

RMA Administrative Assisting Practice Test (Sample)

Study Guide



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SAMPLE

Questions

- 1. What are HCPCS codes used for?**
 - A. Identifying insurance claims**
 - B. Identifying medical services and procedures**
 - C. Categorizing delinquent accounts**
 - D. Tracking prescription medications**
- 2. What order of filing has the oldest documents in the front?**
 - A. Chronological**
 - B. Reverse chronological**
 - C. Shingling**
 - D. Random**
- 3. In which system are "encounter forms" typically found?**
 - A. Patient scheduling software**
 - B. Medical practice management software**
 - C. Electronic health records**
 - D. Billing software**
- 4. What kind of codes are HCPCS?**
 - A. Numerical codes for medications**
 - B. Alphanumeric billing codes**
 - C. Exclusive codes for surgical procedures**
 - D. Pseudocode used for educational purposes**
- 5. What is billing reconciliation?**
 - A. Adjusting patient accounts**
 - B. Matching billing records with services paid**
 - C. Creating financial forecasts**
 - D. Reviewing insurance claims**
- 6. In the context of medical billing, what does EMR stand for?**
 - A. Electronic Medical Records**
 - B. Emergency Medical Reports**
 - C. Electronic Maintenance Records**
 - D. Effective Medical Recordkeeping**

- 7. What is the typical response time for an urgent referral request?**
- A. 1 hour**
 - B. 24 hours**
 - C. 48 hours**
 - D. 72 hours**
- 8. What type of services do C codes cover?**
- A. Outpatient prospective payment systems**
 - B. Alcohol and drug abuse treatment**
 - C. Transportation and ambulance services**
 - D. Orthotics and prosthetics**
- 9. When should credit adjustments be posted?**
- A. After the payment is completed**
 - B. At the same time payment is posted**
 - C. Once a week on Thursdays**
 - D. Only during the end of the financial year**
- 10. What type of agreement does “assignment of benefits” represent?**
- A. A waiver of patient confidentiality**
 - B. A legal agreement for payment**
 - C. A contract for medical services**
 - D. A policy for insurance refunds**

Answers

SAMPLE

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

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Explanations

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1. What are HCPCS codes used for?

- A. Identifying insurance claims
- B. Identifying medical services and procedures**
- C. Categorizing delinquent accounts
- D. Tracking prescription medications

HCPCS codes, or Healthcare Common Procedure Coding System codes, are used primarily for identifying medical services and procedures. These codes play a crucial role in the healthcare billing process by providing a standardized way to represent various medical interventions, treatments, and equipment. This standardization helps healthcare providers communicate effectively with insurers and facilitates the processing of claims. Using HCPCS codes allows for accurate and uniform recording of services provided, which is essential for ensuring correct reimbursement and tracking healthcare services. While other choices might involve aspects of healthcare documentation, they do not specifically pertain to the core purpose of HCPCS codes.

2. What order of filing has the oldest documents in the front?

- A. Chronological**
- B. Reverse chronological
- C. Shingling
- D. Random

The order of filing that places the oldest documents in the front is chronological filing. This method organizes documents based on date, starting with the earliest documents first and progressing to the most recent. This approach is particularly useful for accessing historical information and tracking the development of events over time, as it allows for a straightforward review of records in the order they occurred. In contrast, reverse chronological filing would place the most recent documents at the front, making it easier to access current information while requiring more effort to find older documents. Shingling is a technique used for organizing documents that involves overlapping pages or similar items for easier access but does not specifically relate to the chronology of the documents. Random filing does not follow any specific order, which can lead to difficulty in locating documents efficiently. In summary, chronological filing is ideal for maintaining a clear historical sequence, making it effective for reviewing documents based on when they were created or received.

3. In which system are "encounter forms" typically found?

- A. Patient scheduling software
- B. Medical practice management software**
- C. Electronic health records
- D. Billing software

Encounter forms, often referred to as charge capture forms, are typically located in medical practice management software. These forms are critical for documenting the services provided to a patient during a visit and are used to facilitate the billing process. In a medical practice management environment, these encounter forms provide essential details such as diagnosis codes, procedure codes, and other relevant information necessary for insurance claims and financial tracking. This type of software is designed to handle the administrative and financial operations of a medical practice, making it the ideal platform for such documentation. By integrating patient information with billing procedures, practice management software streamlines the workflow, ensuring that clinicians capture the necessary data for billing accurately and efficiently. Thus, the placement of encounter forms within this system enhances the overall management and oversight of patient care and financial processes.

4. What kind of codes are HCPCS?

- A. Numerical codes for medications
- B. Alphanumeric billing codes**
- C. Exclusive codes for surgical procedures
- D. Pseudocode used for educational purposes

HCPCS, or the Healthcare Common Procedure Coding System, is a set of alphanumeric billing codes used to describe medical procedures, services, and supplies. This classification allows for uniformity in billing and ensures that various healthcare providers can accurately communicate the services rendered to patients, facilitating smooth processing and reimbursement by insurance companies. The alphanumeric nature of these codes is significant as it allows for a broader range of codes compared to purely numerical systems. HCPCS includes everything from ambulance services and durable medical equipment to certain drugs and non-physician services. This comprehensive coding system is vital for billing and documenting healthcare services accurately. The other options inaccurately represent the nature of HCPCS codes. They are not exclusive to surgical procedures, nor are they limited to medications, and they certainly are not designed for educational purposes as pseudocode. This broad application across various medical services highlights the importance and the correct classification of HCPCS as alphanumeric billing codes.

5. What is billing reconciliation?

- A. Adjusting patient accounts
- B. Matching billing records with services paid**
- C. Creating financial forecasts
- D. Reviewing insurance claims

Billing reconciliation involves the process of matching billing records, such as invoices and statements, with the actual services provided and the payments received. This process ensures accuracy in financial documents and helps to identify discrepancies between what was billed and what has been paid. When discrepancies are identified, further investigation can take place to resolve any potential issues, such as unprocessed claims or billing errors. The goal of billing reconciliation is to maintain clear and accurate financial records within an organization, which is crucial for both operational efficiency and compliance with accounting standards. The other options, while related to billing practices, do not capture the specific purpose of reconciliation. Adjusting patient accounts may refer to correcting account balances, creating financial forecasts is more related to predicting future revenues, and reviewing insurance claims is focused on ensuring claims are processed correctly rather than on the reconciliation of billing records.

6. In the context of medical billing, what does EMR stand for?

- A. Electronic Medical Records**
- B. Emergency Medical Reports
- C. Electronic Maintenance Records
- D. Effective Medical Recordkeeping

In the context of medical billing, EMR stands for Electronic Medical Records. This option is correct because EMRs are digital versions of patients' paper charts. They contain the medical and treatment history of the patients and are used by healthcare providers to streamline the documentation process, enhance patient care, and facilitate billing operations. EMRs help in tracking data over time, identify which patients are due for preventive screenings, and improve the overall efficiency of the healthcare practice. The other options do not accurately represent the term EMR within the medical billing context. Emergency Medical Reports and Electronic Maintenance Records imply different types of documentation, while Effective Medical Recordkeeping does not specifically denote a standardized electronic system like EMR does. Thus, only Electronic Medical Records accurately captures the concept associated with EMR in medical billing.

7. What is the typical response time for an urgent referral request?

- A. 1 hour**
- B. 24 hours**
- C. 48 hours**
- D. 72 hours**

The typical response time for an urgent referral request is 24 hours because this timeframe allows healthcare providers to prioritize immediate needs while also ensuring that patients receive timely care. Urgent referrals are generally those that require prompt attention but are not deemed as emergencies requiring immediate action. A 24-hour response time allows for appropriate assessment and action, facilitating the necessary communication and resources to manage the patient's care effectively. This balance between urgency and the realistic logistics of healthcare systems ensures that patients are efficiently routed to the right specialist or service without unnecessary delays. In contrast, shorter response times, such as 1 hour, are often impractical in most healthcare settings, while longer periods like 48 or 72 hours do not align with the urgency implied in the request.

8. What type of services do C codes cover?

- A. Outpatient prospective payment systems**
- B. Alcohol and drug abuse treatment**
- C. Transportation and ambulance services**
- D. Orthotics and prosthetics**

C codes are specific to the healthcare billing and coding system, particularly associated with outpatient prospective payment systems (OPPS). These codes are used to identify specific outpatient services that are reimbursed under the OPPS, which was established to provide a uniform payment system for outpatient hospital services. In outpatient settings, the efficient categorization of services helps streamline billing processes and provides clarity in what services are covered under government and insurance reimbursement frameworks. This categorization is especially important for healthcare facilities to receive timely and appropriate compensation for the services rendered to patients. In contrast, the other options pertain to different types of healthcare services that are not specifically covered by C codes. Alcohol and drug abuse treatment, transportation and ambulance services, and orthotics and prosthetics have their own coding systems and guidelines that govern how they are billed and reimbursed, which are distinct from the outpatient prospective payment systems.

9. When should credit adjustments be posted?

- A. After the payment is completed
- B. At the same time payment is posted**
- C. Once a week on Thursdays
- D. Only during the end of the financial year

The correct choice highlights that credit adjustments should be posted at the same time payment is posted. This approach ensures that the financial records reflect the most accurate and current information. Posting credit adjustments concurrently with payments helps maintain a clear and organized accounting system, avoiding discrepancies that might arise if they were recorded at a later time. Timely posting of these adjustments allows for real-time tracking of account balances, ensuring that both credits and payments are accounted for simultaneously. This practice supports efficient financial management and enhanced accuracy in reporting, which is crucial in administrative processes, especially when handling financial dealings. In contrast, other options suggest methods that could lead to gaps in record-keeping or delays in reflecting the actual financial situation, potentially causing confusion or errors in account management.

10. What type of agreement does “assignment of benefits” represent?

- A. A waiver of patient confidentiality
- B. A legal agreement for payment**
- C. A contract for medical services
- D. A policy for insurance refunds

The concept of “assignment of benefits” refers to a legal agreement where a patient transfers their right to receive payment for healthcare services directly to their healthcare provider. This arrangement allows the provider to bill the insurance company directly for the services rendered, simplifying the payment process for both the patient and the provider. As a result, the provider can receive payment more quickly and the patient does not have to handle the invoice and reimbursement process themselves. In this context, the agreement serves as an authorization from the patient to the insurance company, indicating that benefits due to the patient for services must be paid directly to the provider. This facilitates a more efficient billing process and reduces the administrative burden on patients who might otherwise need to pay out-of-pocket and subsequently file for reimbursement from their insurance company. Other options do not capture the essence of what is meant by “assignment of benefits.” While patient confidentiality is important in the healthcare field, it does not relate directly to the concept of assigning benefits. A contract for medical services typically outlines the terms of care provided, rather than the financial transactions involved. A policy for insurance refunds, while related to payments, does not reflect the direct transfer of benefits from the insurance company to the provider, which is core to the assignment of benefits.