

PTCB BILLING AND REIMBURSEMENT PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE

<https://ptcbbillingreimbursement.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. 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
- 2. Which federal agency within the U.S. Department of Health and Human Services is responsible for administering Medicare and Medicaid?**
 - A. Centers for Medicare and Medicaid Services
 - B. National Institutes of Health
 - C. Food and Drug Administration
 - D. Agency for Healthcare Research and Quality
- 3. What is the typical validation audit timeline?**
 - A. 180 days
 - B. 90 days
 - C. 12 months
 - D. 60 days
- 4. Which items are required for drug claim submission under patient/prescriber info?**
 - A. Name of patient, birthdate, sex, relationship to card holder, identification number, group number, prescriber ID #, pharmacy ID #/NPI
 - B. Insurance policy claim number
 - C. Pharmacy stock levels
 - D. Drug expiration date
- 5. What is accreditation?**
 - A. A formal credential indicating additional training
 - B. A seal of approval certifying that an organization or individual has met specific standards
 - C. A government license to operate
 - D. A financial grant to support facility improvements

- 6. Which system is used to determine how much providers should be paid for services rendered and is used by Medicare and many other health insurance companies?**
- A. Hospital Outpatient Prospective Payment System
 - B. Medicare Administrative Contractors
 - C. Resource Based Relative Value Scale
 - D. Durable Medical Equipment Coding
- 7. FQHC stands for which type of health center?**
- A. Federally Qualified Health Center
 - B. Federally Qualified Hospital Center
 - C. Free Qualified Health Center
 - D. Family Quality Health Center
- 8. Which statement defines Average Wholesale Price (AWP)?**
- A. The list price the manufacturer charges wholesalers.
 - B. Derived from the sales to all purchasers.
 - C. The published average cost paid by the pharmacy to the wholesaler.
 - D. The price paid by the pharmacy after discounts.
- 9. Which data elements are typically included to determine patient cost on a drug claim?**
- A. Stock level
 - B. Ingredient cost, dispensing fee, deductible or copay, balance
 - C. Patient age, weight
 - D. Pharmacist license
- 10. CMS rules include determinations of what concepts?**
- A. Medically Necessary Designations
 - B. NPI Requirements
 - C. Medically Necessary / Usual and Customary
 - D. ICD Coding Guidelines

Answers

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

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Explanations

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1. 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.

2. Which federal agency within the U.S. Department of Health and Human Services is responsible for administering Medicare and Medicaid?

- A. Centers for Medicare and Medicaid Services**
- B. National Institutes of Health
- C. Food and Drug Administration
- D. Agency for Healthcare Research and Quality

The Centers for Medicare and Medicaid Services administers Medicare and Medicaid. Within the U.S. Department of Health and Human Services, CMS oversees Medicare—covering the federal health insurance program for seniors and certain disabled individuals—and Medicaid, the joint federal-state program that provides health coverage for low-income people. CMS sets program policies, determines eligibility in collaboration with states, handles enrollments and claims processing, and distributes federal funds to states to run their Medicaid programs. Other agencies like the NIH, FDA, and AHRQ focus on research, drug and device regulation, and healthcare quality research, not on administering these programs.

3. What is the typical validation audit timeline?

- A. 180 days**
- B. 90 days
- C. 12 months
- D. 60 days

Validation audits are typically scheduled on a semi-annual basis. This six month cadence provides enough data to accurately assess billing accuracy, coding, and compliance over a representative period, while still allowing timely detection and correction of issues. Shorter cycles, like three or two months, would be resource-intensive with diminishing returns, whereas a yearly cycle could allow problems to go unaddressed for too long. So, the common timeline is about six months (roughly 180 days).

4. Which items are required for drug claim submission under patient/prescriber info?

- A. Name of patient, birthdate, sex, relationship to card holder, identification number, group number, prescriber ID #, pharmacy ID #/NPI
- B. Insurance policy claim number
- C. Pharmacy stock levels
- D. Drug expiration date

The key idea is that a drug claim must clearly identify who is being billed, who prescribed the drug, and which pharmacy is submitting the claim so the payer can verify eligibility and process payment correctly. The patient's name, birthdate, and sex help uniquely identify the individual and prevent mix-ups with others who have similar names. The relationship to the card holder clarifies whether the patient is the policyholder or a dependent, which affects how coverage rules are applied. The patient's identification number and group number tie the claim to the correct member and plan in the payer's system, enabling proper benefit lookup. The prescriber's ID (usually the prescriber's NPI) links the prescription to the right healthcare provider, ensuring accountability and accurate billing. The pharmacy's ID (or NPI) identifies where the drug was dispensed, ensuring the claim is routed to the correct pharmacy and can be audited. The other options don't represent the standard patient/prescriber information needed to adjudicate and pay a drug claim; they either aren't required for this portion of the submission or aren't used to verify patient eligibility and provider identity.

5. What is accreditation?

- A. A formal credential indicating additional training
- B. A seal of approval certifying that an organization or individual has met specific standards
- C. A government license to operate
- D. A financial grant to support facility improvements

Accreditation is a formal recognition by an independent body that an organization or program meets defined standards and quality criteria. It acts as a seal of approval showing that the entity has been evaluated and meets established benchmarks, usually after a rigorous review process that may include document reviews and on-site visits, and it requires ongoing compliance to maintain that status. This is distinct from licensure, which is a government-granted permission to operate, and from certification, which relates to individuals demonstrating specific competencies. A financial grant is funding to support improvements, not a judgment of overall quality. Accreditation is often voluntary but can be required to participate in certain programs or to receive funding.

6. Which system is used to determine how much providers should be paid for services rendered and is used by Medicare and many other health insurance companies?

- A. Hospital Outpatient Prospective Payment System
- B. Medicare Administrative Contractors
- C. Resource Based Relative Value Scale**
- D. Durable Medical Equipment Coding

This question focuses on how payments to providers for services are determined under Medicare and by many other health insurers. The system that does this is the Resource Based Relative Value Scale, or RBRVS. RBRVS assigns relative value units to each service in three components: physician work, practice expense, and malpractice costs. These components reflect the resources required to deliver the service. The relative values are adjusted for geography to account for regional cost differences. The total RVU for a service is then multiplied by a conversion factor to produce the dollar payment. Under Medicare Part B, this is the primary method for paying physicians, and many private payers adopt or align with this approach. For example, a service might have RVUs totaling 3.2 when adjusted for geography; with a conversion factor of \$36, the payment would be about \$115.20. This framework specifically targets physician services rather than hospital outpatient services or equipment coding, which are governed by separate systems or processes.

7. FQHC stands for which type of health center?

- A. Federally Qualified Health Center**
- B. Federally Qualified Hospital Center
- C. Free Qualified Health Center
- D. Family Quality Health Center

Federally Qualified Health Center is the correct expansion. This designation is given to community-based clinics that meet HRSA requirements to deliver comprehensive primary care in underserved areas and to provide care regardless of a patient's ability to pay, often with a sliding fee scale. FQHCs are governed by a patient-majority board and must offer a wide range of services, including preventive, primary, dental, and behavioral health care. In billing terms, they use a special reimbursement method under Medicare/Medicaid known as the FQHC Prospective Payment System, which pays a per-visit, all-inclusive rate rather than the standard fee-for-service. The other phrases are not official designations for this type of health center.

8. Which statement defines Average Wholesale Price (AWP)?

- A. The list price the manufacturer charges wholesalers.
- B. Derived from the sales to all purchasers.
- C. The published average cost paid by the pharmacy to the wholesaler.**
- D. The price paid by the pharmacy after discounts.

Average Wholesale Price is a published price used as a reference in pharmacy reimbursement. It represents the standard price that pharmacies would pay to obtain drugs from wholesalers, before any negotiated discounts or rebates. This published benchmark, often listed in pricing compendia, is used by payers to determine reimbursement levels, even though the actual price paid can be lower after discounts. The statement that best matches this concept is the one describing the published average cost paid by the pharmacy to the wholesaler, because it captures AWP as the listed, reference price tied to the pharmacy's purchase through the wholesaler. The other options don't fit because AWP isn't simply the list price manufacturers charge wholesalers, nor is it derived from overall sales to all purchasers, nor is it the net price the pharmacy pays after discounts.

9. Which data elements are typically included to determine patient cost on a drug claim?

- A. Stock level
- B. Ingredient cost, dispensing fee, deductible or copay, balance**
- C. Patient age, weight
- D. Pharmacist license

Understanding how patient cost on a drug claim is calculated hinges on four data elements. The ingredient cost is the base price of the medication itself. The dispensing fee covers the pharmacist's professional services and the act of dispensing the medication. The deductible or copay represents the patient's required cost-share under the insurance plan. The balance is what remains after applying the insurer's payment and the patient's cost-share, i.e., what the patient ultimately owes. Items like stock level or a pharmacist's license don't determine the patient's cost on a claim.

10. CMS rules include determinations of what concepts?

- A. Medically Necessary Designations
- B. NPI Requirements
- C. Medically Necessary / Usual and Customary**
- D. ICD Coding Guidelines

Medical necessity and usual and customary charges are what CMS uses to decide coverage and payment. Medical necessity means the service or supply is reasonable and necessary for diagnosing or treating a patient's condition and appropriate for their circumstances. Usual and customary refers to the typical amount charged by providers in the local area for the same service. Together, these determinations drive whether CMS will pay and at what rate. ICD coding guidelines and NPI requirements are important for billing, but they serve different roles—coding ensures accurate claims and NPI identifies the provider—rather than being the CMS determinations that control payment. Medically Necessary Designations aren't a standard CMS term for reimbursement decisions.

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!

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