AMCA Medical Coder & Biller Certification (MCBC) Practice Exam (Sample)

Study Guide

BY EXAMZIFY

Everything you need from our exam experts!

Table of Contents

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. **In an inpatient setting, what diagnosis is sequenced first?**
    A. Secondary diagnosis
    B. Pre-existing condition
    C. Principal diagnosis
    D. Rules-based diagnosis

2. **What does the acronym PPO stand for in healthcare?**
    A. Preferred Provider Organization
    B. Primary Patient Option
    C. Patient Provider Optimization
    D. Policy Provider Organization

3. **What does E/M coding primarily assess?**
    A. Patient Diagnosis
    B. Healthcare Outcomes
    C. Provider Decision Making
    D. Patient's Condition and Treatment Plan

4. **What is the fourth step in outpatient diagnosis coding?**
    A. Abstract the medical conditions from the visit documentation
    B. Verify the code in the Tabular List
    C. Locate the main term in the Alphabetic Index
    D. Check compliance with any applicable official guidelines

5. **Which form must providers complete to renew participation in Medicare?**
    A. CMS 855
    B. CMS 1500
    C. CMS 500
    D. Medicare Application Form

6. **What does PHR stand for in healthcare documentation?**
    A. Physical health record
    B. Personal health records
    C. Private health report
    D. Patient health record

7. **What is the primary responsibility of an accountable care organization (ACO)?**

   A. Increase healthcare costs

   B. Coordinate patient care

   C. Reduce patient volume

   D. Limit provider networks

8. **A provider's coding accuracy is important for which reason?**

   A. To increase patient satisfaction

   B. To ensure proper reimbursement

   C. To enhance clinic reputation

   D. To reduce administrative costs

9. **Which of the following denotes a surgical removal of tissue in medical terminology?**

   A. -tomy

   B. -ectomy

   C. -ostomy

   D. -plasty

10. **How long has it been since a new patient received services from the provider?**

   A. 1 year

   B. 2 years

   C. 3 years

   D. 5 years

Answers

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

Explanations

1. In an inpatient setting, what diagnosis is sequenced first?

A. Secondary diagnosis

B. Pre-existing condition

C. Principal diagnosis

D. Rules-based diagnosis

In an inpatient setting, the principal diagnosis is the main condition for which the patient was admitted to the hospital. This diagnosis drives the treatment provided during the inpatient stay and is prioritized in the medical coding process. It represents the primary reason the patient required care, making it essential for appropriate billing and reimbursement processes. When coding for inpatient stays, the principal diagnosis is assigned and sequenced first in the coding configuration, as this helps in establishing the level of care required and the complexity of treatment. Accurate identification and sequencing of the principal diagnosis ensure that healthcare providers receive the correct payment for their services and can also affect quality metrics and statistics related to hospital performance. The role of the secondary diagnosis, pre-existing conditions, or rules-based diagnosis is important but secondary to the principal diagnosis. These elements enhance the context of the patient's health situation but do not take precedence when determining the primary reason for an inpatient admission. Hence, they are sequenced after the principal diagnosis in the coding structure.

2. What does the acronym PPO stand for in healthcare?

A. Preferred Provider Organization

B. Primary Patient Option

C. Patient Provider Optimization

D. Policy Provider Organization

The acronym PPO stands for Preferred Provider Organization. This type of health insurance plan allows members to choose healthcare providers from a network of pre-selected doctors, hospitals, and other healthcare facilities. The major advantage of a PPO is that members can receive care from both in-network and out-of-network providers, though they typically pay lower out-of-pocket costs when utilizing in-network services.   Understanding the structure of a PPO is important in medical coding and billing because it influences how services are billed, the reimbursement rates, and the necessity for prior authorizations for certain procedures. Each healthcare plan has different rules regarding which services require referrals and how much members are responsible for financially, which can impact the coding and billing processes.   The other options do not accurately define the terminology used in healthcare settings. Knowledge of the correct terminology, such as PPO, is essential for effective communication within healthcare and for ensuring that coding and billing processes are handled correctly.

3. What does E/M coding primarily assess?

A. Patient Diagnosis

B. Healthcare Outcomes

C. Provider Decision Making

D. Patient's Condition and Treatment Plan

E/M coding, which stands for Evaluation and Management coding, primarily assesses the patient's condition and treatment plan. This type of coding is integral in the healthcare process because it documents the complexity of the visit based on the patient's symptoms, medical history, and the healthcare provider's assessment, including the decisions made regarding the patient's care.   In E/M coding, various elements such as the extent of the examination, history, and clinical decision-making play vital roles in determining the appropriate code. The focus is on how the patient's condition is evaluated during the visit and what treatment plans are established as a result. Therefore, understanding the nuances of the patient's condition and the specific actions taken to manage that condition is essential for appropriate coding. While the other options contain relevant aspects of healthcare, they do not capture the primary focus of E/M coding. For instance, patient diagnosis is an important aspect, but E/M coding is more comprehensive than just diagnosing. Similarly, healthcare outcomes and provider decision-making are parts of the larger picture, but the core element of E/M coding is centered on directly assessing the patient's condition and defining the treatment plan. This distinction highlights the holistic approach of E/M coding in the context of patient management and care delivery.

4. What is the fourth step in outpatient diagnosis coding?

A. Abstract the medical conditions from the visit documentation

B. Verify the code in the Tabular List

C. Locate the main term in the Alphabetic Index

D. Check compliance with any applicable official guidelines

The fourth step in outpatient diagnosis coding involves checking compliance with any applicable official guidelines. This step is crucial because the accuracy and appropriateness of coding not only depend on correctly identifying and assigning codes but also on ensuring that those codes align with established coding standards and guidelines. These guidelines may include policies set forth by Medicare, Medicaid, or various private insurers, as well as principles from coding systems like ICD-10-CM. This compliance check ensures that the codes used are justified by the documentation and conform to the regulations governing reimbursement. Failing to adhere to these guidelines can lead to incorrect billing, potential audits, and financial penalties, emphasizing the importance of this step in the overall coding process. This is why understanding and applying the relevant guidelines is considered the fourth step, as it protects both the healthcare provider and the patient by promoting ethical billing practices.

5. Which form must providers complete to renew participation in Medicare?

A. CMS 855

B. CMS 1500

C. CMS 500

D. Medicare Application Form

The CMS 855 form is specifically designed for providers to enroll and renew their participation in Medicare. This form is used to collect the necessary information regarding a provider's practice, including their credentials, service locations, and other relevant details. By completing the CMS 855, providers can ensure that their participation in Medicare remains active and compliant with the program's requirements. Other forms mentioned, such as the CMS 1500, are primarily used for billing purposes rather than for enrollment or renewal. The CMS 1500 form is a standard claim form used by healthcare providers to bill Medicare and other insurers for services rendered to patients. The CMS 500 is not a recognized Medicare form associated with provider enrollment or renewal, and while "Medicare Application Form" might sound relevant, it lacks the specificity and recognition that the CMS 855 has in federal regulations regarding provider enrollment. Hence, the CMS 855 is indeed the correct choice for renewing participation in Medicare.

6. What does PHR stand for in healthcare documentation?

A. Physical health record

B. Personal health records

C. Private health report

D. Patient health record

The term "PHR" stands for Personal Health Records. A Personal Health Record is a collection of health information that is maintained and managed by the individual patient. This information often includes the patient's medical history, medications, allergies, lab results, immunization records, and other health-related data. The significance of PHRs lies in their ability to empower patients to take control of their health management. By having access to their own health data, patients can make informed decisions, communicate more effectively with healthcare providers, and ensure that their records are accurate and up-to-date. PHRs can facilitate better coordination of care, especially when patients see multiple specialists or have numerous medical visits, because all their information is consolidated and readily accessible. In contrast, while other terms like Physical Health Record or Patient Health Record might suggest a formal or standard record used in a clinical setting, they do not accurately reflect the individualized and patient-centered aspect of a Personal Health Record.

7. What is the primary responsibility of an accountable care organization (ACO)?

   A. Increase healthcare costs

   B. Coordinate patient care

   C. Reduce patient volume

   D. Limit provider networks

The primary responsibility of an accountable care organization (ACO) is to coordinate patient care. This involves organizing services across various healthcare providers to ensure that patients receive the right care at the right time, avoiding unnecessary duplication of services and preventing medical errors. By focusing on care coordination, ACOs aim to improve the quality of care and promote better health outcomes for patients. This often includes managing chronic conditions, facilitating communication among healthcare providers, and implementing preventive measures to maintain patient health. The structure of an ACO allows healthcare providers to work collaboratively to enhance patient experiences, optimize treatment plans, and ultimately reduce costs by ensuring efficient use of healthcare resources. This patient-centered approach is at the heart of the ACO model, aligning incentives for both providers and patients through shared savings programs.

8. A provider's coding accuracy is important for which reason?

   A. To increase patient satisfaction

   B. To ensure proper reimbursement

   C. To enhance clinic reputation

   D. To reduce administrative costs

The importance of a provider's coding accuracy largely centers on ensuring proper reimbursement. When medical coding is accurately performed, it directly impacts how healthcare providers are compensated for their services. Accurate coding reflects the complexity and specificity of the services rendered, which is essential for receiving the appropriate payment from insurance companies and government payers. Errors in coding can lead to delayed payments, underpayments, or even claim denials, ultimately affecting a provider's revenue cycle. Moreover, accurate coding is essential for compliance with regulations and can help prevent audits, which can be costly and disrupt cash flow. Ensuring that codes correctly match the services delivered minimizes the risk of issues with payers and increases the likelihood of collecting the full amount owed for services provided. While the other options such as increasing patient satisfaction, enhancing clinic reputation, and reducing administrative costs are relevant considerations, they are more indirect effects of accurate coding rather than the primary reason driving the need for precision in coding practices. Coding accuracy fundamentally serves the purpose of securing correct reimbursement, making it the focus of the question.

9. Which of the following denotes a surgical removal of tissue in medical terminology?

A. -tomy

B. -ectomy

C. -ostomy

D. -plasty

The term that denotes surgical removal of tissue in medical terminology is represented by the suffix "-ectomy." This suffix is used to indicate the excision or removal of a particular organ or tissue. For example, a "appendectomy" refers specifically to the surgical removal of the appendix, while a "mastectomy" refers to the removal of breast tissue. The other suffixes cover different types of surgical procedures. "-tomy" refers to an incision or cutting into a part of the body, which doesn't imply removal but rather a surgical entry. "-ostomy" indicates the creation of an opening or stoma, typically to allow waste to exit the body, but it doesn't involve the removal of tissue per se. Lastly, "-plasty" refers to surgical repair or reconstruction of a tissue or organ, which may involve altering the structure but not necessarily removing it. Thus, "-ectomy" specifically captures the meaning of surgical removal.

10. How long has it been since a new patient received services from the provider?

A. 1 year

B. 2 years

C. 3 years

D. 5 years

In the context of medical coding and billing, determining how long it has been since a new patient last received services from a provider is essential for assessing the patient's status and for proper coding purposes. If the answer indicates that it has been 3 years since the patient last received services, this aligns with standard definitions typically used in healthcare settings. Many practices classify a patient as new if they have not been seen within the last three years, which is often the timeframe used to differentiate new patients from established patients in various coding guidelines. This timeframe influences how providers file claims, as coding for new and established patients can lead to different reimbursement rates and requirements for documentation. By noting that it has been 3 years, it reflects a clear understanding of the guidelines that dictate patient classification within the healthcare system. Other timeframes presented might reflect different interpretations of what constitutes a "new" patient, but the rule of three years is widely accepted and serves as a benchmark for many medical practices.

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://amcamedicalcoderbiller.examzify.com

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