

Health Insurance Billing Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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Questions

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- 1. What are mandates classified as?**
 - A. Surveys**
 - B. Standards**
 - C. Laws**
 - D. Voluntary guidelines**
- 2. Which insurance is defined as reimbursement for income lost as a result of a temporary or permanent illness or injury?**
 - A. Disability**
 - B. Liability**
 - C. Indemnity**
 - D. Fee-for-service**
- 3. Which refers to the contractual right of a third-party payer to recover health care expenses from a liable party?**
 - A. Arbitration**
 - B. Claims adjudication**
 - C. Subrogation**
 - D. Appeal**
- 4. Which coding system is used to report procedures and services on inpatient hospital claims?**
 - A. CPT**
 - B. ICD-10-CM**
 - C. ICD-10-PCS**
 - D. HCPCS level II**
- 5. What is preprinted in Block 21 of the CMS-1500 claim?**
 - A. Diagnosis pointers**
 - B. Days or units**
 - C. Modifiers**
 - D. Charges**

- 6. According to the birthday rule, who is considered the primary policyholder when both parents have group health insurance policies?**
- A. The parent whose birth month and day occurs earlier in the calendar year.**
 - B. The parent who was born first.**
 - C. Both parents are primary policyholders.**
 - D. The parent whose income is higher.**
- 7. Which of the following is often used to measure the effectiveness of healthcare services?**
- A. a. patient satisfaction surveys**
 - B. b. financial audits**
 - C. c. insurance claim submissions**
 - D. d. staff performance reviews**
- 8. Which professional organization provides industry and regulatory education and networking opportunities for its members and offers the Certified Medical Reimbursement Specialist (CMRS) credential?**
- A. MAB**
 - B. AHIMA**
 - C. AMBA**
 - D. AAMA**
- 9. Which payment system is based on the physician's work, practice expenses, and malpractice insurance expenses?**
- A. Per diem**
 - B. Ambulatory payment classifications**
 - C. Resource-Based Relative Value Scale system**
 - D. Diagnosis-related groups**
- 10. What is sent by the third-party payer to the patient detailing the results of processing a claim?**
- A. Appeal letter**
 - B. Remittance advice**
 - C. Premium statement**
 - D. Explanation of benefits**

Answers

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

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Explanations

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1. What are mandates classified as?

- A. Surveys**
- B. Standards**
- C. Laws**
- D. Voluntary guidelines**

Mandates are classified as laws because they are established by governmental authority and often entail requirements that must be followed by individuals or organizations. When regulations are mandated, they carry legal weight and noncompliance can result in penalties or legal action. This classification underscores the mandatory nature of these directives, as opposed to optional guidelines or recommendations. In distinction, while standards can be important frameworks within regulatory environments, they are typically not legally enforceable unless codified into law. Surveys often serve only to gather data or opinions and do not impose any legal obligations. Voluntary guidelines, by nature, are suggestions rather than legally binding requirements. Therefore, classifying mandates as laws emphasizes their enforceable nature and the obligation for individuals or entities to adhere.

2. Which insurance is defined as reimbursement for income lost as a result of a temporary or permanent illness or injury?

- A. Disability**
- B. Liability**
- C. Indemnity**
- D. Fee-for-service**

Disability insurance is specifically designed to provide income replacement for individuals who are unable to work due to a temporary or permanent illness or injury. This type of insurance helps to alleviate financial stress by offering a portion of the insured's income while they recover or adjust to a disability. The reimbursement structure is crucial in disability insurance; it typically pays a percentage of the insured's pre-disability income, allowing them to maintain their standard of living even if they are unable to engage in their usual employment due to health issues. This form of insurance is particularly important for those whose livelihoods depend on their ability to work, as it provides a safety net during times of health-related difficulties. It distinguishes itself by focusing not on medical costs, but rather on replacing lost income, thereby providing critical financial support when unexpected health challenges arise.

3. Which refers to the contractual right of a third-party payer to recover health care expenses from a liable party?

- A. Arbitration**
- B. Claims adjudication**
- C. Subrogation**
- D. Appeal**

Subrogation is the process that allows a third-party payer, such as an insurance company, to recover the costs of health care expenses they have paid from another party that is deemed liable for those expenses. This usually occurs in situations where an injury or illness is associated with an event involving another entity that is responsible for covering those costs. For example, if a person is injured in a car accident due to another driver's negligence, the injured party's health insurance may initially cover their medical bills. However, the insurance company can then seek reimbursement from the at-fault driver or their insurance through subrogation. This prevents the injured party from being compensated twice and ensures that the party responsible for the bill ultimately pays. Understanding subrogation is crucial for health care providers and billing professionals because it impacts how claims are processed and how funds are recovered, ensuring appropriate liability and account management. This knowledge is vital for proper billing practices and maximization of reimbursement.

4. Which coding system is used to report procedures and services on inpatient hospital claims?

- A. CPT**
- B. ICD-10-CM**
- C. ICD-10-PCS**
- D. HCPCS level II**

The coding system used to report procedures and services on inpatient hospital claims is ICD-10-PCS. This set of codes is specifically designed for the inpatient setting and is utilized primarily in hospital billing for tracking inpatient procedures. ICD-10-PCS consists of alphanumeric codes that provide detailed information regarding the procedures performed during a patient's hospital stay, capturing complex procedures that may involve multiple steps or levels of specificity. In contrast, CPT (Current Procedural Terminology) is designed mainly for outpatient providers and is often used for services and procedures performed by healthcare providers outside of a hospital setting. ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) is primarily used for coding diagnoses and not procedures. HCPCS Level II codes, while used for various health services, are not specifically focused on inpatient hospital procedures. Thus, ICD-10-PCS is the appropriate choice for reporting such services within the context of inpatient hospital claims.

5. What is preprinted in Block 21 of the CMS-1500 claim?

A. Diagnosis pointers

B. Days or units

C. Modifiers

D. Charges

Block 21 of the CMS-1500 claim form is specifically designated for entering the diagnosis codes related to the patient's condition or the reason for the healthcare services provided. Preprinted in this block are the terms "Diagnosis or Nature of Illness." This allows healthcare providers to indicate the medical necessity and appropriateness of the services claimed. In this context, diagnosis pointers are crucial because they provide the connection between the services billed in Block 24D and the specific diagnosis codes noted in Block 21. By aligning the services provided with the corresponding diagnosis codes, payers can better assess the validity of the claims. The accuracy and relevance of these pointers are essential for ensuring that the claims are processed correctly and efficiently. The other choices, while related to the billing process, do not accurately describe what is preprinted in this block. Days or units refer to the quantity of service provided and are recorded in a different section of the form. Modifiers are utilized to provide additional details about the service but are also documented in other areas. Charges are typically recorded in Block 24F and are not preprinted in Block 21. This alignment highlights the significance of diagnosis pointers in this specific area of the CMS-1500 claim form.

6. According to the birthday rule, who is considered the primary policyholder when both parents have group health insurance policies?

A. The parent whose birth month and day occurs earlier in the calendar year.

B. The parent who was born first.

C. Both parents are primary policyholders.

D. The parent whose income is higher.

The birthday rule is a guideline used in health insurance to determine which parent's policy is considered primary for covering a dependent child when both parents have health insurance. This rule specifies that the primary policyholder is the parent whose birthday falls earlier in the calendar year, irrespective of the year they were born. This means that if one parent has a birthday in January and the other in March, the parent with the January birthday would be designated as the primary policyholder. This approach helps streamline processes for claims and coordination of benefits between insurance plans, ensuring that both parents' coverage is maintained effectively without ambiguity. The focus of the rule is purely on the order of the calendar year rather than other factors such as age or income, which eliminates unnecessary complications. Other considerations, like the order of birth or financial contribution to the policy, do not influence the designation of the primary policyholder. Therefore, the rule is a straightforward method for deciding which policy kicks in first when there are claims for medical services for the child.

7. Which of the following is often used to measure the effectiveness of healthcare services?

- A. a. patient satisfaction surveys**
- B. b. financial audits**
- C. c. insurance claim submissions**
- D. d. staff performance reviews**

Patient satisfaction surveys are a widely recognized method for measuring the effectiveness of healthcare services because they provide direct feedback from patients regarding their experiences. These surveys can assess various aspects of care, including the quality of treatment, the attentiveness of healthcare staff, and the overall patient experience within the healthcare system. When healthcare facilities analyze the results from these surveys, they gain valuable insights into areas where they excel and where improvements are needed. This information can guide policy changes, staff training, and overall service enhancements, ultimately leading to better health outcomes and a higher standard of care. The focus on patient experience is crucial, as it often correlates directly with the perceived quality of care and can impact a facility's reputation, patient loyalty, and financial performance. In contrast, financial audits primarily assess the monetary aspects of a healthcare facility, while insurance claim submissions focus on the administrative process of billing and reimbursement. Staff performance reviews evaluate employee function and productivity but don't directly capture the patient's experience or satisfaction. Each of these options serves distinct purposes within the healthcare system, but patient satisfaction surveys specifically aim to measure the quality and effectiveness of healthcare services from the patient's perspective.

8. Which professional organization provides industry and regulatory education and networking opportunities for its members and offers the Certified Medical Reimbursement Specialist (CMRS) credential?

- A. MAB**
- B. AHIMA**
- C. AMBA**
- D. AAMA**

The organization that provides industry and regulatory education and networking opportunities for its members, along with offering the Certified Medical Reimbursement Specialist (CMRS) credential, is indeed AMBA. AMBA, or the American Medical Billing Association, focuses specifically on the field of medical billing and reimbursement. It offers resources and support to professionals in this industry, including training programs that lead to certification. The CMRS credential is significant as it demonstrates a professional's expertise and commitment to excellence in medical reimbursement practices. In contrast, AHIMA, or the American Health Information Management Association, is more oriented towards health information management and not specifically focused on medical billing credentials. AAMA, the American Association of Medical Assistants, represents medical assistants and their certification programs, but does not focus on medical reimbursement specifically. Lastly, MAB does not represent a well-known organization in this context regarding medical billing certification. Thus, AMBA stands out as the professional organization dedicated to medical billing and reimbursement professionals, offering the relevant certification.

9. Which payment system is based on the physician's work, practice expenses, and malpractice insurance expenses?

A. Per diem

B. Ambulatory payment classifications

C. Resource-Based Relative Value Scale system

D. Diagnosis-related groups

The correct choice is based on the Resource-Based Relative Value Scale (RBRVS) system, which is specifically designed to account for three main components: the physician's work, the practice expenses, and the cost of malpractice insurance. This system enables a more accurate reflection of the resources required to provide various medical services and procedures. The RBRVS assigns relative value units (RVUs) to different services, which are then adjusted by geographic factors and converted into a payment amount. This structure aims to fairly compensate physicians based on the complexity and resource intensity of their work, rather than solely on the services rendered or the number of patients treated. In contrast, the other options serve different purposes. The per diem payment system is typically used for inpatient care, indicating a daily rate rather than a service-based approach. Ambulatory payment classifications (APCs) are utilized for outpatient services and categorize these procedures for payment, but they do not center around the comprehensive breakdown that RBRVS provides. Lastly, diagnosis-related groups (DRGs) are used mainly for inpatient hospital billing, categorizing hospital cases to determine reimbursement based on the diagnosis, rather than the specific nuances of a physician's practice costs and work. This distinction highlights why RBRVS is the relevant system when

10. What is sent by the third-party payer to the patient detailing the results of processing a claim?

A. Appeal letter

B. Remittance advice

C. Premium statement

D. Explanation of benefits

The term relating to the document that a third-party payer sends to the patient, explaining the results of processing a claim, is the Explanation of Benefits (EOB). This document serves multiple purposes: it outlines the services provided, the amount billed, the amount covered by the insurance, the patient's financial responsibility, and any adjustments made by the insurance company. The EOB is essential for patients as it provides transparency regarding their healthcare expenses and ensures they understand how their claims were processed. It informs the patient of what was paid, what is still owed, and any reasons for denial or adjustment in claims. This level of communication helps maintain a clear understanding between the patient and the insurer regarding payment responsibilities. The other options do not accurately fulfill this function. An appeal letter is typically a request to reconsider a denied claim, a remittance advice is sent to healthcare providers detailing payments made, and a premium statement summarizes the insurance premium payments rather than claim processing results.