

Physician Office Billing Practice Test (Sample)

Study Guide



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SAMPLE

Questions

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- 1. What impact do healthcare regulations have on billing practices?**
 - A. They enhance the speed of claim processing**
 - B. They govern compliance, privacy, and billing accuracy**
 - C. They determine insurance premiums for patients**
 - D. They simplify the claims filing process**
- 2. What is a charge capture system in physician billing?**
 - A. A method of collecting and recording charges for services provided**
 - B. A system for scheduling patient appointments**
 - C. A program for managing patient referrals**
 - D. A method for tracking inventory of medical supplies**
- 3. The type of payment structure that PPO's usually offer in their contracts with providers is called?**
 - A. fee-for-service**
 - B. discounted fee-for-service**
 - C. episode-of-care**
 - D. capitated**
- 4. Who receives payment from a health insurance claim?**
 - A. the destination payer**
 - B. the referring provider**
 - C. the billing provider**
 - D. the pay to provider**
- 5. What is the main purpose of an open enrollment period?**
 - A. To allow employees to increase their deductions.**
 - B. To limit who can enroll in a health plan.**
 - C. To provide a set time for changes in health insurance coverage.**
 - D. To allow employers to change their health plan providers.**

- 6. Which rule determines a child's primary coverage based on the earlier date of birth of the parents?**
- A. Birthday rule**
 - B. Gender rule**
 - C. Parent rule**
 - D. Custody rule**
- 7. What does "deductible" refer to in patient billing?**
- A. The total amount billed for services rendered**
 - B. The amount paid by patients before insurance coverage starts**
 - C. The maximum amount an insurance company will pay**
 - D. The amount covered by insurance after a patient pays**
- 8. The first health plan to pay when more than one plan is active is referred to as what?**
- A. Supplemental insurance**
 - B. Primary insurance**
 - C. Secondary insurance**
 - D. Tertiary insurance**
- 9. Where should you locate information about a patient's health plan during an appointment?**
- A. Patient's information form and insurance card**
 - B. Patient's insurance card only**
 - C. Patient's signed acknowledgment of receipt of notice privacy practices**
 - D. Patient's health survey and patient information form**
- 10. What key factor defines someone as categorically needy under Medicaid?**
- A. High medical expenses**
 - B. Low income**
 - C. Having dependent children**
 - D. Ownership of property**

Answers

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

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Explanations

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1. What impact do healthcare regulations have on billing practices?

- A. They enhance the speed of claim processing**
- B. They govern compliance, privacy, and billing accuracy**
- C. They determine insurance premiums for patients**
- D. They simplify the claims filing process**

Healthcare regulations significantly influence billing practices by establishing standards and guidelines that ensure compliance, privacy, and accuracy in the billing process. Compliance with these regulations helps protect patient information and ensures that providers adhere to ethical and legal billing practices. For instance, regulations such as the Health Insurance Portability and Accountability Act (HIPAA) set forth requirements for maintaining patient confidentiality and secure handling of medical information, directly impacting how billing is conducted. Moreover, regulations ensure that claims submitted to insurers are accurate and reflect the services provided, which helps to minimize errors that can lead to claim denials and delayed payments. While there may be benefits to the speed of claim processing, the primary purpose of healthcare regulations is to establish a robust framework for compliance and accuracy—focusing on maintaining patient rights and organizational integrity in billing practices. Thus, option B captures the essence of the role that healthcare regulations play in shaping billing practices.

2. What is a charge capture system in physician billing?

- A. A method of collecting and recording charges for services provided**
- B. A system for scheduling patient appointments**
- C. A program for managing patient referrals**
- D. A method for tracking inventory of medical supplies**

A charge capture system in physician billing refers to the method of collecting and recording charges for services provided to patients. This system is essential in ensuring that all services rendered by healthcare providers are accurately documented and billed to the patient or their insurance provider. It plays a critical role in revenue cycle management within healthcare practice, enhancing the accuracy of billing, minimizing lost charges, and improving overall financial performance. A well-functioning charge capture system helps ensure that the healthcare provider captures every service delivered, whether it's a consultation, diagnostic test, or treatment. By doing so, it supports proper reimbursement and compliance with billing regulations. The effectiveness of this system directly impacts the financial health of a physician's office, making it a vital component in the billing process. In contrast, the other options focus on different aspects of medical office management. Scheduling patient appointments is a critical function for maintaining patient flow but does not pertain to how charges are captured. Managing patient referrals is important for coordinating care but is not related to billing procedures. Finally, tracking inventory of medical supplies, while necessary for operational efficiency, is also unrelated to charge capture and billing practices.

3. The type of payment structure that PPO's usually offer in their contracts with providers is called?

- A. fee-for-service**
- B. discounted fee-for-service**
- C. episode-of-care**
- D. capitated**

PPOs (Preferred Provider Organizations) typically utilize a discounted fee-for-service payment structure in their contracts with providers. This approach allows providers to receive payments based on the services rendered to patients, but at rates that have been negotiated and reduced compared to their standard fees. Discounted fee-for-service arrangements are beneficial for both the provider and the insurer. The insurer can offer lower premiums to members since they negotiate rates with providers, while providers benefit from a steady stream of patients associated with the PPO network. Members are often encouraged to utilize in-network providers who accept these discounted rates, leading to cost-effective healthcare solutions. In contrast, fee-for-service is a more straightforward approach without negotiated discounts, which may not reflect the financial dynamics found in PPO agreements. Episode-of-care and capitated payment models are structured differently, focusing on overall care management or an all-inclusive amount for a spectrum of services over time, rather than per individual service negotiated to a discount. Thus, the correct understanding of the PPO payment structure aligns strongly with the concept of discounted fee-for-service.

4. Who receives payment from a health insurance claim?

- A. the destination payer**
- B. the referring provider**
- C. the billing provider**
- D. the pay to provider**

In the context of health insurance claims, the pay to provider is the entity that is designated to receive payment for services rendered to a patient. This typically refers to the healthcare provider, such as a physician or medical facility, that has contracted with the insurance company to deliver services and bill for those services. When a claim is submitted, the insurance company processes it and issues payment based on the terms of the patient's coverage and the agreements in place with the provider. The pay to provider designation ensures that any payments are directed to the appropriate healthcare entity that provided the care, rather than being sent to other parties like the patient or a referring physician who may not have directly conducted the services. This correct response accurately reflects the billing and payment processes inherent in healthcare financing, where the provider directly involved in the patient's care is the one receiving the payment for their services.

5. What is the main purpose of an open enrollment period?

- A. To allow employees to increase their deductions.**
- B. To limit who can enroll in a health plan.**
- C. To provide a set time for changes in health insurance coverage.**
- D. To allow employers to change their health plan providers.**

The main purpose of an open enrollment period is to provide a designated timeframe during which individuals can make changes to their health insurance coverage. This period is essential because it allows employees the opportunity to enroll in health plans, switch between different plans, or make adjustments to their existing coverage according to their needs and life circumstances. Open enrollment typically occurs annually and is a crucial time for employees to assess their healthcare needs, review available options, and select a plan that best fits their situation without facing penalties or restrictions that might apply outside this window. This structured timeframe helps to manage and streamline the enrollment process and ensures that individuals can make informed decisions about their healthcare options. When open enrollment is not available, individuals may have to wait until the next designated period or experience a qualifying event to make changes, which can limit their access to necessary healthcare services.

6. Which rule determines a child's primary coverage based on the earlier date of birth of the parents?

- A. Birthday rule**
- B. Gender rule**
- C. Parent rule**
- D. Custody rule**

The birthday rule is a widely recognized guideline used in healthcare coverage to determine which parent's insurance plan is considered the primary coverage for a child. According to this rule, if both parents have health insurance plans that cover the child, the plan of the parent whose birthday comes first in the calendar year will be the primary coverage. This means that the month and day of birth are relevant, regardless of the year. This rule helps streamline the process of determining who is responsible for paying for the child's health expenses first, thus minimizing disputes and potential confusion in situations where both parents are insured. It provides a straightforward method of establishing primary and secondary coverage based on an easily identifiable criterion: the birthdays of the parents, rather than relying on more complex factors such as custody agreements or the gender of the parents. In contrast, other rules mentioned in the options, like the gender rule, custody rule, and parent rule, do not have standardized applications in determining insurance coverage for children in the same widely accepted manner as the birthday rule does.

7. What does "deductible" refer to in patient billing?

- A. The total amount billed for services rendered**
- B. The amount paid by patients before insurance coverage starts**
- C. The maximum amount an insurance company will pay**
- D. The amount covered by insurance after a patient pays**

In patient billing, "deductible" specifically refers to the amount that a patient is required to pay out of pocket before their health insurance begins to cover any expenses. This means that before any insurance benefits kick in, the patient must first meet this predetermined financial threshold. For example, if a deductible is set at \$1,000, the patient must pay that amount for medical services before their insurance will start contributing to subsequent costs. Understanding the deductible is crucial for patients as it impacts how much they will owe for healthcare services before they receive assistance from their insurance provider. It helps patients plan for their potential healthcare expenses and clarifies the point at which insurance coverage becomes effective in terms of payments for covered services. The other options pertain to different aspects of patient billing or insurance policies, but they do not accurately define what a deductible is within the context of insurance coverage.

8. The first health plan to pay when more than one plan is active is referred to as what?

- A. Supplemental insurance**
- B. Primary insurance**
- C. Secondary insurance**
- D. Tertiary insurance**

The health plan that pays first when more than one plan is active is referred to as primary insurance. This term is essential in understanding how health insurance claims are processed when multiple insurers are involved. The primary insurance is responsible for covering the initial expenses according to the terms of its policy, which means it will pay first before any other insurance plans step in to assist. This hierarchy ensures that there is a clear order in which claims are handled, preventing confusion over which policy should cover specific costs. The coordination of benefits rule directs how payments are managed, with the primary insurer typically covering a larger portion of the bill, while other policies, such as secondary or tertiary insurance, may cover remaining costs or specific gaps based on their agreements and coverage limits.

9. Where should you locate information about a patient's health plan during an appointment?

A. Patient's information form and insurance card

B. Patient's insurance card only

C. Patient's signed acknowledgment of receipt of notice privacy practices

D. Patient's health survey and patient information form

The correct choice is to locate information about a patient's health plan in both the patient's information form and the insurance card. The patient's information form typically contains essential details such as the patient's full name, date of birth, and contact information, as well as specifics about their insurance coverage, including the provider and policy number. This form provides a comprehensive view of the patient's demographic data, which is vital for billing and compliance purposes. The insurance card is also crucial because it not only confirms the patient's eligibility for coverage but also provides direct information about the health plan, including the plan type, the patient's member ID, and the contact details for the insurance company. Together, these two sources provide a complete picture of the patient's insurance benefits, which is essential for accurate billing and ensuring that services are covered. The other options, while they may include relevant information, do not provide the comprehensive data needed for billing related to the patient's health plan. The insurance card alone misses broader personal details, and the acknowledgment of privacy practices does not include specific insurance details. Similarly, the health survey may focus more on medical history rather than insurance coverage.

10. What key factor defines someone as categorically needy under Medicaid?

A. High medical expenses

B. Low income

C. Having dependent children

D. Ownership of property

The key factor that defines someone as categorically needy under Medicaid is low income. Medicaid is designed to provide health coverage to individuals and families who meet certain financial criteria. The program primarily covers those with limited income, ensuring that vulnerable populations, such as low-income families, the elderly, and individuals with disabilities, have access to necessary healthcare services. Low income is a significant determinant because it reflects the financial inability of individuals or families to afford healthcare without assistance. This criterion is critical in evaluating eligibility for Medicaid, as it serves as a primary guideline for determining who qualifies for coverage. High medical expenses, having dependent children, and ownership of property can influence eligibility in various ways, but they do not inherently define someone as categorically needy. Instead, they are part of the broader picture of financial status and how it interacts with specific state Medicaid programs and guidelines.