THIRD PARTY PAYERS PRACTICE TEST (SAMPLE)

STUDY GUIDE

SAMPLE STUDY GUIDE WITH LIMITED 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. 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. Since 2014, plans report their MLRs and are subject to penalties if their MLRs do not meet the ____% requirements.

A. 85%

B. 80%

C. 90%

D. 75%

2. EPSDT stands for what?

A. Emergency Pediatric Screening and Therapy

B. Early Periodic Screening and Testing

C. Early and Periodic Screening, Diagnosis and Treatment

D. Essential Preventive Services and Treatment

3. The MLR represents the percentage of _____ used for patient care.

A. Costs

B. Premiums

C. Revenue

D. Claims

4. Which statement correctly describes coordination of benefits hierarchy?

A. They determine the order of providers within a network

B. They decide which payer pays first based on primary vs secondary rules, policy provisions, and dependent status

C. They determine patient eligibility by age

D. They set the maximum allowable charge for a claim

5. When a denial cites medical necessity, what actions should be taken?

A. Resubmit with no changes

B. Review policy, update documentation, provide clinical justification, and appeal

C. Ignore and wait

D. Change patient demographics

6. The SGR problem led to adjustments to physician payments in which direction?

A. Upward

B. Downward

C. Stable

D. Unchanged

7. For emergency department services, states may maintain copays that are what?

A. Lower

B. Same

C. Higher

D. None

8. When a patient or spouse is working when they turn 65, they must enroll in Part A and Part B; however, the employer-sponsored insurance plan is the primary payer and Medicare is the secondary payer.

A. Part A and Part B; employer-sponsored plan is primary; Medicare is secondary

B. Part A and Part B; Medicare is primary; employer-sponsored plan is secondary

C. Part A and Part C; employer-sponsored plan is primary; Medicare is secondary

D. Part B and Part D; employer-sponsored plan is primary; Medicare is secondary

9. The Social Security Act of 1935 was designed to improve economic security for which group?

A. The elderly

B. Children

C. The unemployed

D. Rural farmers

10. The acronym PMPM in Medicare payments stands for which phrase?

A. Per Member Per Month

B. Per Medicare Plan Month

C. Payment Per Member Monthly

D. Price Per Managed Module

Answers

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

Explanations

1. Since 2014, plans report their MLRs and are subject to penalties if their MLRs do not meet the ____% requirements.

A. 85%

B. 80%

C. 90%

D. 75%

The key idea is that medical loss ratio (MLR) sets a minimum share of premium dollars that must go toward medical care and quality improvement, not administrative costs or profits. Since the Affordable Care Act, plans in the large-group market must meet an 85% MLR; if they don't, they have to issue rebates to enrollees and may face penalties. This threshold is the one addressed by the question, which is why 85% is the correct standard to reference for penalties in this context. For contrast, the 80% threshold applies to the individual and small-group markets, but the question's focus on penalties in this setting points to the 85% requirement for large groups.

2. EPSDT stands for what?

A. Emergency Pediatric Screening and Therapy

B. Early Periodic Screening and Testing

C. Early and Periodic Screening, Diagnosis and Treatment

D. Essential Preventive Services and Treatment

EPSDT stands for Early and Periodic Screening, Diagnosis and Treatment. This name reflects Medicaid's obligation to provide comprehensive, preventive health services for children under 21, delivered at regular intervals, with appropriate diagnostic follow-up and treatment when issues are identified. The emphasis on both early and periodic screening ensures ongoing monitoring rather than a one-time check. The other options don't fit because they replace key terms or omit critical components like diagnosis and treatment.

3. The MLR represents the percentage of _____ used for patient care.

A. Costs

B. Premiums

C. Revenue

D. Claims

Medical Loss Ratio shows how much of the money collected from premiums actually goes to patient care. It's calculated by taking the amount spent on medical claims plus any quality improvement costs and dividing that by the premiums earned. In other words, it expresses the portion of premium dollars that are used to pay for patient care. Therefore, the blank should be filled with premium dollars (premiums earned), since that is the source of funds being allocated to care. The numerator covers claims and care-related costs, while the denominator is the premium revenue that the insurer earns.

4. Which statement correctly describes coordination of benefits hierarchy?

A. They determine the order of providers within a network

B. They decide which payer pays first based on primary vs secondary rules, policy provisions, and dependent status

C. They determine patient eligibility by age

D. They set the maximum allowable charge for a claim

Coordination of benefits determines which payer pays first when a patient has more than one health insurance policy. The statement that best captures this is that the payer order is decided by primary versus secondary rules, policy provisions, and dependent status. This hierarchy ensures that benefits are coordinated so the total payments don't exceed the cost of care: the primary plan pays first up to its limits, and the secondary plan may cover remaining eligible expenses according to its own rules. Dependent status—such as a child covered by both parents' plans—and specific policy provisions (like birthday rules or employer-based guidelines) drive which plan is primary. The other options describe different concepts. One refers to the order of providers within a network, which is a network arrangement rather than COB. Another mentions eligibility by age, which is not about payer sequencing. The last refers to setting the maximum allowable charge, which is about allowed amounts, not which insurer pays first.

5. When a denial cites medical necessity, what actions should be taken?

A. Resubmit with no changes

B. Review policy, update documentation, provide clinical justification, and appeal

C. Ignore and wait

D. Change patient demographics

When a denial cites medical necessity, the appropriate response is to verify the payer's criteria and strengthen the case for coverage. Start by reviewing the specific medical necessity policy and the member's benefits to confirm what criteria must be met. If the service can meet those criteria, gather and update the documentation to clearly show why it's medically necessary: articulate the patient's diagnosis, symptoms, treatment goals, and how the requested service addresses those needs; include supporting data such as progress notes, test results, imaging, previous treatments tried, and the ordering clinician's rationale. Make sure coding and billing align with the documented rationale, and address any gaps the payer noted. Then file an appeal within the allowed timeline, attaching the updated clinical justification and all supporting records. If the denial remains unresolved, consider requesting a peer-to-peer review or other level of review as part of the appeal process. This approach directly targets the payer's requirement for evidence of medical necessity and makes a clear, documented case for why the service is warranted. Resubmitting with no changes, ignoring the denial, or altering patient demographics would not address the payer's reason for denial and could create ethical or legal issues.

6. The SGR problem led to adjustments to physician payments in which direction?

A. Upward

B. Downward

C. Stable

D. Unchanged

The SGR mechanism was designed to control Medicare spending on physician services by tying payment updates to how fast overall spending grows. When actual spending rose faster than the target growth rate, payments were automatically reduced, not increased, to bring costs back in line. This is why the direction of adjustment is downward. Policymakers often intervened with temporary fixes to prevent these cuts, but the intended effect of the SGR itself was to slow payment growth by reducing rates when spending outpaced targets.

7. For emergency department services, states may maintain copays that are what?

A. Lower

B. Same

C. Higher

D. None

The key idea here is that emergency department visits are more resource-intensive, so cost-sharing is often set higher for them than for other medical services. A higher copay for ED visits helps reflect the greater cost and complexity of these visits and encourages patients to seek appropriate care settings or use urgent care when appropriate. That's why the best choice is Higher. The other options would imply ED copays are the same, lower, or nonexistent, which doesn't align with how many plans structure cost sharing to account for the higher level of care and use involved.

8. When a patient or spouse is working when they turn 65, they must enroll in Part A and Part B; however, the employer-sponsored insurance plan is the primary payer and Medicare is the secondary payer.

A. Part A and Part B; employer-sponsored plan is primary; Medicare is secondary

B. Part A and Part B; Medicare is primary; employer-sponsored plan is secondary

C. Part A and Part C; employer-sponsored plan is primary; Medicare is secondary

D. Part B and Part D; employer-sponsored plan is primary; Medicare is secondary

The situation tests understanding of how Medicare coordinates with an employer group plan for someone who is 65 or older and still working. When the employer has 20 or more employees, the employer-sponsored group health plan is the primary payer and Medicare is the secondary payer. In this arrangement, you enroll in both Part A and Part B of Medicare, but the employer plan pays first and Medicare covers remaining eligible costs as the secondary payer. This matches the choice that specifies Part A and Part B with the employer-sponsored plan as primary and Medicare as secondary. The other setups would apply in different circumstances, such as Medicare being primary (usually when the employer has fewer than 20 employees) or involving Part C (Medicare Advantage) or Part D (drug coverage), which aren't aligned with the described primary/secondary arrangement here.

9. The Social Security Act of 1935 was designed to improve economic security for which group?

A. The elderly

B. Children

C. The unemployed

D. Rural farmers

The point of the Social Security Act of 1935 was to provide retirement income that would secure older Americans economically. It introduced old-age insurance funded by payroll taxes, creating a stable, ongoing monthly benefit for people after they stop working. This focus on ensuring a steady income in retirement was meant to reduce poverty among the elderly during the hardships of the era, making the elderly the primary group targeted for economic security. While the act did include other provisions like unemployment benefits and aid for children, the cornerstone aim was to protect seniors in their retirement.

10. The acronym PMPM in Medicare payments stands for which phrase?

A. Per Member Per Month

B. Per Medicare Plan Month

C. Payment Per Member Monthly

D. Price Per Managed Module

PMPM stands for Per Member Per Month. This describes the monthly amount paid for each enrolled beneficiary, regardless of how many services or how much care that member uses. In Medicare, this capitation-style approach helps plans predict costs, manage risk, and budget more effectively by treating all members the same in a given month. Think of it as a fixed monthly fee for each member, which contrasts with per-visit or per-service payments. For example, with 2,000 members and a PMPM of $25, the plan would receive $50,000 for that month, no matter how many services were used. The other phrases don't reflect the standard terminology: they either rearrange the wording in ways not used in Medicare discussions or introduce terms (like "Plan Month" or "Managed Module") that aren't part of the established PMPM concept.

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://thirdpartypayers.examzify.com

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