RMA ADMINISTRATIVE ASSISTING 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. 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

2. What do CPT codes primarily identify?

A. Healthcare providers and specialists

B. Medical equipment and supplies

C. Medical procedures and services

D. Patient demographics and information

3. What is involved in the "Storing and filing" step?

A. Organizing documents for ease of access

B. Securing documents permanently in the file

C. Creating digital backups of files

D. Transferring documents to external storage

4. What are revised codes intended to achieve?

A. Increase billing rates

B. Update CPT codes to reflect changes in healthcare service or procedures

C. Maintain consistency in medical practices

D. Reduce the number of insurance claims

5. What type of services do L codes cover?

A. Orthotics and prosthetics

B. Drugs administered other than orally

C. Enteral therapy

D. Misc medically services

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6. On the 837P/CMS - 1500 form, where is the "Total charge" for services documented?

A. Block 21

B. Block 28

C. Block 33

D. Block 24

7. Why might a healthcare provider choose to use an 837P form?

A. To ensure every patient has insurance

B. To submit insurance claims electronically

C. To provide a paper trail for audits

D. To maintain patient records

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

A. Patient scheduling software

B. Medical practice management software

C. Electronic health records

D. Billing software

9. What action should be taken if an insurance company denies a claim?

A. Forget about the claim

B. Automatically appeal the decision

C. Request an explanation and adjust the account if necessary

D. Notify the patient to pay out of pocket

10. What is a common benefit of using bundled codes in healthcare billing?

A. Increases paperwork for billing

B. Streamlines billing by grouping procedures

C. Reduces the need for insurance verification

D. Limits coverage for services rendered

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Answers

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

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Explanations

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1. 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.

2. What do CPT codes primarily identify?

A. Healthcare providers and specialists

B. Medical equipment and supplies

C. Medical procedures and services

D. Patient demographics and information

CPT codes, or Current Procedural Terminology codes, primarily identify medical procedures and services. These codes are standardized alphanumeric codes used by healthcare professionals to describe the procedures, tests, evaluations, and surgeries that are performed in the medical field. By providing a uniform language that streamlines communication among providers, insurers, and patients, CPT codes facilitate billing, coding, and recording of services rendered, ensuring that accurate and comprehensive documentation is maintained. While other options mention healthcare providers, medical equipment, and patient information, they do not accurately reflect the primary function of CPT codes, which is specifically to categorize and identify the various medical services and procedures provided to patients. This vital role of CPT codes helps in understanding the nature of the healthcare services delivered, which is essential for billing and maintaining medical records.

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3. What is involved in the "Storing and filing" step?

A. Organizing documents for ease of access

B. Securing documents permanently in the file

C. Creating digital backups of files

D. Transferring documents to external storage

The "Storing and filing" step primarily involves the systematic organization of documents to ensure they can be easily accessed when needed. This encompasses not only securing documents in a way that they are protected but also arranging them in a manner that allows for efficient retrieval. By organizing documents thoughtfully, administrative professionals make it easier to find essential information quickly, enhancing productivity. Securing documents permanently relates more to the long-term retention and preservation of records, which is just one facet of the broader storing and filing process. While creating digital backups, transferring documents to external media, and other actions contribute to overall document management, they do not encapsulate the comprehensive approach required in the storing and filing step itself, which is fundamentally about organizing for easy access and retrieval.

4. What are revised codes intended to achieve?

A. Increase billing rates

B. Update CPT codes to reflect changes in healthcare service or procedures

C. Maintain consistency in medical practices

D. Reduce the number of insurance claims

Revised codes, particularly in the context of Current Procedural Terminology (CPT) codes, are intended to update and refine the coding system to accurately reflect changes in healthcare services or procedures. As medical practices evolve with advancements in technology, treatment methods, and overall healthcare delivery, it becomes essential to modify the coding system to ensure that it represents the most current practices accurately. This updating process allows healthcare providers to document and communicate services provided to patients effectively, aligning coding with current medical practices, regulatory requirements, and payer guidelines. As a result, using revised codes helps ensure that healthcare professionals are reimbursed appropriately for the services they deliver, and that billing reflects actual care provided. The other options do not accurately encapsulate the primary objective of revised codes. Adjusting billing rates, maintaining consistency in medical practices, or reducing the number of insurance claims does not directly address the intent behind the systematic update of codes in response to evolving healthcare scenarios.

5. What type of services do L codes cover?

A. Orthotics and prosthetics

B. Drugs administered other than orally

C. Enteral therapy

D. Misc medically services

L codes are specifically designated for billing and coding related to orthotics and prosthetics. These codes are utilized in the healthcare system to identify the various types of devices, such as artificial limbs or orthopedic supports, provided to patients. By using L codes, healthcare professionals can ensure accurate billing and reflect the specific nature of the service provided, which helps to facilitate proper reimbursement and record-keeping. In contrast, the other options refer to different types of services that do not fall under the L code classification. For instance, drugs administered other than orally would be categorized under different coding systems, while enteral therapy and miscellaneous medical services also have their unique classifications that do not include L codes. This specificity in coding is crucial for effective healthcare management and financial processing within medical facilities.

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6. On the 837P/CMS - 1500 form, where is the "Total charge" for services documented?

A. Block 21

B. Block 28

C. Block 33

D. Block 24

On the 837P/CMS-1500 form, the "Total charge" for services is documented in Block 28. This block is specifically designated for the total amount billed by the healthcare provider for the services rendered. The entry in this block reflects the cumulative charges related to the specific encounter or service provided to the patient. It's important for this block to be accurately filled out, as it plays a critical role in the claims processing and reimbursement activities by insurance payers. The other blocks mentioned in the choices serve different purposes. Block 21 is used for the Diagnosis or Nature of Illness or Injury, Block 33 is where the billing provider's information is submitted, and Block 24 is designated for itemized services and procedures, including individual line item charges but not the total charge. Understanding the purpose of each block helps ensure that proper billing practices are followed and that claims are processed efficiently.

7. Why might a healthcare provider choose to use an 837P form?

A. To ensure every patient has insurance

B. To submit insurance claims electronically

C. To provide a paper trail for audits

D. To maintain patient records

The 837P form is specifically designed for the electronic submission of insurance claims in the healthcare industry. By using this form, healthcare providers can efficiently transmit claims to insurance payers, facilitating quicker processing and payment. The electronic format helps streamline administrative tasks, reduces errors associated with paper forms, and speeds up reimbursement cycles, making it an essential tool for healthcare providers looking to enhance their billing strategies and maintain cash flow. In contrast, while ensuring every patient has insurance, providing a paper trail for audits, and maintaining patient records are important aspects of healthcare administration, these are not the primary reasons for using the 837P form. The primary function of the 837P is centered around the electronic claims submission process, which plays a crucial role in the billing and revenue cycle of healthcare services.

8. 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.

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9. What action should be taken if an insurance company denies a claim?

A. Forget about the claim

B. Automatically appeal the decision

C. Request an explanation and adjust the account if necessary

D. Notify the patient to pay out of pocket

The appropriate action to take when an insurance company denies a claim is to request an explanation and adjust the account if necessary. This step is crucial because understanding the reason behind the denial allows for informed decisions on how to proceed. It opens a dialogue with the insurance company that can sometimes lead to reversing the denial if the issue can be clarified or corrected, such as a clerical error or insufficient documentation. Furthermore, adjusting the account as needed ensures that financial records are accurate, which is important both for the practice's accounting and for the patient's understanding of their financial responsibility. This approach demonstrates professionalism and a commitment to resolving issues on behalf of the patient. The other options either suggest inaction or would not adequately address the situation, leading to potential financial and administrative complications. It is essential to follow up on denied claims to ensure proper reimbursement and to maintain transparent communication with all relevant parties.

10. What is a common benefit of using bundled codes in healthcare billing?

A. Increases paperwork for billing

B. Streamlines billing by grouping procedures

C. Reduces the need for insurance verification

D. Limits coverage for services rendered

Bundled codes in healthcare billing provide a common benefit by streamlining billing processes through the grouping of related procedures into a single code. This approach simplifies the billing workflow for providers and reduces administrative tasks, such as separate claims submissions for each individual procedure. By consolidating multiple services into one code, healthcare providers can expedite the billing process and minimize the potential for coding errors or discrepancies that may arise when billing for multiple codes individually. Moreover, bundled codes facilitate easier billing and processing for insurance companies, which can lead to quicker reimbursements. Thus, this method enhances overall efficiency and effectiveness within healthcare billing.

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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://rmaadminassistant.examzify.com

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

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