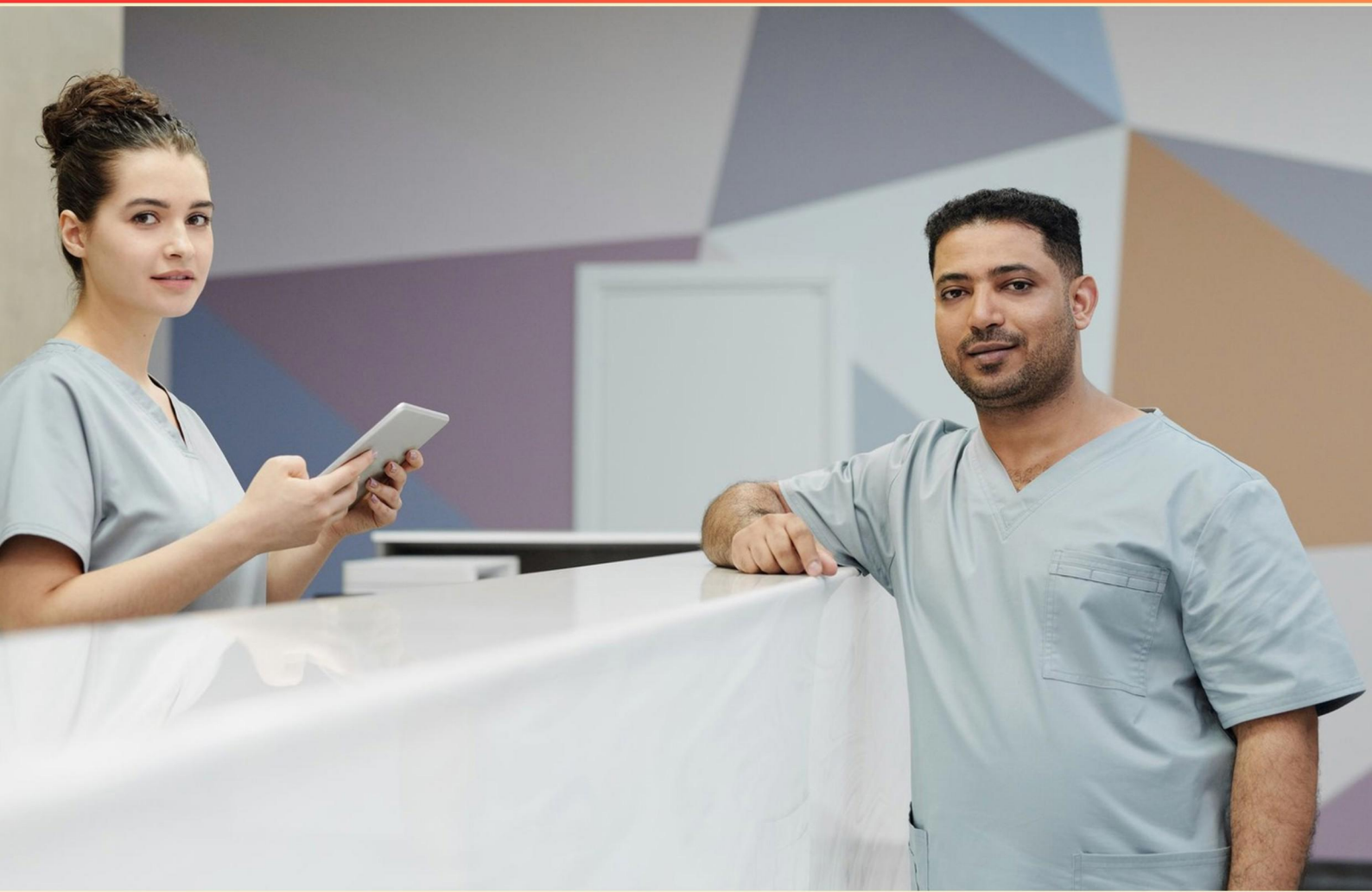


MEDICAL BILLING AND REIMBURSEMENT PRACTICE EXAM (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

**VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE**

<https://medicalbillingreimbursement.examzify.com>



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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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1. How does the National Drug Code (NDC) interact with HCPCS billing for medications?

- A. NDC identifies devices; used for reimbursement.
- B. NDC identifies drugs and is often required on claims or in DME billing; used for reimbursement and inventory.
- C. NDC replaces HCPCS codes for all medications.
- D. NDC is only used in inpatient billing.

2. What is precertification in medical billing?

- A. The process of submitting prior authorization before any service.
- B. The process of proving to the insurance company that the service is medically necessary.
- C. The process of coding only the diagnosis.
- D. The process of renewing benefit eligibility.

3. Which option best summarizes HIPAA's Privacy and Security rules?

- A. It requires consent for all disclosures and has no breach notification.
- B. It applies only to electronic records.
- C. It protects PHI and secures data handling with breach notification.
- D. It only applies to hospitals.

4. What is timely filing, and what is the general Medicare time limit for submitting claims?

- A. Claims must be filed within a stated period from the date of service; Medicare generally requires within 12 months.
- B. Claims must be submitted within 30 days.
- C. There is no deadline for Medicare claims.
- D. Claims must be filed within 5 years.

5. What information is required in Blocks 1a to 13 of the Patient/Insured Section?

- A. Health plan ID number, name, address, policy and group numbers, birth date, gender, and other claim ID.
- B. Patient occupation and employer name.
- C. Provider tax ID and license number.
- D. Insurance card color and patient fingerprint.

- 6. Which CPT procedures typically have 0-, 10-, and 90-day global periods, and how does that affect billing?**
- A. Minor procedures often have 0-day; moderate usually 10-day; major surgeries 90-day; post-op care included in global period.
 - B. All procedures have a 30-day global period; post-op care is not included.
 - C. Global periods are only used for dental codes; not for medical.
 - D. Global periods are irrelevant to billing; they do not affect post-op care.
- 7. Compare DRGs and APCs; identify where each applies.**
- A. DRGs are inpatient prospective payment system (in hospitals); APCs are outpatient prospective payment system (outpatient departments).
 - B. DRGs are outpatient; APCs are inpatient.
 - C. DRGs and APCs are the same system.
 - D. DRGs reflect physician fees; APCs reflect facility fees.
- 8. What is the purpose of Block 25 on the CMS-1500 form?**
- A. To record the Federal Tax ID Number.
 - B. The patient's insurance policy number.
 - C. The diagnosis code.
 - D. The provider's NPI.
- 9. What is the purpose of a claims scrubber in billing software?**
- A. To encrypt patient data.
 - B. To automatically approve all claims.
 - C. To generate patient statements.
 - D. To help identify mistakes in claims before submission.
- 10. Block 31 on the CMS-1500 form requires which of the following?**
- A. The signature of the physician or supplier to verify that the claim is correct.
 - B. The date of service.
 - C. The patient's contact email.
 - D. The insurance policy number.

Answers

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

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Explanations

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1. How does the National Drug Code (NDC) interact with HCPCS billing for medications?

- A. NDC identifies devices; used for reimbursement.
- B. NDC identifies drugs and is often required on claims or in DME billing; used for reimbursement and inventory.**
- C. NDC replaces HCPCS codes for all medications.
- D. NDC is only used in inpatient billing.

The key idea is that the National Drug Code uniquely identifies the exact drug product, while HCPCS codes describe the billed item or service. In medical billing, the HCPCS code indicates what is being billed (the drug or service and its general form), but many payers require the NDC to accompany that code so the precise product—manufacturer, formulation, strength, and packaging—is clearly identified. This exact product identification supports correct reimbursement, pricing, and inventory management, especially for medications and related durable medical equipment. The NDC thus complements HCPCS by providing exact product detail; it does not replace HCPCS, and it's not limited to inpatient billing or to devices.

2. What is precertification in medical billing?

- A. The process of submitting prior authorization before any service.
- B. The process of proving to the insurance company that the service is medically necessary.**
- C. The process of coding only the diagnosis.
- D. The process of renewing benefit eligibility.

Precertification is the pre-authorization step with the insurer to verify that a proposed service is medically necessary and likely covered before it's performed. This approval hinges on demonstrating medical necessity and alignment with the patient's benefits, so the service will be paid if it's approved. In practice, clinicians submit supporting documentation, the payer reviews it against medical criteria, and a decision is issued before care is delivered. This is why the best choice emphasizes proving medical necessity to the insurance company. The other options aren't the main function: precertification isn't simply coding a diagnosis, isn't about renewing benefits, and isn't the blanket act of submitting prior authorization before every service.

3. Which option best summarizes HIPAA's Privacy and Security rules?

- A. It requires consent for all disclosures and has no breach notification.
- B. It applies only to electronic records.
- C. It protects PHI and secures data handling with breach notification.**
- D. It only applies to hospitals.

HIPAA's Privacy and Security rules revolve around protecting a patient's health information and ensuring it is handled securely. The Privacy Rule sets who may access or disclose PHI and gives patients rights over their data. The Security Rule requires safeguards for electronic PHI—administrative, physical, and technical controls to prevent unauthorized access, disclosure, alteration, or destruction. In addition, the Breach Notification Rule requires that when unsecured PHI is breached, affected individuals (and sometimes authorities) are notified. The best summary, then, is that HIPAA protects PHI and requires secure data handling with a mechanism for notifying individuals when a breach occurs. The other statements misstate aspects: consent for all disclosures is not required and breach notification does exist; HIPAA applies to more than just electronic records (PHI in any form is covered by privacy protections, with electronic safeguards specifically for ePHI); and HIPAA covers more than just hospitals, extending to covered entities like providers, health plans, and their business associates.

4. What is timely filing, and what is the general Medicare time limit for submitting claims?

- A. Claims must be filed within a stated period from the date of service; Medicare generally requires within 12 months.**
- B. Claims must be submitted within 30 days.
- C. There is no deadline for Medicare claims.
- D. Claims must be filed within 5 years.

Timely filing is the deadline by which a claim must be submitted after the date of service. For Medicare, the general limit is within 12 months from the date of service. Submitting within this window allows the claim to be considered for payment; filing after the window is typically denied unless a valid exception or extension applies. The other options aren't correct because Medicare has a defined filing window (not 30 days, not no deadline, and not 5 years).

5. What information is required in Blocks 1a to 13 of the Patient/Insured Section?

- A. Health plan ID number, name, address, policy and group numbers, birth date, gender, and other claim ID.**
- B. Patient occupation and employer name.
- C. Provider tax ID and license number.
- D. Insurance card color and patient fingerprint.

Blocks 1a through 13 are designed to capture the insured's identity and policy details so the claim can be correctly linked to the patient's coverage. The information included—health plan ID number, the insured's name and address, policy and group numbers, the patient's birth date and gender, and any other claim ID—lets the payer verify eligibility, apply the correct benefits, and route payment accurately. The health plan ID identifies the insurer or plan, the name and address support contact and records matching, while the policy and group numbers tie the claim to the specific contract. Birth date and gender help prevent misidentification among patients with similar names, and other claim IDs (like subscriber IDs) facilitate cross-referencing with related records. Other options don't fit because occupation and employer are not part of this section, provider tax ID and license belong to the provider information areas, and details like insurance card color or a patient fingerprint are not fields used in the CMS-1500 patient/insured blocks.

6. Which CPT procedures typically have 0-, 10-, and 90-day global periods, and how does that affect billing?

- A. Minor procedures often have 0-day; moderate usually 10-day; major surgeries 90-day; post-op care included in global period.
- B. All procedures have a 30-day global period; post-op care is not included.
- C. Global periods are only used for dental codes; not for medical.

D. Global periods are irrelevant to billing; they do not affect post-op care.

Global periods define how long postoperative care is bundled into the price of a surgical CPT code. The 0-day, 10-day, and 90-day durations indicate how many days after the procedure routine post-op care is considered part of the surgical package. Shorter global periods are for less invasive procedures, longer periods for more extensive surgeries. This matters for billing because if a service occurs within the global period and is part of the normal postoperative care, it is not billed separately; it's included in the surgical payment. Once the global period ends, postoperative care can be billed separately if it's still needed or if it's unrelated to the original procedure. For example, with a procedure that has a 0-day global, the day-of-surgery postoperative activity is included, but a visit on a later day would generally be billed separately. With a 10-day global, routine postoperative visits within the first 10 days are included in the surgical code, and after day 10 you'd bill separately for related postoperative care if needed. With a 90-day global, most postoperative care within 90 days is bundled, with separate billing only for anything outside that window or for unrelated issues.

7. Compare DRGs and APCs; identify where each applies.

A. DRGs are inpatient prospective payment system (in hospitals); APCs are outpatient prospective payment system (outpatient departments).

- B. DRGs are outpatient; APCs are inpatient.
- C. DRGs and APCs are the same system.
- D. DRGs reflect physician fees; APCs reflect facility fees.

DRGs are used for inpatient hospital stays, while APCs are used for outpatient encounters. In Medicare and many payers, the inpatient prospective payment system (IPPS) assigns each hospitalization to a Diagnosis-Related Group, with a fixed payment based on the assigned DRG (reflecting the expected resources for that admission). Outpatient services fall under the outpatient prospective payment system (OPPS), where each outpatient encounter or individual service is grouped into an Ambulatory Payment Classification and paid at a predetermined rate for that encounter. Physician fees are not the primary driver of DRG or APC payments; DRGs and APCs cover the hospital facility costs for the stay or visit, while professional services billed by physicians are typically paid separately under a physician fee schedule. So the statement that DRGs apply inpatient and APCs apply outpatient is correct, and the other options misplace the settings or conflate facility and professional payments.

8. What is the purpose of Block 25 on the CMS-1500 form?

A. To record the Federal Tax ID Number.

- B. The patient's insurance policy number.
- C. The diagnosis code.
- D. The provider's NPI.

Block 25 collects the Federal Tax Identification Number of the billing provider or organization submitting the claim. This identifier is used by payers for tax reporting and to link the claim to the correct legal entity, helping ensure payments are issued to the right business and reported properly to the IRS. It's a tax-identity detail, not the patient's policy number, nor the diagnosis code, and it's separate from the provider's NPI, which is stored in a different field.

9. What is the purpose of a claims scrubber in billing software?

- A. To encrypt patient data.
- B. To automatically approve all claims.
- C. To generate patient statements.
- D. To help identify mistakes in claims before submission.**

A claims scrubber is a pre-submission checker that reviews claims for errors before they are sent to the payer. It analyzes coding accuracy (CPT/ICD-10-CM), modifiers, patient and provider demographics, dates of service, charges, and payer-specific rules. It flags mismatches, missing information, or data that typically trigger denials, and it often provides guidance on fixes. By catching these issues early, it helps reduce claim denials and resubmissions, leading to faster, cleaner reimbursement. Encryption protects data, and scrubbers aren't about securing information. They don't automatically approve claims—their job is to identify issues so corrections can be made before submission. Generating patient statements is a separate billing task for patient outreach and billing balances, not about pre-submission claim quality.

10. Block 31 on the CMS-1500 form requires which of the following?

- A. The signature of the physician or supplier to verify that the claim is correct.**
- B. The date of service.
- C. The patient's contact email.
- D. The insurance policy number.

Block 31 is where the physician or supplier signs to certify that the information on the claim is true and that the services were provided as billed. This attestation is the provider's formal authorization that the claim is accurate, which payers require before processing. The signature links the claim to the provider's responsibility for the submitted data. The date of service is recorded in other parts of the form, and items like a patient's email or the policy number belong in other blocks, so Block 31 specifically serves as the provider's certified approval of the claim.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://medicalbillingreimbursement.examzify.com>

We wish you the very best on your exam journey. You've got this!

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