

PHYSICIAN OFFICE BILLING PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

<https://physicalofficebilling.examzify.com>



Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.

ALL RIGHTS RESERVED.

No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.

Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.

SAMPLE

Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	16

SAMPLE

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

SAMPLE

- 1. 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

- 2. 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.

- 3. 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

- 4. The term maximum benefit limit applies to?**
 - A. a monetary amount
 - B. a number of visits
 - C. a number of providers
 - D. a family deductible

- 5. Which of the following type of plan do employers or employee organizations offer their employees?**
 - A. group health plan
 - B. individual health plan
 - C. FEHB plan
 - D. URO

- 6. A provider who directly treats a patient is called a(n):**
- A. direct provider
 - B. indirect provider
 - C. physician assistant
 - D. nurse practitioner
- 7. What is the purpose of modifier codes in billing?**
- A. To increase the total billable amount
 - B. To provide additional information about a procedure or service
 - C. To defer payment of the bill
 - D. To categorize patient demographics
- 8. What is another term for a HIPAA-mandated electronic transaction for claims?**
- A. CMS 1500
 - B. HIPAA X12 837 Health Care Claim
 - C. HCFA 1500
 - D. EDI
- 9. What does the abbreviation FMAP represent?**
- A. Federal Medical Assistance Program
 - B. Federal Medicaid Assistance Percentage
 - C. Federal Minimum Assistance Program
 - D. Federally Managed Assistance Program
- 10. What is the role of a billing specialist in a physician's office?**
- A. To perform surgeries and assist physicians
 - B. To manage billing processes and resolve insurance issues
 - C. To provide medical advice to patients
 - D. To oversee the scheduling of appointments

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. 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.

2. 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.

3. 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.

4. The term maximum benefit limit applies to?

A. a monetary amount

B. a number of visits

C. a number of providers

D. a family deductible

The term "maximum benefit limit" specifically refers to a predetermined monetary amount that an insurance policy will pay for covered services during a specific time period, often per year. This limit applies to the total reimbursement the insurer is obligated to provide, which can impact how much financial assistance the insured receives for their medical expenses. Once the insured reaches this limit, they may have to cover any additional costs out of pocket. While options that reference a number of visits, providers, or a family deductible relate to insurance coverage in general, they do not accurately define the maximum benefit limit as it pertains to monetary restrictions imposed by an insurance policy. The core concept is centered around financial limits, making the understanding of maximum benefit limit essential for both patients and healthcare providers in managing healthcare costs.

5. Which of the following type of plan do employers or employee organizations offer their employees?

- A. group health plan**
- B. individual health plan
- C. FEHB plan
- D. URO

A group health plan is the correct choice because it refers to a health insurance plan that is offered by employers or employee organizations to a group of people, typically to their employees and, in some cases, their families. These plans are designed to provide coverage at a lower cost per person than individual plans because the risk is shared among all participants. Employers negotiate terms and costs with insurance providers, which allows them to offer more comprehensive benefits. Individual health plans, on the other hand, are purchased by individuals for their own use and are not typically offered by employers. The FEHB plan, or Federal Employees Health Benefits plan, specifically serves federal employees and their families, making it a more specialized option. URO, or Utilization Review Organization, does not refer to a health plan but rather to a type of organization that evaluates the necessity and efficiency of health care services. This distinction highlights why the group health plan is the appropriate choice in the context of employer-provided health insurance options.

6. A provider who directly treats a patient is called a(n):

- A. direct provider**
- B. indirect provider
- C. physician assistant
- D. nurse practitioner

The term that most accurately describes a provider who directly treats a patient is "direct provider." This designation refers to any healthcare professional who is actively engaged in providing care and treatment to a patient during a clinical encounter. This includes various types of providers, such as physicians, nurse practitioners, and physician assistants, among others. Understanding the roles of different healthcare providers is crucial in a billing context, as each type may have varying impacts on the management of patient records, billing procedures, and reimbursement processes. The correct identification of these roles ensures that billing codes are appropriately applied and accurately reflect the services provided to patients. While "physician assistant" and "nurse practitioner" are also valid roles that involve direct patient care, they are specific types of direct providers and do not encompass the broader category that "direct provider" represents. "Indirect provider," on the other hand, would refer to those who do not directly interact with patients but may provide support or administrative functions related to care delivery.

7. What is the purpose of modifier codes in billing?

- A. To increase the total billable amount
- B. To provide additional information about a procedure or service**
- C. To defer payment of the bill
- D. To categorize patient demographics

The purpose of modifier codes in billing is to provide additional information about a procedure or service. Modifiers are two-digit codes added to CPT (Current Procedural Terminology) codes that help clarify the circumstances under which a service was performed. They can indicate various situations, such as whether a procedure was performed bilaterally, if multiple procedures were carried out, or if a service was altered in some way. Using modifiers is crucial for ensuring accurate billing and compliance with health insurance requirements. They help insurance payers understand the context of the service provided, which can influence coverage decisions and payment. Accurate use of modifiers can also help prevent claim denials and ensure that services rendered are adequately compensated.

8. What is another term for a HIPAA-mandated electronic transaction for claims?

- A. CMS 1500
- B. HIPAA X12 837 Health Care Claim**
- C. HCFA 1500
- D. EDI

The term HIPAA X12 837 Health Care Claim refers specifically to the standardized electronic format mandated by the Health Insurance Portability and Accountability Act (HIPAA) for submitting healthcare claims to payers. This format is designed to facilitate electronic transactions between healthcare providers and insurers, ensuring that claims are processed efficiently and accurately. This standardized format helps streamline the billing process, reduces paperwork, and minimizes errors that can occur with manual claims submission. The X12 837 transaction set is part of a series of standards developed by the Accredited Standards Committee (ASC) X12 and is integral to the electronic data interchange (EDI) in healthcare. While the other options listed relate to claims submission, they do not specifically denote the HIPAA-mandated electronic transaction format. The CMS 1500 and HCFA 1500 refer to paper claim forms used for submitting claims, and EDI is a broader term that encompasses the electronic exchange of data in many formats, not limited to HIPAA transactions. Therefore, the HIPAA X12 837 Health Care Claim is the precise term that aligns with the question.

9. What does the abbreviation FMAP represent?

- A. Federal Medical Assistance Program
- B. Federal Medicaid Assistance Percentage**
- C. Federal Minimum Assistance Program
- D. Federally Managed Assistance Program

The abbreviation FMAP stands for Federal Medicaid Assistance Percentage. This term is pivotal in the context of Medicaid funding. FMAP is a formula used by the federal government to determine the share of state expenditures for Medicaid that they can receive federal matching funds for, thus impacting how states fund their Medicaid programs. Each state has its own FMAP percentage, which can vary based on factors such as income levels among the population in that state. Understanding FMAP is crucial for healthcare administrators and billing specialists because it influences the reimbursement rates for providers participating in Medicaid, and ultimately affects the financial health of state Medicaid programs and the services available to beneficiaries.

10. What is the role of a billing specialist in a physician's office?

- A. To perform surgeries and assist physicians
- B. To manage billing processes and resolve insurance issues**
- C. To provide medical advice to patients
- D. To oversee the scheduling of appointments

The role of a billing specialist in a physician's office is crucial for the financial health of the practice, focusing on managing billing processes and resolving insurance issues. This specialist ensures that all services provided are accurately coded and billed to patients or insurance companies. They interpret insurance policies and benefits to communicate effectively with patients about their financial responsibilities. By handling claims submissions, follow-ups on unpaid claims, and immediate inquiries regarding billing discrepancies, the billing specialist ensures that the practice receives timely payments. This role also involves maintaining detailed records and ensuring compliance with federal and state regulations regarding healthcare billing. Therefore, the answer aligns perfectly with the responsibilities held by a billing specialist, underscoring their importance in the operations of a physician's office. The alternative options do not fit the billing specialist's responsibilities. Performing surgeries and assisting physicians pertains to clinical roles, while providing medical advice directly to patients falls within the domain of healthcare providers. Overseeing the scheduling of appointments relates to administrative functions, which are typically managed by receptionists or office managers rather than billing specialists.

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://physicalofficebilling.examzify.com>

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

SAMPLE