for-service model, emphasizing the importance of coordination and value-based care.

2. What does selecting OPTION 3 on the ABN signify?

A. The patient agrees to the service

B. The patient does not want the care in question

C. The patient wants to appeal the decision

D. The patient wants to change the provider

Selecting OPTION 3 on the Advance Beneficiary Notice of Noncoverage (ABN) indicates that the patient does not want the care in question. This choice is significant as it means the patient is explicitly rejecting the service that Medicare may not cover. The ABN is a critical tool used by healthcare providers to communicate with patients about items or services that may not be covered by Medicare. By making this selection, the patient acknowledges their understanding of the potential financial implications and is making an informed decision about their care preferences. Understanding the implications of this option is essential for both patients and providers, as it shapes decisions around treatment and out-of-pocket costs.

3. Services that are deemed not to meet certain conditions for coverage are categorized as what?

- A. Medically unnecessary**
- B. Experimental treatments**
- C. Preventive care**
- D. Routine services**

Services that are categorized as medically unnecessary refer to those that do not meet the established standards for coverage under Medicare. This classification is significant as it implies that the service in question does not align with the criteria necessary to justify its use for a patient's condition or situation. For example, if a service does not provide any demonstrable benefit or is not considered appropriate according to medical guidelines, it would fall under this category. This designation is crucial in determining whether Medicare will reimburse for those services, and it helps guide providers in offering services that are appropriate and necessary for patient care. In contrast, the other options each pertain to specific aspects of healthcare delivery. Experimental treatments are often those under investigation and not yet widely accepted or proven effective, while preventive care focuses on services aimed at preventing illness or disease. Routine services are generally considered standard care that is typically covered by insurance, but they may not be the focus of a discussion regarding conditions for coverage like medically unnecessary services.

4. What is the maximum number of diagnosis codes that can be reported on the HIPAA 837P?

- A. 8**
- B. 10**
- C. 12**
- D. 15**

The HIPAA 837P is a standard format used for submitting healthcare claims electronically. In this context, the maximum number of diagnosis codes that can be reported is indeed 12. Each diagnosis code submitted helps to clarify the patient's condition and the rationale for the submitted services, which is crucial for proper billing and reimbursement processes. Having the capability to report multiple diagnosis codes allows healthcare providers to give a comprehensive picture of the patient's health status. This enables insurers to understand the circumstances surrounding the services provided and also to verify the medical necessity of those services based on the patient's diagnoses. Reporting up to 12 diagnosis codes helps healthcare providers articulate all relevant conditions that may impact treatment or services rendered. Understanding this limit is important for accurately completing claim forms and ensuring claims are processed without delays.

5. What do ABN modifiers indicate?

- A. Type of service
- B. Whether services are considered medically necessary**
- C. Billing errors
- D. Service quality ratings

ABN modifiers, or Advanced Beneficiary Notice modifiers, specifically indicate whether services provided to a Medicare beneficiary are considered medically necessary. When a healthcare provider believes that a service may not be covered by Medicare, they can issue an ABN to the patient to inform them about the potential for non-coverage. This notice allows patients to make informed decisions about their care and whether they want to proceed with the service, understanding that they may have to pay for it out-of-pocket if Medicare does not cover it. The purpose of ABN modifiers is to communicate the Medicare guidelines regarding medical necessity, ensuring that beneficiaries are aware of their financial responsibilities prior to receiving services that may not be covered by Medicare. This is crucial for both patient transparency and provider compliance with Medicare regulations.

6. How does a recovery auditor approach claims when reviewing payments?

- A. Using Medicare's payment policies**
- B. Creating new guidelines
- C. Collaborating with patient representatives
- D. Reviewing only new claims

The approach of a recovery auditor when reviewing claims is grounded in Medicare's established payment policies. These policies provide the framework for determining whether claims have been paid correctly and whether the services billed were medically necessary, appropriately documented, and aligned with the conditions specified by Medicare. By utilizing Medicare's payment policies, recovery auditors can systematically assess claims for compliance, identify any overpayments, and ensure that the reimbursement aligns with the guidelines established by the Centers for Medicare & Medicaid Services (CMS). This use of established policies allows for a standardized method of review, promoting consistency and fairness in the auditing process. Other strategies, such as creating new guidelines or collaborating with patient representatives, do not reflect the official role and responsibilities of recovery auditors. Additionally, focusing solely on new claims would limit the auditor's ability to identify patterns or anomalies in previously submitted claims, which is crucial for a comprehensive review process.

7. Which of the following is considered cost sharing by the beneficiary?

- A. Premiums**
- B. Coinsurances**
- C. Supplemental insurance**
- D. Lifetime limits**

Coinsurance is a term that refers to the portion of healthcare costs that a beneficiary is responsible for paying after meeting their deductible. In a typical Medicare plan, after the beneficiary has paid their deductible, they may need to pay a certain percentage of the costs for covered services. This arrangement signifies the sharing of costs between the insurer and the insured, and thus is classified as a form of cost sharing by the beneficiary. Premiums represent the monthly fees that beneficiaries must pay to maintain their Medicare coverage. Supplemental insurance, also known as Medigap, refers to additional insurance that covers costs not fully paid by Medicare. Lifetime limits, which are caps on the total benefits that can be paid out over a beneficiary's lifetime, are not directly related to cost sharing but rather reflect the limitations of insurance coverage. Each of these other factors affects overall costs and coverage but does not constitute the beneficiary's direct out-of-pocket responsibility in the way that coinsurance does.

8. What type of services are classified as 'incident-to' under Medicare?

- A. Services provided by independent contractors**
- B. Services performed in emergency rooms**
- C. Services provided under a physician's supervision**
- D. Services outsourced to third-party vendors**

'Incident-to' services under Medicare refer specifically to those services that are provided as part of a patient's care and are performed in a physician's office or other outpatient setting. These services must be delivered by a qualified non-physician practitioner, such as a nurse practitioner or physician assistant, under the direct supervision of a physician. The key aspect of 'incident-to' billing is that the services must be part of a plan established by the physician and provided under their supervision to be eligible for reimbursement at full physician rates. This allows for greater flexibility in patient care while ensuring that a licensed physician is overseeing the overall treatment plan. In contrast, options such as services provided by independent contractors or services outsourced to third-party vendors do not fall under this classification due to a lack of direct supervision and integration into the physician's care plan. Similarly, while services performed in emergency rooms are crucial, they are not classified as 'incident-to' because they typically involve immediate medical emergencies rather than ongoing care under a physician's plan.

9. What is usually a requirement for a Medicare private fee-for-service plan?

- A. Enrollment in Part B only**
- B. Use of specific providers only**
- C. Acceptance of all medical conditions**
- D. Approval from previous insurance carriers**

For a Medicare private fee-for-service (PFFS) plan, one of the primary requirements is typically enrollment in Part B of Medicare. Part B covers outpatient services, doctors' visits, preventive services, and some home health care, which are crucial for a PFFS plan to function effectively. These plans are designed to provide more flexibility in choosing healthcare providers— Medicare beneficiaries can seek care from any provider who accepts the plan, which is facilitated by the beneficiary being enrolled in Part B. While some options focus on restrictions or conditions, such as specific providers or approval from previous insurance carriers, they do not align with the nature of PFFS plans that allow for greater choice and flexibility as long as the provider accepts the plan's terms. Moreover, acceptance of all medical conditions pertains more to guaranteed issue rights under certain types of plans, rather than being a specific requirement for PFFS.

10. Which of the following are types of plans offered under Medicare Advantage?

- A. Medicare private fee-for-service plans**
- B. Health Maintenance Organizations**
- C. Medicare prescription drug plans**
- D. Medicare coordinated care plans**

The correct response identifies Medicare private fee-for-service plans as types of plans offered under Medicare Advantage. Medicare Advantage plans, also known as Medicare Part C, provide an alternative way for beneficiaries to receive their Medicare benefits through private insurance companies approved by Medicare. Private fee-for-service (PFFS) plans are a specific type of Medicare Advantage plan that allow beneficiaries to see any doctor or hospital that accepts the plan's payment terms, which offers flexibility. This is particularly beneficial for those who value a wider selection of healthcare providers. In the context of the other options: Health Maintenance Organizations (HMOs) are indeed another type of Medicare Advantage plan where members must use a network of doctors and hospitals for their care, typically requiring referrals for specialists. However, the question emphasizes that private fee-for-service plans are a separate, distinct type. Medicare prescription drug plans (Part D) provide medication coverage but are separate from Medicare Advantage. Lastly, while coordinated care plans can refer to various formats that help manage care, they do not specifically represent a standalone type covered under Medicare Advantage, as they can include other structures like HMOs. Thus, recognizing private fee-for-service plans as a type of Medicare Advantage accurately aligns with the focus of the question.