

AMCA MEDICAL CODER & BILLER CERTIFICATION (MCBC) PRACTICE EXAM (SAMPLE) STUDY GUIDE



Prepare with structure. Pass with confidence



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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

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- 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 PECOS stand for?**
 - A. Provider Enrollment Chain and Ownership System
 - B. Patient Electronic Health Care Organization System
 - C. Primary Emergency Care Operations Standard
 - D. Professional Evaluation and Credentialing Online System
- 3. What term refers to Medicare computer programs that profile average billing patterns for Evaluation and Management (E/M) codes?**
 - A. Cost analysis
 - B. Profile management
 - C. Benchmarking
 - D. Billing analysis
- 4. What is the purpose of coding morbidity data?**
 - A. To provide a basis for insurance claims
 - B. To analyze population health trends
 - C. To convert diagnoses into numeric codes
 - D. To assist in treatment planning
- 5. What does the term "coinsurance" refer to in health insurance?**
 - A. A fixed amount a patient pays
 - B. The patient's total cost for services
 - C. The percentage of each claim that the patient pays
 - D. The amount paid by the insurer

- 6. What does the revenue cycle monitoring primarily ensure after claims submission?**
- A. Patient satisfaction
 - B. Compliance with billing regulations
 - C. Payer adjudication results
 - D. Financial responsibility
- 7. What is the global period associated with a simple procedure?**
- A. Zero global period
 - B. One-week global period
 - C. Thirty-day global period
 - D. Two-day global period
- 8. What is the role of the primary care physician in a HMO system?**
- A. To specialize in various medical fields
 - B. To manage all aspects of patient care
 - C. To provide emergency medical services
 - D. To refer patients directly to specialists without oversight
- 9. What does sequencing refer to in the context of medical coding?**
- A. Recording multiple procedures on one claim
 - B. Listing the correct order of a principal diagnosis
 - C. Combining claims for submission
 - D. Updating patient demographic information
- 10. What type of disability may allow a worker to be rehabilitated in a different line of work?**
- A. Temporary disability
 - B. Partial disability
 - C. Permanent disability
 - D. Complete disability

Answers

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

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Explanations

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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 PECOS stand for?

- A. Provider Enrollment Chain and Ownership System**
- B. Patient Electronic Health Care Organization System
- C. Primary Emergency Care Operations Standard
- D. Professional Evaluation and Credentialing Online System

The term PECOS stands for Provider Enrollment Chain and Ownership System. This system is utilized by the Centers for Medicare & Medicaid Services (CMS) to streamline the enrollment process for health care providers who wish to submit claims to Medicare. PECOS allows providers to enroll electronically, manage their enrollment records, and update any necessary information regarding their practice, making it a vital tool in ensuring that medical billing and coding processes function smoothly. The significance of this system lies in its ability to maintain accurate records of healthcare provider enrollments, as well as their ownership details, which helps in adherence to compliance regulations. Additionally, the system improves the efficiency of the enrollment process, reducing paperwork and expediting approvals for providers seeking to participate in Medicare programs. Understanding the role of PECOS is essential for medical coders and billers, as it directly impacts how claims are processed and the overall billing workflow in healthcare settings.

3. What term refers to Medicare computer programs that profile average billing patterns for Evaluation and Management (E/M) codes?

- A. Cost analysis
- B. Profile management
- C. Benchmarking**
- D. Billing analysis

The term that refers to Medicare computer programs profiling average billing patterns for Evaluation and Management (E/M) codes is benchmarking. This process involves comparing healthcare providers' billing practices against established standards or averages. By analyzing these profiles, Medicare can identify potential discrepancies or variations in billing practices, helping ensure that providers adhere to appropriate coding and billing guidelines. Benchmarking is crucial for maintaining the integrity of billing processes and enhancing the quality of care. The other terms, while related to the business aspect of healthcare, do not specifically align with the concept of profiling average billing patterns. Cost analysis typically focuses on evaluating the costs associated with services rather than profiling billing. Profile management implies a broader scope of managing data profiles without the specific context of averages and comparisons. Billing analysis, while it examines billing practices, doesn't inherently include the comparative aspect that benchmarking does.

4. What is the purpose of coding morbidity data?

- A. To provide a basis for insurance claims
- B. To analyze population health trends
- C. To convert diagnoses into numeric codes**
- D. To assist in treatment planning

The primary purpose of coding morbidity data is to convert diagnoses into numeric codes. This coding process standardizes medical information, allowing for consistent documentation and communication within the healthcare system. By assigning specific codes for various diagnoses, healthcare providers and coders can ensure that patient information is accurately represented in electronic health records and claims submissions. While converting diagnoses into numeric codes is crucial for accurate billing and record-keeping, it also serves broader purposes, such as tracking health statistics and ensuring compliance with regulations. For example, these codes facilitate research, funding allocations, and public health initiatives by providing quantifiable data on disease prevalence and associated health issues. The other options, while relevant to aspects of morbidity data handling, do not capture the fundamental role of coding itself. For instance, insurance claims may rely on these codes, but the act of coding serves a more primary function in the organization and analysis of health data. Similarly, while analyzing population health trends and assisting in treatment planning are essential applications of morbidity data, they come after the coding process, which is foundational to the accurate usage and interpretation of health information.

5. What does the term "coinsurance" refer to in health insurance?

- A. A fixed amount a patient pays
- B. The patient's total cost for services
- C. The percentage of each claim that the patient pays**
- D. The amount paid by the insurer

Coinurance refers to the percentage of each medical claim that the patient is responsible for paying after their deductible has been met. This means that when a patient receives medical services, both the insurance company and the patient share the cost of those services. For example, if a patient has a coinsurance rate of 20%, they will pay 20% of the allowed amount for the service, while the insurance company covers the remaining 80%. Understanding coinsurance is crucial for patients to comprehend their financial responsibilities when navigating their health insurance plans, and it plays a significant role in determining the total out-of-pocket costs for care. Knowing how coinsurance works can also help patients make informed decisions about their healthcare and financial planning.

6. What does the revenue cycle monitoring primarily ensure after claims submission?

- A. Patient satisfaction
- B. Compliance with billing regulations
- C. Payer adjudication results**
- D. Financial responsibility

The monitoring of the revenue cycle primarily focuses on ensuring accurate and timely responses to claims that have been submitted. This includes analyzing the results of payer adjudication, which refers to the process by which insurance payers review and decide on the validity of claims submitted by healthcare providers. By closely examining payer adjudication results, organizations can identify trends, track claim denials, and assess whether the claims are being processed efficiently. Understanding the outcomes of these adjudications is essential for optimizing revenue, as it allows practices to address any issues that may arise during the claims process and to take corrective actions if necessary. Thus, ensuring an effective revenue cycle hinges significantly on monitoring these outcomes to improve overall financial performance and operational efficiency. While patient satisfaction, compliance with billing regulations, and financial responsibility are indeed important aspects of the healthcare revenue cycle, they are not the primary focus of monitoring after claims submission. Instead, the emphasis is on how claims fare against payer policies and practices, which significantly impacts the financial health of medical practices and facilities.

7. What is the global period associated with a simple procedure?

- A. Zero global period**
- B. One-week global period
- C. Thirty-day global period
- D. Two-day global period

A simple procedure typically has a zero global period, which means that the procedure includes only the day of the procedure itself, and there are no follow-up days included for postoperative care. In practical terms, this means that the physician is not responsible for any follow-up visits related to that procedure, and any additional services or complications that arise would be billed separately and outside of the initial procedure charge. Understanding the concept of global periods is crucial in medical coding and billing, as it helps determine how and when procedures are billed. For simple procedures, since care and management are minimal or nonexistent after the procedure, a zero global period is appropriate. This aligns with the guidelines set by entities such as the American Medical Association, which outlines how different types of surgical procedures are categorized in relation to follow-up care.

8. What is the role of the primary care physician in a HMO system?

- A. To specialize in various medical fields
- B. To manage all aspects of patient care**
- C. To provide emergency medical services
- D. To refer patients directly to specialists without oversight

In a Health Maintenance Organization (HMO) system, the primary care physician serves a critical role in managing all aspects of patient care. This includes being the first point of contact for patients, overseeing their overall health, coordinating care, and guiding them through the healthcare system. The primary care physician is responsible for diagnosing and treating various health conditions, managing chronic diseases, and conducting routine check-ups. By managing patient care, the primary care physician also acts as a gatekeeper for specialist referrals, ensuring that patients receive appropriate and necessary care. This holistic approach allows for better continuity of care, as the primary care physician maintains an ongoing relationship with the patient and understands their medical history and specific health needs. The other options do not accurately reflect the role of the primary care physician in an HMO system. Specializing in various medical fields is more aligned with specialists rather than primary care providers. While primary care physicians may provide essential and urgent care, providing emergency medical services is typically not their primary function. Lastly, referring patients directly to specialists without oversight contradicts the managed care model, which emphasizes coordination and management of care under the primary physician's guidance.

9. What does sequencing refer to in the context of medical coding?

- A. Recording multiple procedures on one claim
- B. Listing the correct order of a principal diagnosis**
- C. Combining claims for submission
- D. Updating patient demographic information

In the context of medical coding, sequencing specifically refers to the correct order of the principal diagnosis and other related diagnoses or procedures that are recorded in a patient's medical record. The principal diagnosis is the primary reason for the patient's encounter and must be accurately represented at the top of the list to reflect the nature of the patient's medical condition. Effective sequencing is crucial, as it affects reimbursement and the overall integrity of medical records. It ensures that the severity of the patient's condition is communicated properly and can impact treatment plans and resource allocation. Understanding how to properly sequence diagnoses according to coding guidelines is essential for coders and billers to ensure accurate claims submission and compliance with regulations.

10. What type of disability may allow a worker to be rehabilitated in a different line of work?

- A. Temporary disability
- B. Partial disability**
- C. Permanent disability
- D. Complete disability

Partial disability is a condition in which an individual may have some limitations in their ability to perform their work tasks but retains enough capacity to pursue a different line of work. This type of disability often allows for rehabilitation options that can help the individual transition into a new job or career path that accommodates their remaining physical or mental capabilities. Such individuals may be eligible for vocational rehabilitation services designed to help them gain new skills or adapt to new job roles suited to their abilities. In contrast, temporary disability refers to an impairment that is not permanent and typically allows for recovery and a return to the original job without significant changes. Complete disability means the individual is entirely unable to perform any work, severely limiting rehabilitation options. Permanent disability implies a long-term condition that may not allow for sufficient recovery to return to work, which can restrict the ability to transition into a different line of work effectively.

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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://amcamedicalcoderbiller.examzify.com>

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

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