PTCB Billing and Reimbursement Practice Test (Sample)

Study Guide

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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

1. **Which agency is responsible for improving healthcare access for geographically isolated or vulnerable populations?**

   A. Centers for Medicare & Medicaid Services

   B. Food and Drug Administration

   C. AHRQ

   D. Health Resources & Services Administration

2. **Deductible is**

   A. The set amount that must be paid by the patient before insurer coverage begins

   B. The co-pay per prescription

   C. The total annual maximum out-of-pocket

   D. The discount applied by manufacturer

3. **Which organization is commonly referred to as the Medicare Benefits Manager in the context of Medicare and Medicaid?**

   A. CBO

   B. FDA

   C. NIH

   D. CMS

4. **HRSA focuses on improving access to healthcare for which populations?**

   A. Rural communities

   B. Pediatric populations

   C. Economically or medically vulnerable populations

   D. Elderly populations

5. **Which revenue code is associated with drugs requiring detailed coding, including radionuclides, vaccines, toxoids, immune globulins, and blood factors?**

   A. Revenue Code 0250

   B. Revenue Code 0637

   C. Revenue Code 0636

   D. Revenue Code 0270

6. Medicaid's federal matching rate for state funding is approximately what percent on average?

   A. 10%

   B. 75%

   C. 100%

   D. 53%

7. Which of the following is an example of a prior approval type?

   A. Request for restricted meds

   B. Set of guidelines for patient education

   C. Prescription fill without PA

   D. Generic substitution

8. The purpose of measuring adherence rates in this context is to:

   A. Evaluate hospital throughput

   B. Assess patient medication-taking behavior

   C. Measure caregiver workload

   D. Monitor drug supply chain

9. HCPCS Level 1 codes correspond to which coding system?

   A. Current Procedural Terminology codes (CPT)

   B. ICD-10-PCS codes

   C. DRG codes

   D. National Drug Codes (NDC)

10. URAC's role includes offering quality benchmark programs to improve quality and accountability of health care organizations. Which statement best matches this?

   A. A government agency regulating pharmaceutical advertising

   B. An independent nonprofit organization offering quality benchmark programs to improve quality and accountability of health care organizations.

   C. A private hospital chain

   D. A professional association for nurses

Answers

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

Explanations

1. Which agency is responsible for improving healthcare access for geographically isolated or vulnerable populations?

A. Centers for Medicare & Medicaid Services

B. Food and Drug Administration

C. AHRQ

D. Health Resources & Services Administration

The agency focused on extending access to care for people in rural or otherwise underserved or vulnerable situations is Health Resources and Services Administration. HRSA expands access by funding and supporting community health centers, running programs to recruit and place clinicians in underserved areas, and providing targeted grants to reduce disparities. This mission to improve access distinguishes it from other agencies: Centers for Medicare & Medicaid Services mainly handles payment and coverage; the Food and Drug Administration regulates drugs and devices for safety; and the Agency for Healthcare Research and Quality concentrates on research to improve care quality and outcomes, rather than directly expanding access.

2. Deductible is

A. The set amount that must be paid by the patient before insurer coverage begins

B. The co-pay per prescription

C. The total annual maximum out-of-pocket

D. The discount applied by manufacturer

Deductible is the amount the patient must pay out of pocket before the insurer starts to cover costs for covered medications and services. It's typically an annual amount. Until that threshold is met, the patient bears the cost of prescriptions entirely. After meeting the deductible, the plan may require coinsurance or a copayment, until hitting the annual out-of-pocket maximum, at which point the insurer generally pays 100% of covered expenses. The fixed co-pay per prescription is not the deductible—it's a separate amount paid at each fill once the plan calls for a copay. The total annual maximum out-of-pocket is the cap on what the patient pays in a year, not the deductible itself. The discount from the manufacturer is not the deductible; it's a separate manufacturer discount or coupon and is independent of the insurer's deductible.

3. Which organization is commonly referred to as the Medicare Benefits Manager in the context of Medicare and Medicaid?

A. CBO

B. FDA

C. NIH

D. CMS

Centers for Medicare & Medicaid Services oversees the Medicare program, sets coverage policies, and processes or delegates processing of claims and benefits for beneficiaries. In that sense, it is commonly referred to as the Medicare Benefits Manager. The other organizations operate in different domains: the Congressional Budget Office provides budget analysis for legislation, the FDA regulates foods and drugs, and NIH funds medical research; none manages Medicare benefits.

4. HRSA focuses on improving access to healthcare for which populations?

A. Rural communities

B. Pediatric populations

C. Economically or medically vulnerable populations

D. Elderly populations

HRSA's primary focus is ensuring access to healthcare for economically or medically vulnerable populations. This includes people who face barriers due to low income, lack of insurance, chronic health conditions, or living in areas with provider shortages, as well as groups like pregnant women and children who need ongoing care. HRSA supports programs and grants that expand services in underserved communities, such as community health centers and targeted initiatives for uninsured or underinsured individuals. Because the emphasis is on vulnerability and barriers to care across various groups, the focus is not limited to a single demographic like rural communities or the elderly, but on those who are economically or medically at risk.

5. Which revenue code is associated with drugs requiring detailed coding, including radionuclides, vaccines, toxoids, immune globulins, and blood factors?

A. Revenue Code 0250

B. Revenue Code 0637

C. Revenue Code 0636

D. Revenue Code 0270

Drugs that require detailed coding on hospital claims must be billed under a specific category that flags the need for itemized information. For radionuclides, vaccines, toxoids, immune globulins, and blood factors, this category is the code used for drugs requiring detailed coding. Using it ensures the claim carries exact drug identifiers (like NDC), precise dosage, and unit measures, which is essential for accurate reimbursement and compliance because these items can vary greatly in cost and quantity. This code is chosen because it communicates to the payer that the charge isn't a generic drug line item but a set of items that must be itemized and verified. Other revenue codes group drugs in broader categories and don't require the same level of item-level detail, so they wouldn't be appropriate for these complex drugs. On the claim, the revenue code for these items would appear with the corresponding detailed drug data to support proper payment.

6. Medicaid's federal matching rate for state funding is approximately what percent on average?

A. 10%

B. 75%

C. 100%

D. 53%

Medicaid is funded through a federal–state partnership using a matching rate called FMAP (Federal Medical Assistance Percentage). This rate isn't fixed; it varies by state based on per-capita income and ranges from around 50% up to the low 80s. When you look at all states together, the average FMAP sits in the low-to-mid 50s. That's why the approximate average is about 53%. So, for example, if a state spends $1 million on Medicaid, the federal government would contribute roughly $530,000 and the state would cover the remainder. The other percentages don't fit the typical overall average: 10% is far too low for Medicaid's federal share, 75% is higher than the general average, and 100% would mean the federal government pays all costs, which isn't how FMAP works.

7. Which of the following is an example of a prior approval type?

A. Request for restricted meds

B. Set of guidelines for patient education

C. Prescription fill without PA

D. Generic substitution

Prior authorization is a process where the insurer must approve coverage for a medication before it is dispensed, usually for drugs that are restricted or require justification of medical necessity. A request for restricted meds is an example of this process because it directly involves submitting information to obtain payer approval for a drug that is not automatically covered. The other options don't involve getting payer approval: guidelines for patient education are educational resources, not a payment approval step; a prescription filled without prior authorization means no PA was needed or obtained; and generic substitution concerns substituting a generic version for a brand name under formulary rules, which is a substitution policy rather than a PA action.

8. The purpose of measuring adherence rates in this context is to:

A. Evaluate hospital throughput

B. Assess patient medication-taking behavior

C. Measure caregiver workload

D. Monitor drug supply chain

Measuring adherence rates focuses on patient medication-taking behavior. This tells you whether patients are actually taking their prescribed medications as intended, which directly influences real-world effectiveness and outcomes. If adherence is low, clinicians can intervene with counseling, simplified regimens, or support to improve use and, in turn, impact reimbursement considerations tied to therapy success. The other areas—hospital throughput, caregiver workload, and the drug supply chain—relate to workflow efficiency, staff tasks, or drug availability, not the act of how a patient uses the medication.

9. HCPCS Level 1 codes correspond to which coding system?

A. Current Procedural Terminology codes (CPT)

B. ICD-10-PCS codes

C. DRG codes

D. National Drug Codes (NDC)

HCPCS Level I codes are the CPT codes used to describe medical procedures and services. CPT, which stands for Current Procedural Terminology, is published and maintained by the American Medical Association and consists of five-digit numeric codes used for billing and reimbursement by payers, including Medicare and private insurers, for physician services and outpatient procedures. ICD-10-PCS codes are a separate system used to classify inpatient hospital procedures, not outpatient or professional services. DRG codes are grouping categories used to determine inpatient reimbursement, not the individual procedures themselves. National Drug Codes identify medications and drug products, not the procedures or services performed. So, HCPCS Level I codes correspond to CPT codes.

10. URAC's role includes offering quality benchmark programs to improve quality and accountability of health care organizations. Which statement best matches this?

A. A government agency regulating pharmaceutical advertising

B. An independent nonprofit organization offering quality benchmark programs to improve quality and accountability of health care organizations.

C. A private hospital chain

D. A professional association for nurses

URAC serves as an independent nonprofit organization that provides quality benchmark programs to improve the quality and accountability of health care organizations. This description fits because URAC is not a government regulator, a private hospital chain, or a nursing professional association. Instead, it offers accreditation and quality standards that organizations can pursue to demonstrate quality practices, which can influence payer decisions and reimbursement by signaling a commitment to quality and accountability.

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://ptcbbillingreimbursement.examzify.com

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