

Healthcare

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Question: 1

The depreciation of equipment is what?

- A. A variable cost.
- B. An income statement.
- C. A fixed cost.
- D. A balance sheet.

Answer: C

Explanation:

The depreciation of equipment refers to the allocation of the cost of an asset over its useful life.

Depreciation is a non-cash accounting method that reduces the value of tangible assets on the balance sheet over time in accordance with their usage and age.

Depreciation is classified as a fixed cost in accounting and financial analysis. A fixed cost is one that does not vary with the level of production or sales. Unlike variable costs, which fluctuate with operational activity (such as raw materials or direct labor costs), fixed costs remain constant regardless of business activity levels. Since depreciation is calculated periodically (usually annually) and is not influenced by the day-to-day operations of a business, it is considered a fixed cost.

It's important to understand that while depreciation is a fixed cost, it does not involve an actual outlay of cash during the period. Instead, it is an accounting representation that helps businesses allocate the cost of an asset over its expected useful life. This allocation is crucial for accurately reflecting the wear and tear on the asset as it is used in the business operations, which in turn affects the financial statements.

In financial reporting, depreciation impacts both the income statement and the balance sheet. On the income statement, depreciation is recorded as an expense, which reduces the company's taxable income. On the balance sheet, it is accounted for by reducing the asset's book value and accumulating depreciation in a contra-asset account. Over time, as the asset depreciates, its accumulated depreciation increases.

In summary, the treatment of depreciation as a fixed cost is essential for cost analysis, financial planning, and compliance with accounting standards. It helps in assessing the true cost of maintaining the capital assets necessary to run a business and provides a systematic approach to expense recognition, which is critical for accurate financial reporting and analysis.

Question: 2

The period between when the service is rendered and when the bill is paid is referred to as:

- A. the age of accounts payable
- B. the endorsement period
- C. the age of accounts receivable

D. the adjustments period

Answer: C

Explanation:

The term "the age of accounts receivable" refers to the period between the provision of a service or delivery of goods and the payment for those services or goods. This time frame is critical in business accounting as it affects the company's cash flow and overall financial health.

Traditionally, the age of accounts receivable is tracked through a process known as aging analysis. This analysis helps businesses identify how long invoices have been outstanding and is typically categorized into intervals such as 30, 60, 90, or 120 days. This categorization allows companies to see which accounts are current and which are overdue, enabling more effective credit and collection strategies. The significance of monitoring the age of accounts receivable lies in its direct impact on a company's liquidity. A shorter receivables period is generally preferable as it means that the business is receiving its due payments more quickly, thereby ensuring that it has sufficient funds available for operational needs, investments, or to meet its own financial obligations, such as accounts payable.

To manage and analyze accounts receivable effectively, many businesses employ computerized financial systems. These software programs automate the process of tracking when an invoice was issued and when it is paid, thus simplifying the task of managing cash flows. They provide detailed reports that highlight overdue payments, which are critical for initiating collection efforts and for assessing the creditworthiness of clients.

In summary, the age of accounts receivable is a crucial financial metric that helps businesses manage their receivables more efficiently. By understanding how long it takes for clients to settle their invoices, companies can better control their financial operations and maintain a healthy cash flow.

Question: 3

The physician orders 750 mg of a liquid medication. You have a preparation on hand of 1,500 mg/ tsp. How many teaspoons will you give?

- A. 1 tsp or 10 mL
- B. 2 tsp or 20 mL
- C. 3 tsp or 30 mL
- D. 1/2 tsp or 2.5 mL

Answer: D

Explanation:

To determine the correct dosage of a liquid medication, it's essential to understand the concentration of the medication and the amount prescribed by the physician. In this scenario, the physician has prescribed 750 mg of a medication, and the preparation available is 1,500 mg per teaspoon.

First, identify the concentration of the medication in the available preparation. Here, it is given as 1,500 mg per teaspoon. Knowing the volume equivalent of a teaspoon is useful in this calculation. A standard teaspoon is equal to 5 mL. Thus, the concentration can also be expressed as 1,500 mg per 5 mL.

Next, calculate the amount of the liquid medication needed to provide the prescribed dose of 750 mg. Since the concentration is 1,500 mg per 5 mL, you can set up a proportion to find out how many teaspoons or milliliters are needed for 750 mg. The equation is:
Therefore, you need to administer 0.5 teaspoons of the medication to deliver a dose of 750 mg. Since each teaspoon is equivalent to 5 mL, 0.5 teaspoons equals 2.5 mL. Hence, you would give 0.5 tsp or 2.5 mL of the liquid medication to meet the physician's order. This calculation ensures the patient receives the correct dosage in the appropriate volume of liquid medication.

Question: 4

Of the following, what is the coding for radiology?

- A. 70000 to 79999
- B. 00100 to 01999
- C. 10000 to 69999
- D. 80000 to 89999

Answer: A

Explanation:

In the context of medical billing and coding, different medical specialties and services are assigned specific code ranges to streamline billing processes and ensure accurate record-keeping. The coding system helps in categorizing and specifying the type of medical service provided to a patient. For radiology services, the designated code range is from 70000 to 79999. This range includes all diagnostic imaging services such as X-rays, MRIs, CT scans, ultrasounds, and other radiographic procedures. These codes are crucial for radiologists and other healthcare providers to bill accurately for the radiological services rendered to patients.

To give a broader context, other medical services are also categorized within specific code ranges. For instance, the code range 10000 to 69999 is allocated to surgical procedures, covering everything from minor surgical interventions to major operations. The 80000 to 89999 range is reserved for pathology and laboratory services, which include tests and analyses conducted on biological samples. Anesthesia services are coded within the 00100 to 01999 bracket, encompassing all procedures related to the administration of anesthesia during surgeries and other medical procedures.

Understanding these code ranges is essential for healthcare professionals to ensure they comply with billing regulations and maintain accurate medical records for patient care and insurance reimbursement purposes. The coding system facilitates efficient data management and financial transactions across the healthcare industry.

Question: 5

What is the abbreviation for by mouth?

- A. no
- B. po
- C. do
- D. mo

Answer: B

Explanation:

The abbreviation "po" stands for the Latin phrase "per os," which translates to "by mouth" in English. This term is frequently utilized in medical contexts, particularly in prescription writing and when giving instructions for medication administration.

When a doctor prescribes medication, they will specify the route of administration, which is crucial for ensuring the drug's effectiveness and safety. The route "po" indicates that the medication should be taken orally, swallowed, and processed through the gastrointestinal system. This is distinct from other routes such as intravenous (IV), topical, or intramuscular (IM), each of which delivers medication differently within the body.

In practice, using "po" in medical orders helps ensure clarity and minimizes errors in healthcare settings. It is a part of a standardized system of abbreviations that are understood universally among healthcare providers. This standardization is vital for maintaining consistency and clear communication across different practitioners and healthcare facilities, thereby enhancing patient care.

Question: 6

This amount is the numerical value for prefix, -deka.

- A. One million.
- B. One thousand.
- C. One Hundred.
- D. Ten.

Answer: D

Explanation:

The question asks for the numerical value associated with the prefix "deka." The correct answer is "Ten." In the metric system, different prefixes are used to represent various orders of magnitude. Each prefix indicates a specific multiplier for the base unit it is associated with.

For example, the prefix "mega-" denotes a factor of one million. Therefore, when "mega-" is used with a base unit like the meter (as in "megameter"), it signifies one million meters. Similarly, "kilo-" represents a thousand times the base unit, so a "kilometer" is one thousand meters.

Moving further down the scale, "hecto-" stands for a hundredfold increase. Therefore, a "hectometer" equals one hundred meters.

Finally, the prefix "deka-" (also spelled "deca-") signifies ten times the base unit. Hence, a "dekameter" comprises ten meters. This explanation confirms that the correct answer to the question is indeed "Ten," correlating with the "deka-" prefix.

Question: 7

All of the following are sites for intramuscular injections EXCEPT:

- A. the vastus lateralis

- B. the ventrogluteal
- C. the dorsogluteal
- D. the triceps

Answer: D

Explanation:

The question asks us to identify which among the listed sites is not commonly used for intramuscular injections. The sites mentioned are the vastus lateralis, the triceps, the ventrogluteal, the dorsogluteal, and the triceps repeated multiple times.

The vastus lateralis muscle is located on the side of the thigh. It is one of the most commonly used sites for intramuscular injections, especially in infants and young children, where it is preferred due to its large muscle mass and limited major nerves and blood vessels.

The ventrogluteal site, located on the hip, away from the buttocks, is another preferred site for intramuscular injections due to its deep location and minimal major nerves and blood vessels. This site is particularly suitable for volumes greater than 1 mL and for viscous and irritating medications.

The dorsogluteal site, found in the buttocks, was once a common site for intramuscular injections. However, it is less favored now due to the risk of damaging the sciatic nerve and significant blood vessels, along with inconsistent absorption rates of medication.

The triceps muscle, located at the back of the upper arm, is not a standard site for intramuscular injections. This muscle is generally smaller and has less depth compared to the other sites mentioned, making it less ideal for the administration of intramuscular injections. The triceps area might be considered in cases where other more common sites are not available, but this is rare and not typically recommended due to its proximity to nerves and smaller muscle mass.

Thus, among the options given, the triceps is the site that is not typically used for intramuscular injections. This site could pose higher risks of complications due to improper needle placement and is not recommended especially when other safer and more effective sites are available for use.

Question: 8

Which of the following would not be an outpatient service provided in an acute-care facility?

- A. Sleep lab testing
- B. Pulmonary function testing
- C. Cardiac catheterization
- D. Radiation therapy

Answer: C

Explanation:

Acute-care facilities are designed to provide short-term treatment for patients suffering from severe episodes of illness, injury, or recovery from surgery. The range of services offered in these facilities is vast, aiming to cover numerous diagnostic and therapeutic needs that can be addressed without requiring an overnight hospital stay.

Among the services typically provided by acute-care facilities, we find outpatient services such as sleep lab testing, outpatient radiology exams, pulmonary function testing, radiation therapy, and various

forms of therapy like physical, speech, and occupational therapy. These services are structured to be completed within the same day, allowing patients to return home without the need for an extended hospital stay.

Sleep lab testing, for example, involves studying a patient's sleep patterns to diagnose and treat sleep disorders. This testing typically does not require an overnight stay or extensive post-procedure recovery, making it ideal for an outpatient setting. Similarly, pulmonary function tests, which assess lung function and breathing, are non-invasive and quick, thus not necessitating prolonged patient monitoring.

However, cardiocatheterization, a procedure mentioned in the initial query, typically does not fall under the standard outpatient services provided by acute-care facilities. Cardiocatheterization involves the insertion of a catheter into a chamber or vessel of the heart. This procedure is used to diagnose and treat cardiovascular conditions like blockages and heart diseases. While some facilities might offer this as an outpatient service under very controlled circumstances, it generally requires more extensive preparation and post-procedure monitoring to manage potential complications, such as bleeding from the catheter insertion site or arrhythmias. Due to these complexities, cardiocatheterization is often conducted in settings equipped for longer patient stays or more intensive monitoring, making it less likely to be classified strictly under outpatient services in many acute-care facilities.

Thus, when comparing typical outpatient services in acute-care settings—like sleep lab testing or pulmonary function testing—to cardiocatheterization, it becomes evident why the latter is not commonly provided as an outpatient service. It involves more invasive procedures and a higher level of risk that necessitates a different level of care and patient monitoring than what is usually available in the outpatient context of acute care facilities.

Question: 9

When an HMO hires physicians and pays them a salary to provide medical services, what HMO model is being implemented?

- A. Group.
- B. IPA.
- C. Network.
- D. Staff.

Answer: D

Explanation:

The correct answer to the question of which HMO model is being implemented when an HMO hires physicians and pays them a salary to provide medical services is the "Staff" model.

In the Staff model of an HMO (Health Maintenance Organization), the HMO directly employs physicians. These physicians receive a salary from the HMO and provide medical services exclusively to the HMO's members. This model enables the HMO to have extensive control over the medical services provided, as the physicians are direct employees. This internal structure often aims to streamline processes and improve the consistency of patient care since all healthcare services are managed under one organizational umbrella.

Apart from the Staff model, there are other HMO models mentioned which operate differently: - The "Group" model involves an HMO contracting with a single multi-specialty group practice, which agrees to provide care to HMO members. In this setup, the physicians are not salaried employees of the HMO, but of the group practice. - The "IPA" (Independent Practice Association) model has the HMO

contracting with an association of independent physicians who maintain their separate practices but agree to provide care to HMO members under contract terms. - The "Network" model is a broader system where the HMO contracts with multiple physician groups or practices to provide services to its members. This model offers a wide range of providers and specialties. Each of these models has different implications for how care is delivered, how physicians are compensated, and how risks are shared between the providers and the HMO. However, when specifically referring to an HMO hiring and salaried physicians, the Staff model is the applicable scenario. This model often focuses on preventive care and may provide incentives for physicians to focus on efficiency and quality of care, aligning the interests of the provider with the health outcomes of the HMO's members.

Question: 10

What is the amount of money an employee earns before taxes or deductions are taken out?

- A. the prior earnings
- B. the net income
- C. the gross income
- D. the total earnings

Answer: C

Explanation:

The correct answer to the question about the amount of money an employee earns before taxes or deductions are taken out is "the gross income."

Gross income, often referred to as gross pay or gross salary, is the total amount of money an employee receives from their employer before any deductions such as taxes, social security, pensions, and health insurance premiums are subtracted. This figure includes all forms of income earned by the employee, which can encompass wages, salaries, bonuses, overtime pay, and other forms of compensation. It is essential to differentiate between gross income and net income, which is sometimes simply called "take-home pay." Net income is the amount of money that an employee actually receives after all deductions have been made. These deductions can be mandatory, like state and federal taxes and Social Security contributions, or voluntary, such as contributions to retirement accounts or payment for employer-provided health insurance.

Understanding the distinction between gross and net income is crucial for financial planning and budgeting. Gross income provides a baseline for the initial calculation of what an employee earns, which is then adjusted to reflect the actual amount available for spending after all necessary deductions are accounted for.

In summary, when discussing the amount an employee earns before any deductions, the term to use is "gross income." It represents the total earnings without considering the reductions that affect the net take-home pay.

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