PTCB BILLING AND REIMBURSEMENT 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.

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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. RBRVS stands for which of the following?

A. Relative Value Scale for Resources

B. Resource Based Relative Value Scale

C. Resource Based Relative Value Schedule

D. Relative Value Scale Based on Resources

2. AWP is defined as the published average 'cost' of a drug product paid by the pharmacy to the wholesaler.

A. WAC

B. AAC

C. AWP

D. ASP

3. Which documentation helps avoid audits in the context of prior authorization-related billing?

A. Marketing materials and approvals.

B. Unverified patient consent.

C. Service is medically necessary; met any prior approval requirements; therapy is required per accepted standards of care; medication is formulary.

D. Diagnosis unrelated.

4. In time-based billing for established patients, what does the initial 15 minutes refer to?

A. The total appointment length

B. A free-time window

C. The initial time increment used for billing

D. Not billable

5. Deductible is

A. The set amount that must be paid by the patient before insurer coverage begins

B. The co-pay per prescription

C. The total annual maximum out-of-pocket

D. The discount applied by manufacturer

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6. HCPCS stands for what?

A. Healthcare Common Procedure Coding System
B. Health Care Coverage Procedure and Coding System
C. Hospital Coding and Procedure System
D. Health Care Cost and Procedure System

7. Dispensing Fee is defined as

A. WAC
B. Dispensing Fee
C. U&C
D. MAC

8. Which items constitute required insurance information for drug claims?

A. Group number, Member ID, Card issuer Id, RxBIN, RxPCN
B. Date of birth, address, phone
C. NDC, DAW, days supply
D. Prescriber ID, Pharmacy ID

9. HOPPS is a payment system used for which setting?

A. Hospital Outpatient Prospective Payment System
B. Medically Necessary / Usual and Customary
C. Durable Medical Equipment
D. ICD Codes

10. Which of the following is an example of a prior approval type?

A. Request for restricted meds
B. Set of guidelines for patient education
C. Prescription fill without PA
D. Generic substitution

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Answers

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

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Explanations

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1. RBRVS stands for which of the following?

A. Relative Value Scale for Resources

B. Resource Based Relative Value Scale

C. Resource Based Relative Value Schedule

D. Relative Value Scale Based on Resources

RBRVS stands for Resource-Based Relative Value Scale. This is the system Medicare uses to determine payments for physician services by assigning a relative value to each service based on the resources it requires. The values reflect three components—work effort, practice expenses, and malpractice costs—which are combined into RVUs and then adjusted for geographic differences. The concept is that reimbursement mirrors resource intensity rather than a flat fee. The other wordings miss the standard terminology or swap words (for example, using Schedule instead of Scale or rearranging the order), so the accepted expansion is Resource-Based Relative Value Scale.

2. AWP is defined as the published average 'cost' of a drug product paid by the pharmacy to the wholesaler.

A. WAC

B. AAC

C. AWP

D. ASP

AWP is a published, widely used price reference that represents the average price a pharmacy would be expected to pay to obtain a drug from a wholesaler, based on the manufacturer's listed prices. It serves as a benchmark rather than the exact amount a pharmacy actually spends after discounts, which is why it's described as the published average cost paid to the wholesaler. The Wholesale Acquisition Cost is the manufacturer's list price to wholesalers before discounts, not the published average price used for reimbursement. The Average Actual Acquisition Cost reflects the real price the pharmacy pays after discounts, rebates, and other factors, so it isn't a published average. The Average Sales Price pertains to Medicare reimbursement for physician-administered drugs and is a different pricing measure entirely.

3. Which documentation helps avoid audits in the context of prior authorization-related billing?

A. Marketing materials and approvals.

B. Unverified patient consent.

C. Service is medically necessary; met any prior approval requirements; therapy is required per accepted standards of care; medication is formulary.

D. Diagnosis unrelated.

The key idea is that strong, auditable documentation for prior-authorization billing shows four things: medical necessity, that the required prior authorization was obtained, that the therapy follows accepted standards of care, and that the prescribed medication is on the formulary. Medical necessity explains why the service or drug is needed for the patient's condition. Demonstrating that the prior authorization was completed and approved shows the payer's requirements were met before billing. Documenting that the therapy is in line with evidence-based standards confirms the treatment is appropriate for the condition, and confirming formulary status ensures coverage without needing a separate exception. Put together, this creates a solid paper trail that supports reimbursement and helps avoid audits. Relying on marketing materials doesn't establish the patient-specific medical necessity or PA status. Unverified patient consent addresses consent to treatment rather than payer requirements for coverage. A diagnosis unrelated to the service would not justify the claim and would raise audit flags.

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4. In time-based billing for established patients, what does the initial 15 minutes refer to?

A. The total appointment length

B. A free-time window

C. The initial time increment used for billing

D. Not billable

In time-based billing, the encounter is counted in 15-minute blocks. The initial 15 minutes are the first billing increment and serve as the starting point to determine the level of service and the amount billed for the visit with an established patient. Any additional time is added in subsequent 15-minute increments, and the total time spent with the patient (in those blocks) guides the billing level. This initial 15-minute period is not the total appointment length by itself, nor a free window, nor is it nonbillable. For example, a visit longer than the first 15 minutes is billed by adding more 15-minute blocks, with the total time helping decide the appropriate code and charge.

5. Deductible is

A. The set amount that must be paid by the patient before insurer coverage begins

B. The co-pay per prescription

C. The total annual maximum out-of-pocket

D. The discount applied by manufacturer

Deductible is the amount the patient must pay out of pocket before the insurer starts to cover costs for covered medications and services. It's typically an annual amount. Until that threshold is met, the patient bears the cost of prescriptions entirely. After meeting the deductible, the plan may require coinsurance or a copayment, until hitting the annual out-of-pocket maximum, at which point the insurer generally pays 100% of covered expenses. The fixed co-pay per prescription is not the deductible—it's a separate amount paid at each fill once the plan calls for a copay. The total annual maximum out-of-pocket is the cap on what the patient pays in a year, not the deductible itself. The discount from the manufacturer is not the deductible; it's a separate manufacturer discount or coupon and is independent of the insurer's deductible.

6. HCPCS stands for what?

A. Healthcare Common Procedure Coding System

B. Health Care Coverage Procedure and Coding System

C. Hospital Coding and Procedure System

D. Health Care Cost and Procedure System

HCPCS stands for Healthcare Common Procedure Coding System. It is the coding framework used in U.S. healthcare billing to report procedures, services, and supplies for reimbursement. It includes Level I codes, which are the CPT codes used by physicians, and Level II codes for items not in CPT—such as durable medical equipment, prosthetics, and certain outpatient services. The system is managed by CMS and updated annually, and it's commonly used on claims submitted to Medicare and many other insurers. The other options do not reflect the official name used by CMS.

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7. Dispensing Fee is defined as

A. WAC

B. Dispensing Fee

C. U&C

D. MAC

Dispensing fee is the fixed per-prescription amount that a payer reimburses the pharmacy to cover the act of dispensing, separate from the drug's purchase price. It reflects the pharmacy's labor, supplies, and overhead involved in filling the prescription and providing counseling. This fee is not the drug's wholesale acquisition cost, nor is it the usual price charged to customers, and it isn't a maximum allowable cost used to cap reimbursement for generics. So, the dispensing fee specifically compensates the dispensing service itself.

8. Which items constitute required insurance information for drug claims?

A. Group number, Member ID, Card issuer Id, RxBIN, RxPCN

B. Date of birth, address, phone

C. NDC, DAW, days supply

D. Prescriber ID, Pharmacy ID

The essential pieces are the identifiers that direct a claim to the correct payer and plan. The group number links the patient to a specific employer or plan group, the member ID uniquely identifies the patient within that plan, the card issuer ID identifies the payer issuing the insurance card, and the RxBIN and RxPCN work with the pharmacy benefits manager to route the claim and determine benefits. Together, these elements ensure the claim is processed under the correct coverage and benefit rules. Patient demographics like date of birth, address, and phone are used for verification but not for routing claims. Drug specifics such as NDC, DAW, and days' supply relate to the product and dispensing details, not the payer routing. Prescriber ID and Pharmacy ID identify the provider and place of dispensing but aren't the insurance routing keys.

9. HOPPS is a payment system used for which setting?

A. Hospital Outpatient Prospective Payment System

B. Medically Necessary / Usual and Customary

C. Durable Medical Equipment

D. ICD Codes

HOPPS stands for Hospital Outpatient Prospective Payment System. It's the Medicare framework that pays hospital outpatient departments a fixed, predetermined rate per visit based on Ambulatory Payment Classifications, rather than reimbursing actual charges. This applies to outpatient services provided in a hospital setting—things like outpatient clinics, ambulatory surgery, imaging, and similar encounters within the hospital. The other options aren't payment systems for a setting: Medically Necessary/Usual and Customary relates to coverage decisions and pricing concepts, Durable Medical Equipment refers to a separate DMEPOS payment framework, and ICD Codes are diagnostic codes used for billing and documentation.

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10. Which of the following is an example of a prior approval type?

A. Request for restricted meds

B. Set of guidelines for patient education

C. Prescription fill without PA

D. Generic substitution

Prior authorization is a process where the insurer must approve coverage for a medication before it is dispensed, usually for drugs that are restricted or require justification of medical necessity. A request for restricted meds is an example of this process because it directly involves submitting information to obtain payer approval for a drug that is not automatically covered. The other options don't involve getting payer approval: guidelines for patient education are educational resources, not a payment approval step; a prescription filled without prior authorization means no PA was needed or obtained; and generic substitution concerns substituting a generic version for a brand name under formulary rules, which is a substitution policy rather than a PA action.

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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:

https://ptcbbillingreimbursement.examzify.com

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

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