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Questions & Answers PDF

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Question: 1

If a patient is severely hearing impaired but is able to read lips fairly well and has slight hearing from hearing aids, the CMAA should

A. speak loudly and stand one to two feet away from the patient.
B. enunciate very carefully and avoid making distracting gestures.
C. write out communications on a whiteboard or on the computer for patient to read.
D. speak slowly and clearly from three to six feet, facing the patient, and use gestures.

Answer: D

Explanation:
If a patient is severely hearing impaired but is able to read lips fairly well and has slight hearing from hearing aids, the CMAA should speak slowly and clearly from three to six feet, facing the patient, and use gestures to augment communication (but not excessively). The CMAA should avoid speaking loudly and should verify that the patient is understanding the communication. If patient is given instructions, these should also be provided in writing.

Question: 2

The correct plural for vertebra is

A. vertebraes.
B. vertebrae.
C. vertebras.
D. vertebrea.

Answer: B

Explanation:
The correct plural for vertebra is vertebrae. The same plural rule holds true for axilla (axillae) and sclera (sclerae). Other plural rules include:

-um to -a	bacterium, diverticulum	bacteria, diverticula
-us to -i	thrombus, embolus, bronchus	thrombi, emboli, bronchi (Exceptions: corpus/corpora, meatus/meatus, viscus/viscera, plexus, plexuses)
-is to -es	metastasis, testis, diagnosis	metastases, testes, diagnoses (Exceptions: epididymis/epididymides, femur/femora, iris/irides)
-ma or -oma to -mata	carcinoma, fibroma, condyloma	carcinomata, fibromata, condylomata (Note: simply adding -s is now also acceptable)
-ax, -ix, and -yx to -ces	thorax, appendix, calyx	thoraces, appendices, calyces
-nx to -nges	pharynx, phalanx	pharynges, phalanges

Question: 3

When a new patient checks in, the CMAA should confirm identity with

A. the patient's name and address.
B. the patients name and birthdate.
C. two forms of ID with at least one a photo ID.
D. one form of ID.

Answer: C

Explanation:
When a new patient checks in, the CMAA should confirm identity with two forms of ID with at least one a photo ID, such as a passport, driver's license, military ID, Native American tribal ID, or federal, state, or local government ID. At subsequent visits, patients are usually asked their name and birthdate although some require photo IDs at each visit or if any information is requested. Some practices now take photos of all patients with their permission and place them in the medical records to further verify ID.

Question: 4

When scheduling diagnostic procedures for a patient, the CMAA should first

A. verify that services are covered under the patient's insurance plan.
B. ask the patient if services are covered under the patient's insurance plan.
C. inform the patient that the insurance company may not cover costs.
D. schedule the procedure and advise the patient to check with the insurance.

Answer: A

Explanation:

When scheduling diagnostic procedures for a patient, the CMAA should first verify that services are covered under the patient's insurance plan. If information on the patient's insurance card is not adequate, then the CMAA may need to contact the insurance company by telephone. In some cases, preauthorization may be required for procedures. Once the appointment is made, the patient should be advised of any pre-test and post-test instructions and the procedure noted in the patient's medical record and the diagnostic procedure tracking log.

Question: 5

The best method of obtaining copayment from a patient is to state

A. "Your copayment is $20.00."
B. "Can you make your $20.00 copayment?"
C. "I think you have a $20.00 copayment due."
D. "How would you like to make your $20.00 copayment."

Answer: D

Explanation:
The best method of obtaining copayment from a patient is to state: "How would you like to make your $20.00 copayment?" This informs the patient of the amount, the need to pay, and assumes the patient will do so. Copayments are usually collected when the patient checks in although some practices may collect the copayment when the patient checks out. The CMAA should provide a receipt for all cash payments and for check payments on request of the patient. If paying by credit card, the CMAA should make sure that the patient signs the payment receipt and retains a copy.

Question: 6

71. If the answering machine shows four patients called requesting visits, which of the following patients should be scheduled first
• T. Stanton: Burning and frequency of urination, low-grade fever.
• S. Locke: Intermittent abdominal cramping and diarrhea X 4 in 12 hours.
• W. Barrett: Flu, cough, increasing shortness of breath.
• E. Nehlich: Persistent short-term memory loss.

A. T. Stanton.
B. S. Locke.
C. W. Barrett.
D. E. Nehlich.

Answer: C

Explanation:
If the answering machine shows four patients called requesting visits, the patient with the most acute problem should be scheduled first. In this case W. Barrett has flu and a cough with increasing shortness of breath, which could indicate a complication such as pneumonia. S. Locke, with abdominal pain and

cramping, may receive instructions for home care by the physician. Both T. Stanton (urinary frequency and burning) and E. Nehlich (memory loss) should be scheduled with T. Stanton's needs more acute than E. Nehlich's.

Question: 7

If a patient responds to the CMAA slowly and in very broken English, the CMAA should

A. ask for a translator before proceeding.
B. speak slowly and loudly to make sure the patient understands.
C. rely on pictures and sign language to communicate meaning.
D. ask what language the patient speaks at home and if the patient can understand.

Answer: D

Explanation:
If a patient responds to the CMAA slowly and in very broken English, the CMAA should ask what language the patient speaks at home and if the patient can understand. Patients are often able to understand more than their speech would indicate. Using simple language and speaking somewhat slowly and clearly may help with the patient's comprehension. Gesture and pictures, if available, may help with communication as well. It's important to remember that patients may be very intelligent but simply lacking in English skills.

Question: 8

If a patient by the name of Jennifer Brown presents an insurance card with the name of Mary Jones at a visit, the most likely reason is

A. the patient stole the insurance card from Mary Jones.
B. the patient is covered under Mary Jones' family plan.
C. the patient is attempting to use a friend's card.
D. the patient accidentally brought the wrong card.

Answer: B

Explanation:
If a patient by the name of Jennifer Brown presents this insurance card at a visit, the most likely reason is that that the patient is covered under Mary Jones' family plan. Cards may vary with some cards listing all covered members. Some may issue separate cards to family members with each card listing the individual's name and/or ID number. In some cases, the CMAA may have to verify coverage with the insurance company.

Question: 9

If paper health records are filed using terminal digit filing and a patient's health record is numbered 44-62-10, in which section will the chart be filed?

A. Section 44.
B. Section 62.
C. Section 10.
D. Either Section 10 or section 44.

Answer: C

Explanation:
If paper health records are filed using terminal digit filing and a patient's health record is numbered 44-62-10, the chart will be filed in section 10 as the last digits are the primary set of numbers referred to for filing purposes, and the middle set (62) is the secondary set, indicating the correct subsection in section 10. The chart will be placed between charts 43 and 45 in subsection 62 in section 10. Other filing methods include straight numeric filing, alphanumeric filing (initials of patient precede number), and middle digit filing.

Question: 10

If a patient is part of an HMO and needs a regular referral (non-emergent) to see a specialist, gaining approval usually takes

A. 24 hours.
B. 2 to 3 days.
C. 3 to 10 days.
D. 2 to 3 weeks.

Answer: C

Explanation:
If a patient is part of an HMO and needs a regular (non-emergent) referral to see a specialist, gaining approval usually takes 3 to 10 days although this varies according to the carrier. If the physician

indicates that the referral is urgent (but non-life threatening, approval is usually received within 24 hours. For stat (emergent) referrals, approval should be received within a few minutes to an hour.

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