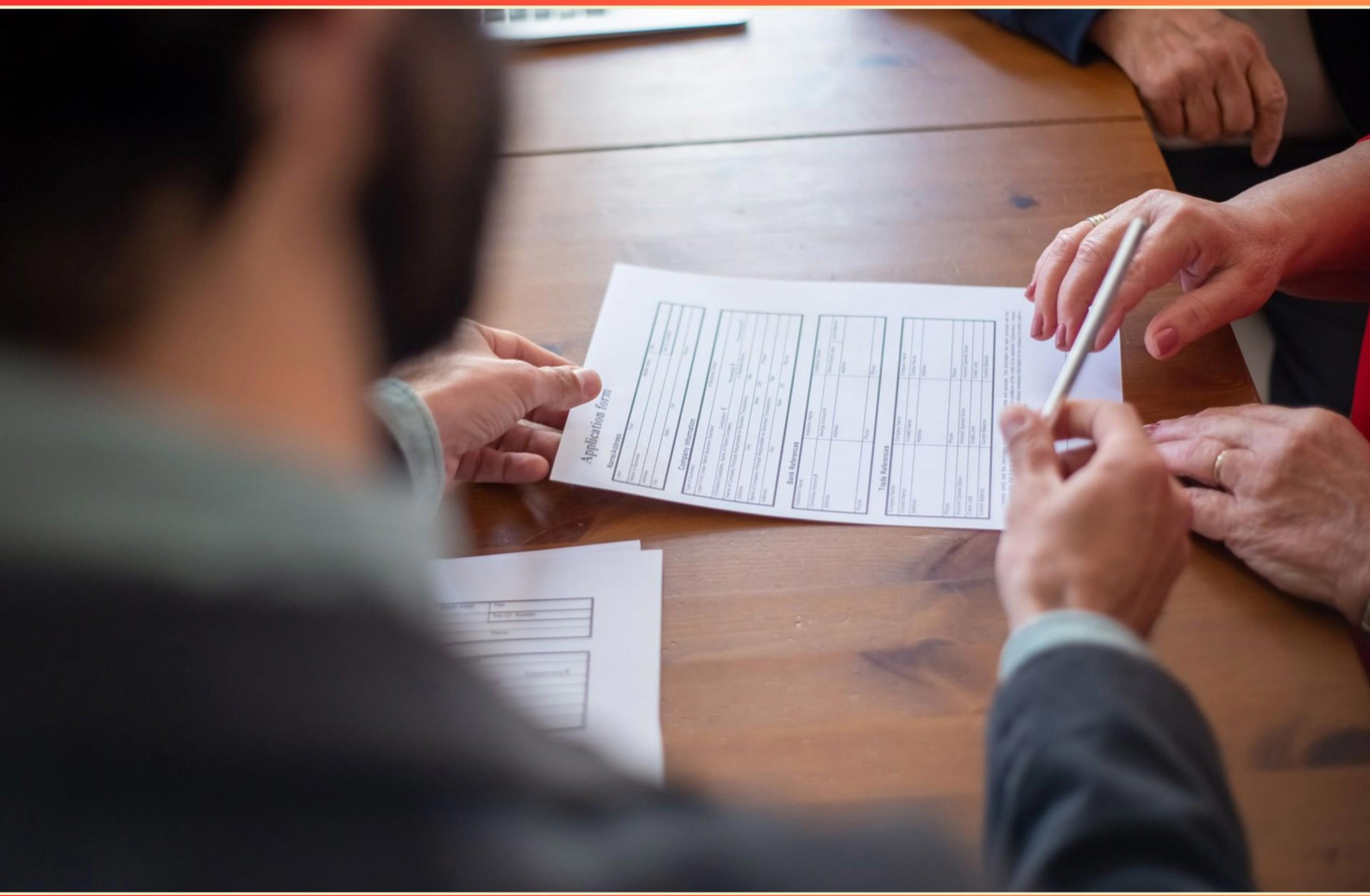
FREEDOM HEALTH AND OPTIMUM HEALTHCARE CERTIFICATION PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR THE FULL VERSION STUDY GUIDE

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Table of Contents

Copyright 1

Table of Contents 2

Introduction 3

How to Use This Guide 4

Questions 5

Answers 8

Explanations 10

Next Steps 15

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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.

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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!

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Questions

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1. FIDE stands for Fully Integrated Dual Eligible.

A. False

B. True

C. Fully Integrated Dual Eligibility

D. Fully Integrated Direct Enrollment

2. In payer contracts, what is the 'allowed amount'?

A. The negotiated payment the payer will make for a service.

B. The maximum out-of-pocket expense for the patient.

C. The total billed charges by the provider.

D. The amount of the pre-authorization required.

3. What is the relationship between CPT coding and ICD-10-CM coding in a claim?

A. CPT codes report procedures or services; ICD-10-CM codes report diagnoses.

B. CPT codes report diagnoses; ICD-10-CM codes report medications.

C. CPT codes report patient demographics; ICD-10-CM codes report facility charges.

D. CPT codes report billing codes; ICD-10-CM codes report provider IDs.

4. Which of the following is NOT a valid reason for involuntary disenrollment?

A. Moving to a new address in the same plan service area

B. Nonpayment of premiums

C. Loss of Medicaid eligibility

D. Violation of plan rules related to safety issues

5. If preventive care and screening tests are obtained from out-of-network providers, who is responsible for the costs?

A. Medicare pays for everything

B. The HMO plan pays everything

C. The member is responsible for the costs

D. Medicare and the HMO plan share costs

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6. Beneficiaries do not need to pay their monthly Medicare Part B premium if they pay the premium for a Medicare Supplement plan.

A. True

B. False

C. Sometimes

D. Not specified

7. What is the primary purpose of CPT coding guidelines?

A. To assign patient eligibility for services

B. To standardize the coding of medical procedures and services

C. To set insurance premiums

D. To determine provider reimbursements

8. What is the purpose of the ANOC letter?

A. It helps clients decide whether to change plans based on yearly changes

B. It lists the physician directory

C. It updates the pharmacy network

D. It sets the premiums for the year

9. Which step in the billing cycle occurs immediately after claim submission?

A. Payment posting.

B. Charge capture.

C. Accounts receivable follow-up.

D. Pre-authorization.

10. Which of the following describes eligibility for the integrated D-SNP under the 2025 SEP?

A. The beneficiary must have Medicaid through an affiliated managed care plan.

B. The beneficiary must be under 65

C. The beneficiary cannot be enrolled in any other plan

D. The beneficiary must reside outside the U.S.

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Answers

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

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Explanations

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1. FIDE stands for Fully Integrated Dual Eligible.

A. False

B. True

C. Fully Integrated Dual Eligibility

D. Fully Integrated Direct Enrollment

This question tests your knowledge of what the acronym FIDE stands for in the Medicare/Medicaid dual-eligibles context. FIDE stands for Fully Integrated Dual Eligible, a term used for programs that coordinate Medicare and Medicaid benefits for people who qualify for both. The wording uses the adjective "Eligible" to describe the beneficiaries—those who are Dual Eligible—so that form is correct. The alternative with "Eligibility" would describe the state of being eligible rather than the group itself, which isn't the standard expansion. The option with "Direct Enrollment" doesn't fit the concept of integrated benefits. So the statement is true.

2. In payer contracts, what is the 'allowed amount'?

A. The negotiated payment the payer will make for a service.

B. The maximum out-of-pocket expense for the patient.

C. The total billed charges by the provider.

D. The amount of the pre-authorization required.

The allowed amount is the negotiated payment rate under the payer contract—the amount the insurer agrees to reimburse the provider for a service. This figure is the basis for how much the payer will pay the provider, and it also influences what the patient will owe after applying deductible and coinsurance. It is not the patient's maximum out-of-pocket limit, nor the provider's total billed charges, and it has nothing to do with pre-authorization requirements. The patient's responsibility is typically calculated from the allowed amount, with any remaining balance (in some cases) handled according to network rules and state laws.

3. What is the relationship between CPT coding and ICD-10-CM coding in a claim?

A. CPT codes report procedures or services; ICD-10-CM codes report diagnoses.

B. CPT codes report diagnoses; ICD-10-CM codes report medications.

C. CPT codes report patient demographics; ICD-10-CM codes report facility charges.

D. CPT codes report billing codes; ICD-10-CM codes report provider IDs.

The main idea is that CPT codes describe what was done, while ICD-10-CM codes describe why it was done. CPT stands for Current Procedural Terminology and is used to bill for procedures, services, and supplies—things like surgeries, imaging, or office visits. ICD-10-CM captures the patient's diagnoses or conditions that prompted the encounter, establishing medical necessity for the procedure. On a claim, both pieces are needed—the ICD-10-CM diagnosis explains the reason for the service, and the CPT code identifies the actual service performed. For example, a colonoscopy performed because of a suspected polyp would include a CPT code for the colonoscopy itself and an ICD-10-CM code for the relevant diagnosis. The other statements mix up these roles: CPT does not report diagnoses, ICD-10-CM does not report medications, and patient demographics or facility charges aren't the primary function of these codes.

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4. Which of the following is NOT a valid reason for involuntary disenrollment?

A. Moving to a new address in the same plan service area

B. Nonpayment of premiums

C. Loss of Medicaid eligibility

D. Violation of plan rules related to safety issues

Involuntary disenrollment occurs when a member no longer meets eligibility or violates plan rules, not simply due to routine changes like a move within the service area. Moving to a new address within the same plan service area does not affect eligibility or enrollment, so it isn't a valid trigger for involuntary disenrollment. In contrast, not paying premiums can lead to disenrollment because ongoing payment is part of maintaining eligibility. Loss of Medicaid eligibility ends coverage tied to that program, which is another valid reason. Violating plan rules related to safety issues can also justify involuntary disenrollment to protect the safety of others and maintain a compliant, safe environment. So, the move within the service area isn't a valid reason for involuntary disenrollment, whereas the other circumstances listed are.

5. If preventive care and screening tests are obtained from out-of-network providers, who is responsible for the costs?

A. Medicare pays for everything

B. The HMO plan pays everything

C. The member is responsible for the costs

D. Medicare and the HMO plan share costs

When you use out-of-network providers for preventive care, the plan typically doesn't cover those services the same way as in-network care does. HMOs rely on network contracts, so preventive services are usually paid at 100% only when you stay in-network; going out-of-network often means little to no coverage or only partial coverage, leaving you responsible for the balance billed by the provider. Medicare/Medicare Advantage plans follow similar logic for out-of-network services. In short, the member bears the costs when preventive care is obtained out of network.

6. Beneficiaries do not need to pay their monthly Medicare Part B premium if they pay the premium for a Medicare Supplement plan.

A. True

B. False

C. Sometimes

D. Not specified

Medicare Part B premium is separate from a Medicare Supplement (Medigap) policy. Medigap helps cover costs that Part B doesn't pay (like coinsurance and deductibles), but it does not waive or replace the monthly Part B premium charged by Medicare. You still owe the Part B premium to Medicare, even if you have a Medigap plan. In rare cases, Part B premiums can be paid by programs like Medicaid or the Medicare Savings Program for those who qualify, but this is not related to purchasing Medigap. So the statement is not correct.

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7. What is the primary purpose of CPT coding guidelines?

A. To assign patient eligibility for services

B. To standardize the coding of medical procedures and services

C. To set insurance premiums

D. To determine provider reimbursements

CPT coding guidelines are about creating a consistent language for describing medical procedures and services. By standardizing the codes and the rules for using them, healthcare providers, coders, and payers can communicate clearly exactly what was done, reducing ambiguity and errors in reporting. This uniformity supports accurate billing, data collection, and analysis, and helps ensure that services are documented in a way that can be reliably interpreted across different systems and organizations. While reimbursements and coverage are influenced by payer contracts and policies, the primary purpose of CPT guidelines is to standardize how procedures and services are described, not to determine eligibility or set premiums.

8. What is the purpose of the ANOC letter?

A. It helps clients decide whether to change plans based on yearly changes

B. It lists the physician directory

C. It updates the pharmacy network

D. It sets the premiums for the year

The main idea this question tests is understanding what an Annual Notice of Change (ANOC) is for. An ANOC explains what will change for the coming year in a member's plan—benefits, cost-sharing, networks, and drug formularies—and it also notes if premiums will change. Its purpose is to give clients the information they need to decide whether to stay with their current plan or switch to a different one during enrollment. So, the best answer is that the ANOC helps clients decide whether to change plans based on yearly changes. It provides the details of upcoming changes so members can compare their current plan to other options and choose what fits their health needs and budget. The other choices aren't the primary purpose. It's not simply a physician directory, nor is its main function to update the pharmacy network, and while it may mention premium changes, it doesn't "set" the premiums—that decision is made by the plan and regulatory processes, not by the ANOC itself.

9. Which step in the billing cycle occurs immediately after claim submission?

A. Payment posting.

B. Charge capture.

C. Accounts receivable follow-up.

D. Pre-authorization.

Understanding how charges become part of a claim is essential. Charge capture is the step where the care provided is translated into billable line items in the billing system, ensuring every service and quantity is represented as a charge on the claim. Submitting the claim to the payer relies on those captured charges, and having them properly captured right after submission helps confirm that all services billed are accurately reflected and ready for adjudication. This keeps the claim complete and reduces the risk of denials due to missing or incorrect line items. Pre-authorization happens before services are delivered to ensure approval is in place. Payment posting occurs after the payer processes and pays the claim, and accounts receivable follow-up happens after claims are adjudicated to address denials or outstanding balances.

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10. Which of the following describes eligibility for the integrated D-SNP under the 2025 SEP?

A. The beneficiary must have Medicaid through an affiliated managed care plan.

B. The beneficiary must be under 65

C. The beneficiary cannot be enrolled in any other plan

D. The beneficiary must reside outside the U.S.

The crucial idea is dual eligibility with Medicaid coordination. An integrated D-SNP is designed for people who qualify for both Medicare and Medicaid and whose Medicaid benefits are managed through an affiliated Medicaid managed care plan. This alignment allows the D-SNP to coordinate Medicare and Medicaid services within one plan, which is why having Medicaid through an affiliated managed care plan is the eligibility criterion under the 2025 SEP. Age under 65 isn't a deciding factor, since dual eligibles can be elderly or younger if disabled. Being enrolled in other plans isn't the defining requirement for this SEP, and residing outside the U.S. isn't relevant because Medicare coverage applies in the U.S. only.

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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:

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

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