

RMA Administrative Assisting Practice Test (Sample)

Study Guide



Everything you need from our exam experts!

This is a sample study guide. To access the full version with hundreds of questions,

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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. Don't worry about getting everything right, 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, and take breaks to retain information better.

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.

7. Use Other Tools

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!

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Questions

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- 1. What defines an "Add-on" code in medical billing?**
 - A. A service that is sometimes performed with the primary procedure**
 - B. A service that is the main procedure being billed**
 - C. A service that is always performed in addition to the primary procedure**
 - D. A service that is only documented in special cases**
- 2. Which of the following statements is TRUE regarding point of service billing?**
 - A. It delays the payment until after services are rendered**
 - B. It can be done at the location of service delivery**
 - C. It requires prior insurance authorization**
 - D. It is only applicable for outpatient services**
- 3. What practice is an example of unethical billing in healthcare?**
 - A. Phantom billing**
 - B. Upcoding**
 - C. Unbundling**
 - D. All of the above**
- 4. Which of the following is described by R codes?**
 - A. Non-Medicare misc codes**
 - B. Diagnostic radiology services**
 - C. Pathology and laboratory services**
 - D. Medicaid codes**
- 5. What type of codes identify services related to transportation and physical therapy?**
 - A. CPT codes**
 - B. ICD-10-CM codes**
 - C. HCPCS codes**
 - D. DRG codes**

6. What is an 837P form used for?

- A. To submit paper claims to insurance**
- B. As a standard electronic healthcare insurance claim form**
- C. To document patient insurance coverage**
- D. To file appeals for denied claims**

7. Why is it important to reconcile financial discrepancies?

- A. To maximize profit**
- B. To ensure accurate reporting**
- C. To minimize patient complaints**
- D. To reduce administrative costs**

8. Which type of information is included in section 2 of the 837P/CMS-1500 form?

- A. Carrier block**
- B. Patient/insured information**
- C. Billing codes**
- D. Provider information**

9. Which codes are specifically used for alcohol and drug abuse treatment?

- A. H codes**
- B. E codes**
- C. M codes**
- D. A codes**

10. 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**

Answers

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

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Explanations

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1. What defines an "Add-on" code in medical billing?

- A. A service that is sometimes performed with the primary procedure
- B. A service that is the main procedure being billed
- C. A service that is always performed in addition to the primary procedure**
- D. A service that is only documented in special cases

An "Add-on" code in medical billing is defined as a service that is always performed in addition to the primary procedure. This distinction is crucial because add-on codes are specifically used to indicate services that augment or enhance the main procedure being billed. The use of add-on codes allows for more accurate billing and ensures that healthcare providers are compensated for the additional services they provide during a patient's treatment. This clarity in billing is essential, as it helps to prevent misunderstandings or disputes related to billing for services that might not be directly included in the main procedure. Add-on codes are used in situations where certain procedures are inherently linked to a primary service, thereby making it clear that they should not be billed as standalone services. In contrast, options that suggest an add-on code may sometimes be performed with the primary procedure or only documented in special cases do not accurately reflect the definitive nature of add-on codes. Similarly, describing an add-on code as the main procedure being billed overlooks its purpose, which is to supplement rather than replace the primary code.

2. Which of the following statements is TRUE regarding point of service billing?

- A. It delays the payment until after services are rendered
- B. It can be done at the location of service delivery**
- C. It requires prior insurance authorization
- D. It is only applicable for outpatient services

Point of service billing refers to the practice of collecting payments or co-payments for medical services at the time the services are provided. This approach is advantageous because it allows healthcare providers to streamline the billing process, ensuring they receive payment right away rather than waiting until after services have been rendered. When considering the true nature of point of service billing, it is clear that the correct statement highlights that this billing practice can occur at the location of service delivery. This means that patients can settle their financial obligations immediately after receiving their treatment, which improves cash flow for healthcare providers and helps ensure that patients are aware of their costs upfront. The other statements do not accurately represent the concept of point of service billing. Delaying payment until after services are rendered contradicts the fundamental idea behind point of service billing. Requiring prior insurance authorization can be a factor for many medical services, but it does not specifically relate to point of service billing itself. Lastly, suggesting that point of service billing is only applicable for outpatient services ignores the flexibility in its application across various healthcare settings, including inpatient services.

3. What practice is an example of unethical billing in healthcare?

- A. Phantom billing**
- B. Upcoding**
- C. Unbundling**
- D. All of the above**

The correct choice highlights that all the listed practices are indeed examples of unethical billing in healthcare. Phantom billing refers to the act of billing for services that were never actually provided to a patient. This practice is deceptive and results in financial losses for both patients and insurance providers. Upcoding involves billing for a more expensive service than what was actually rendered, which misrepresents the care provided and leads to inflated costs and potential fraud. Unbundling is the practice of separating a comprehensive service into individual components to increase reimbursement beyond what is ethically justified, effectively creating artificial charges that do not reflect the true nature of care given. Recognizing that all these practices compromise the integrity of healthcare billing underscores the importance of ethical standards in healthcare administration. Ethical billing practices are essential to maintain trust between healthcare providers, patients, and insurance companies, and to ensure that billing accurately reflects the actual services delivered.

4. Which of the following is described by R codes?

- A. Non-Medicare misc codes**
- B. Diagnostic radiology services**
- C. Pathology and laboratory services**
- D. Medicaid codes**

The choice indicating diagnostic radiology services is correct because R codes specifically refer to the coding used in medical billing to categorize these types of services. Diagnostic radiology encompasses a variety of imaging services that healthcare providers utilize to diagnose medical conditions, such as X-rays, MRIs, and CT scans. R codes help to standardize the reporting and billing for these services across different healthcare settings. Understanding the context of the other options provides clarity. Non-Medicare misc codes represent a different classification that may not align specifically with the systematic identification used for radiology services. Pathology and laboratory services are generally identified by different codes, often the ones starting with the letter P or specific laboratory codes. Medicaid codes fall under a separate coding system dealing with services provided under the Medicaid program, which does not adhere to the R code structure for diagnostic radiology. Thus, the choice related to diagnostic radiology services distinctly fits the description of R codes.

5. What type of codes identify services related to transportation and physical therapy?

- A. CPT codes**
- B. ICD-10-CM codes**
- C. HCPCS codes**
- D. DRG codes**

The correct answer is HCPCS codes because these codes are specifically designed to cover a variety of services, including those related to transportation and physical therapy. The Healthcare Common Procedure Coding System (HCPCS) includes Level I codes, which are the same as Current Procedural Terminology (CPT) codes, and Level II codes, which address non-physician services such as ambulance transportation and durable medical equipment. CPT codes, while also relevant to healthcare services, primarily focus on procedures and services provided by healthcare professionals, so they do not encompass transportation services and other items that HCPCS covers. ICD-10-CM codes are used for coding diagnoses and medical conditions, not for classifying services. DRG codes are used for hospital billing, specifically related to inpatient stays and categorizing patients based on diagnosis and treatment, thereby not applicable to transportation and physical therapy services. By understanding these distinctions, it becomes clear why HCPCS codes are the appropriate choice for identifying services related to transportation and physical therapy.

6. What is an 837P form used for?

- A. To submit paper claims to insurance**
- B. As a standard electronic healthcare insurance claim form**
- C. To document patient insurance coverage**
- D. To file appeals for denied claims**

The 837P form is specifically designed as a standard electronic healthcare insurance claim form, which is utilized to transmit healthcare claim information from healthcare providers to insurance payers. This electronic format facilitates efficient data processing and ensures that the claims adhere to uniform guidelines established by the Centers for Medicare and Medicaid Services (CMS). The use of the 837P helps streamline the claims submission process, reducing the likelihood of errors and discrepancies that often occur with paper claims. By employing a standardized electronic format, healthcare providers can ensure that their claims are submitted in a consistent manner that aligns with the requirements of various insurance carriers. In contrast to the other options, the 837P form is not intended for submitting paper claims, documenting insurance coverage, or filing appeals for denied claims. Each of those activities has its own dedicated forms and processes within the healthcare system.

7. Why is it important to reconcile financial discrepancies?

- A. To maximize profit
- B. To ensure accurate reporting**
- C. To minimize patient complaints
- D. To reduce administrative costs

Reconciling financial discrepancies is crucial for ensuring accurate reporting. Accurate reporting is foundational for any organization, particularly in the healthcare field, where financial discrepancies can lead to significant implications. When discrepancies are not reconciled, it can result in errors in financial statements, misallocation of resources, and even compliance issues with regulations. Accurate financial reporting is essential for stakeholders, including management, investors, and regulatory bodies, as it reflects the true financial position of the organization. Inaccuracies can undermine trust and lead to poor decision-making, affecting the organization's overall health and sustainability. Therefore, regular reconciliation helps maintain integrity in financial practices and supports informed decision-making by providing reliable data.

8. Which type of information is included in section 2 of the 837P/CMS-1500 form?

- A. Carrier block
- B. Patient/insured information**
- C. Billing codes
- D. Provider information

The correct answer relates to the inclusion of patient and insured information in section 2 of the 837P/CMS-1500 form. This section is vital because it contains specific details about the patient and the policyholder, such as names, addresses, and insurance identification numbers. This information is essential for processing claims accurately, as it helps ensure that the healthcare provider is reimbursed correctly based on the patient's insurance coverage. Including patient and insured information is crucial for both the provider and the insurance company. Accurate information helps in verifying coverage, coordinating benefits, and preventing claim denials that can occur due to discrepancies or lack of necessary details. While other sections of the form encompass important details such as carrier information, billing codes, and provider information, section 2 specifically focuses on the patient and insured's credentials. This delineation is critical for the processing of medical claims and ensuring that all parties involved have the appropriate data needed for the adjudication process.

9. Which codes are specifically used for alcohol and drug abuse treatment?

A. H codes

B. E codes

C. M codes

D. A codes

The correct answer is A. H codes are specifically designated for services related to mental health, including treatment for alcohol and drug abuse. These codes are part of the Healthcare Common Procedure Coding System (HCPCS) and are utilized by healthcare providers to report health care services and procedures, specifically those that address behavioral health issues. By using H codes for alcohol and drug abuse treatment, providers can accurately convey the nature of the care being offered, which is essential for proper billing and insurance reimbursement. H codes allow for more precise tracking and analysis of how mental health services are delivered, making it easier to address the specific needs of patients undergoing treatment for substance use disorders. The other codes mentioned, such as E codes, M codes, and A codes, serve different purposes within medical coding systems. E codes are typically used to identify external causes of injuries and conditions. M codes relate to specific medical diagnoses or procedures. A codes are not commonly associated with substance abuse treatment. Understanding the specific roles of each code helps to ensure accurate reporting and effective treatment for patients.

10. 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.

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://rmaadminassistant.examzify.com>

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

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