

Certified Medical Administrative Assistants (CMAA) Practice Exam Sample Study Guide



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SAMPLE

Questions

- 1. Which of the following is typically included in 'assets'?**
 - A. Bank loans**
 - B. Cash**
 - C. Liabilities**
 - D. Expenses**
- 2. What should you do as soon as possible when tracing a "skip"?**
 - A. Begin the search immediately**
 - B. Notify the financial advisor**
 - C. Contact the bank**
 - D. Schedule a follow-up**
- 3. What does the abbreviation "Dx" commonly signify in healthcare?**
 - A. Treatment**
 - B. Diagnosis**
 - C. Dosage**
 - D. Procedure**
- 4. Which type of hospital is designed to treat severely ill or injured patients?**
 - A. Long-term care**
 - B. Acute Care**
 - C. Rehabilitation**
 - D. Outpatient care**
- 5. Which term describes an action that decreases assets?**
 - A. Debit**
 - B. Credit**
 - C. Withdrawal**
 - D. Expense**

- 6. Which report would provide insight into the outstanding balances owed to a practice?**
- A. Profit and loss statement**
 - B. Accounts receivable report**
 - C. Cash flow statement**
 - D. Salary report**
- 7. In a medical practice, what is the most widely used computer application?**
- A. Patient scheduling software**
 - B. Electronic Health Records (EHR)**
 - C. Financial management software**
 - D. Telemedicine software**
- 8. Which legislation applies to businesses that charge interest or allow more than four service payments?**
- A. Federal Truth in Lending Act**
 - B. Fair Debt Collection Practices Act**
 - C. Bankruptcy Reform Act**
 - D. Equal Credit Opportunity Act**
- 9. What does predetermination refer to in health insurance?**
- A. The process of appealing an insurance denial**
 - B. The maximum amount an insurance company will pay for a service**
 - C. Determining patient eligibility for services**
 - D. Setting up a payment plan for patients**
- 10. What is the process called for determining if a service is covered by a patient's insurance?**
- A. Authorization**
 - B. Eligibility verification**
 - C. Precertification**
 - D. Claim submission**

Answers

SAMPLE

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

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Explanations

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1. Which of the following is typically included in 'assets'?

- A. Bank loans**
- B. Cash**
- C. Liabilities**
- D. Expenses**

Assets refer to resources owned by an entity that provide future economic benefits. Cash is a clear example of an asset because it is a liquid resource that can be used for transactions, investments, or to cover expenses. It represents the most straightforward asset, as it can easily be accessed and utilized. In contrast, bank loans are considered liabilities because they represent money that the entity owes to creditors. Liabilities are obligations that must be settled in the future, which is the opposite of assets. Similarly, expenses reflect outflows of resources and are recorded on the income statement, making them a part of the financial activity but not an asset in the balance sheet context. Therefore, cash is included in the assets section of a balance sheet, representing ownership and availability for use.

2. What should you do as soon as possible when tracing a "skip"?

- A. Begin the search immediately**
- B. Notify the financial advisor**
- C. Contact the bank**
- D. Schedule a follow-up**

Beginning the search immediately is essential when tracing a "skip," which refers to an individual who has failed to make payments and has become hard to locate. Swift action is crucial because delays can lead to further complications in recovering debts. The sooner the search is initiated, the better the chances of successfully locating the individual. Commencing the search without delay allows access to the most up-to-date information available, including any changes in address, employment status, or financial situations that may have occurred since the last contact. Quick action can also help maintain the momentum in the collection process, potentially increasing the likelihood of a successful resolution. Engaging in a timely search enables the use of various tracking methods, such as social media checks, credit reports, and reaching out to known contacts, which might yield quicker results. While informing the financial advisor, contacting the bank, or scheduling a follow-up could be parts of the overall strategy in dealing with skips, these actions would typically follow the immediate investigation. The target should always be to gather information as quickly as possible to mitigate losses and facilitate the recovery process.

3. What does the abbreviation "Dx" commonly signify in healthcare?

- A. Treatment**
- B. Diagnosis**
- C. Dosage**
- D. Procedure**

The abbreviation "Dx" is commonly used in healthcare to signify "Diagnosis." This term refers to the identification of a disease or condition based on the signs, symptoms, medical history, and often the results of diagnostic tests. Accurate diagnosis is crucial as it guides healthcare providers in developing appropriate treatment plans for patients. In the context of medical documentation and communication, using this abbreviation allows healthcare professionals to quickly convey essential information regarding a patient's health status. It reflects a foundational aspect of medical care, as establishing a correct diagnosis is key to effective patient management and treatment outcomes. Understanding the meaning of "Dx" is essential for anyone involved in medical administrative tasks, as it is frequently encountered in medical records, prescriptions, and consultations.

4. Which type of hospital is designed to treat severely ill or injured patients?

- A. Long-term care**
- B. Acute Care**
- C. Rehabilitation**
- D. Outpatient care**

Acute care hospitals are specifically designed to provide immediate, short-term treatment for patients with severe illnesses, injuries, or those requiring urgent medical attention. These facilities are equipped with advanced medical technology and staffed with healthcare professionals who can address critical health issues and surgical emergencies. In acute care settings, the focus is on stabilizing patients and managing their conditions until they can be moved to less intensive care or discharged. This type of care is essential for individuals facing life-threatening conditions or requiring complex medical interventions that need to happen quickly to ensure the best possible outcomes. In contrast, long-term care facilities typically cater to patients who need assistance over an extended period due to chronic illnesses or disabilities, while rehabilitation centers focus on helping patients recover strength and functionality after serious injuries or surgeries. Outpatient care centers provide treatments or procedures that do not require an overnight stay. Each of these options serves different patient needs, but it is the acute care hospital that is specifically tailored for handling severe and urgent medical situations.

5. Which term describes an action that decreases assets?

- A. Debit**
- B. Credit**
- C. Withdrawal**
- D. Expense**

The correct answer is credit. In accounting, a credit represents an entry that decreases assets or increases liabilities and equity. When you credit an asset account, this signifies that there is a reduction in that asset. For example, if a business sells equipment, the amount received from the sale would lead to a credit in the asset account for that equipment, reflecting a decrease in assets. Although withdrawal and expense may also impact the financial position, they do not specifically categorize the action of decreasing assets in the same fundamental way that credit does. A withdrawal typically refers to the removal of funds from an owner's equity account, and expenses are costs incurred that reduce net income but do not directly indicate a transaction associated with asset reduction. A debit, on the other hand, is used to record increases in assets, which also makes it not applicable in describing the action of decreasing assets.

6. Which report would provide insight into the outstanding balances owed to a practice?

- A. Profit and loss statement**
- B. Accounts receivable report**
- C. Cash flow statement**
- D. Salary report**

The accounts receivable report is critical for providing insight into the outstanding balances owed to a practice. This report details all money that is owed to the practice by patients or insurers for services rendered. It includes information on invoices that have not yet been paid, allowing the medical administrative assistant to track which balances are outstanding and how long they have been overdue. This is essential for managing cash flow and ensuring that the practice can maintain its financial health. Other reports have different primary focuses. A profit and loss statement summarizes revenues and expenses over a specific period, providing overall financial performance insights rather than specific amounts owed. The cash flow statement reflects the inflows and outflows of cash, emphasizing liquidity rather than debts owed. A salary report outlines the wages and compensation related to employees but does not address accounts receivable or outstanding balances. Thus, the accounts receivable report is the most relevant tool for examining outstanding balances.

7. In a medical practice, what is the most widely used computer application?

- A. Patient scheduling software**
- B. Electronic Health Records (EHR)**
- C. Financial management software**
- D. Telemedicine software**

In a medical practice, Electronic Health Records (EHR) are considered the most widely used computer application. EHR systems serve as comprehensive digital records that store patient information, including medical history, medications, allergies, lab results, and treatment plans. These systems enhance care coordination, improve patient safety through better data accessibility, and streamline workflows for healthcare providers. The widespread adoption of EHRs aligns with initiatives aimed at improving patient care and efficiency in healthcare delivery. They facilitate communication between different healthcare providers, which is crucial for integrated care. In contrast, while financial management software is important for managing billing and practice finances, its usage is more specialized and secondary to the central goal of patient care that is addressed by EHRs. Although patient scheduling software is vital for managing appointments, and telemedicine software is becoming increasingly important for remote care, neither offers the comprehensive capabilities or the essential nature of EHR systems in daily medical practice.

8. Which legislation applies to businesses that charge interest or allow more than four service payments?

- A. Federal Truth in Lending Act**
- B. Fair Debt Collection Practices Act**
- C. Bankruptcy Reform Act**
- D. Equal Credit Opportunity Act**

The Federal Truth in Lending Act is designed to promote informed use of credit by requiring disclosures about its terms and cost. This legislation applies specifically to businesses that charge interest or permit payment plans exceeding four installments. It mandates that lenders disclose key information such as the annual percentage rate (APR), terms of repayment, and the total cost of credit. This ensures that consumers are fully aware of the financial implications before agreeing to a credit arrangement. In contrast, the Fair Debt Collection Practices Act focuses on regulating the practices of third-party debt collectors to protect consumers from abusive and misleading practices. The Bankruptcy Reform Act pertains to the process of bankruptcy and how debts are handled legally when an individual or entity files for bankruptcy. The Equal Credit Opportunity Act prevents discrimination in credit practices, ensuring equal treatment in lending but does not specifically relate to the charging of interest or payment plans. Thus, the Federal Truth in Lending Act is the legislation that directly addresses the scenario of businesses charging interest or allowing more than four service payments.

9. What does predetermination refer to in health insurance?

- A. The process of appealing an insurance denial**
- B. The maximum amount an insurance company will pay for a service**
- C. Determining patient eligibility for services**
- D. Setting up a payment plan for patients**

Predetermination in health insurance refers specifically to the maximum amount an insurance company will pay for a particular service. This process involves the insurance provider evaluating a proposed treatment or procedure to establish the allowable charges and to determine the coverage limits before the service is rendered. By having this information in advance, healthcare providers can better understand how much of the service will be reimbursed, allowing them to inform patients about potential out-of-pocket costs. This ensures that all parties are aware of financial responsibilities ahead of time, improving transparency and minimizing surprises regarding medical bills. The other options relate to different aspects of health insurance management, such as appealing a denial, determining eligibility, or setting up payment plans, but they do not encapsulate the core meaning of predetermination as it pertains to maximum allowable payments.

10. What is the process called for determining if a service is covered by a patient's insurance?

- A. Authorization**
- B. Eligibility verification**
- C. Precertification**
- D. Claim submission**

The process of determining if a service is covered by a patient's insurance is known as eligibility verification. This essential step involves checking with the insurance company to confirm whether the specific procedures, treatments, or services are included under the patient's insurance plan. Eligibility verification helps healthcare providers ascertain if the patient qualifies for coverage, what their benefits entail, and if any limitations or exclusions apply to particular services. This process is crucial for ensuring patients understand their financial responsibilities before undergoing treatment and allows providers to manage their billing and collections efficiently. Having accurate eligibility information helps prevent claim denials related to coverage issues later on. While authorization, precertification, and claim submission are all important components in the healthcare and insurance processes, they serve different purposes. Authorization refers to the approval from the insurance company for a specific service or treatment, indicating that the service is medically necessary but does not initially establish if the service is generally covered. Precertification is a similar concept but often applies to more complex treatments requiring additional scrutiny before they are provided. Claim submission is the process of sending a request for payment to the insurance company after services have been rendered, which occurs after eligibility verification has already taken place.