

Medical Billing and Coding Certificate Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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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 16

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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. What does the suffix -scopy signify?**
 - A. Visual examination**
 - B. Process of recording**
 - C. Crushing**
 - D. New opening**

- 2. Which term best describes having understanding and compassion for a patient's condition?**
 - A. Sympathy**
 - B. Empathy**
 - C. Complacency**
 - D. Caution**

- 3. When verifying a patient's financial responsibility, which of the following is least likely to be assessed?**
 - A. Eligibility for insurance benefits**
 - B. Credit history**
 - C. Pre-authorization requirements**
 - D. Primary payer designation**

- 4. Which of the following combining forms relates to the structure of cells?**
 - A. cerebr/o**
 - B. carcin/o**
 - C. cyt/o**
 - D. electr/o**

- 5. What term describes coding without proper documentation in the medical billing process?**
 - A. Assumption coding**
 - B. Truncated coding**
 - C. Inaccurate coding**
 - D. Double coding**

- 6. What defines a 'New Patient' in a healthcare practice?**
- A. An individual who has received services from any physician in the past 2 years**
 - B. An individual who has not received services from the physician for over 5 years**
 - C. An individual who has not received any professional services from the physician or another physician of the same specialty in the past 3 years**
 - D. An individual who is visiting the physician for a follow-up appointment**
- 7. Who is considered a policyholder?**
- A. A person who receives healthcare benefits**
 - B. Anyone covered under an insurance plan**
 - C. A person who owns the insurance policy**
 - D. An insurance representative**
- 8. What does Title III of HIPAA address?**
- A. Application and Enforcement of Group Health Plan Requirements**
 - B. Tax related health provisions**
 - C. Healthcare Access, Portability and Renewability**
 - D. Preventing Health Care Fraud and Abuse**
- 9. What symbol is used in coding to indicate the introduction of a new code?**
- A. A bullet**
 - B. A plus sign**
 - C. A triangle**
 - D. Facing triangles**
- 10. What does a participating physician agree to regarding payment?**
- A. Payment sent to the patient**
 - B. Accepts assignment**
 - C. Demands full upfront payment**
 - D. Refuses insurance plans**

Answers

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

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Explanations

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1. What does the suffix -scopy signify?

- A. Visual examination**
- B. Process of recording**
- C. Crushing**
- D. New opening**

The suffix -scopy signifies a visual examination of a specific part of the body. This suffix is commonly used in medical terminology to describe procedures that involve looking into an organ or a body cavity. For example, a colonoscopy is the visual examination of the colon, while a bronchoscopy involves examining the bronchi of the lungs. The use of -scopy indicates that the procedure is not just observational but involves the use of instruments, like a scope, to provide a clear view, often to diagnose or assess the condition of the area being examined. Understanding this term is essential in medical billing and coding since it helps in accurately identifying and coding procedures related to visual examinations in various medical services.

2. Which term best describes having understanding and compassion for a patient's condition?

- A. Sympathy**
- B. Empathy**
- C. Complacency**
- D. Caution**

The term that best describes having understanding and compassion for a patient's condition is empathy. Empathy involves the ability to not only recognize and understand the feelings and experiences of another person but also to share in their emotional experience. In a healthcare context, when a medical professional exhibits empathy, they are able to connect with patients on a deeper level, which can enhance the therapeutic relationship and promote better patient outcomes. This ability to truly understand what the patient is going through fosters a supportive environment where patients feel cared for and validated. Other terms listed in the choices do not capture this dual aspect of understanding and emotional resonance as effectively. Sympathy refers to feeling pity or sorrow for someone else's misfortunes without the deeper connection that empathy entails. Complacency suggests a sense of self-satisfaction and often a lack of concern for potential issues, which is not aligned with understanding and compassion. Caution indicates being careful or wary, which is important in medical settings but does not directly relate to the emotional understanding or compassion required in patient care.

3. When verifying a patient's financial responsibility, which of the following is least likely to be assessed?

- A. Eligibility for insurance benefits**
- B. Credit history**
- C. Pre-authorization requirements**
- D. Primary payer designation**

When verifying a patient's financial responsibility, assessing credit history is least likely to be a part of the process. Typically, verification focuses on determining the patient's eligibility for insurance coverage, understanding any pre-authorization requirements imposed by the insurer, and identifying the primary payer responsible for the claim. Eligibility for insurance benefits provides essential information about what services are covered under the patient's plan, which directly affects their financial responsibility. Pre-authorization requirements are necessary to understand whether certain procedures need prior approval from the insurance company to avoid unexpected costs for the patient. The primary payer designation is crucial to establish who will be billed first—the insurance company or the patient—before determining the patient's out-of-pocket costs. While credit history can be relevant in assessing an individual's overall financial situation, it does not directly impact the analysis of financial responsibility regarding specific healthcare services and insurance coverage. Therefore, it is not a common practice during the verification of financial responsibilities.

4. Which of the following combining forms relates to the structure of cells?

- A. cerebr/o**
- B. carcin/o**
- C. cyt/o**
- D. electr/o**

The combining form "cyt/o" specifically pertains to cells, making it the correct choice in this context. This form comes from the Greek word "kytos," which means "cell." In medical terminology, "cytology" refers to the study of cells, and various medical terms that include this combining form are related to cell structure, function, and pathology, such as "cytoplasm" (the material within a cell) and "cytogenetics" (the study of genetics at the cellular level). In contrast, the other options relate to different anatomical or physiological aspects. "Cerebr/o" is associated with the brain, specifically the cerebral cortex, while "carcin/o" refers to cancerous conditions or tumors. "Electr/o" pertains to electricity, often used in terms like "electrocardiogram," which records the electrical activity of the heart. Understanding these distinctions is crucial for grasping how specific combining forms in medical terminology can convey precise information about various aspects of health and medicine.

5. What term describes coding without proper documentation in the medical billing process?

- A. Assumption coding**
- B. Truncated coding**
- C. Inaccurate coding**
- D. Double coding**

The term that describes coding without proper documentation is known as assumption coding. This occurs when a coder makes an educated guess about a patient's diagnosis or history based on the limited information available, rather than relying on complete and accurate documentation from the healthcare provider. Assumption coding can lead to various issues, including improper billing, potential denial of claims, and compliance concerns. In the medical billing and coding process, it is crucial to have thorough and precise documentation to ensure that the codes used reflect the true nature of the healthcare services provided. Assumption coding undermines the integrity of the coding process and can lead to financial discrepancies and legal ramifications for healthcare organizations. This understanding highlights the importance of having detailed notes, charts, and documentation in the medical record, as accurate coding depends on solid clinical evidence. Organizations often invest in training and systems that emphasize proper documentation to avoid reliance on assumptions that could lead to adverse outcomes.

6. What defines a 'New Patient' in a healthcare practice?

- A. An individual who has received services from any physician in the past 2 years**
- B. An individual who has not received services from the physician for over 5 years**
- C. An individual who has not received any professional services from the physician or another physician of the same specialty in the past 3 years**
- D. An individual who is visiting the physician for a follow-up appointment**

A 'New Patient' is specifically defined in the context of healthcare as someone who has not received any professional services from the physician or another physician of the same specialty within the past three years. This definition is important because it clarifies the criteria for establishing a new patient relationship, which can affect billing practices, coding, and the healthcare provider's approach to patient care. This definition distinguishes new patients from established patients, who have had prior interactions with the physician or specialty group within the specified time frame. The three-year gap is significant, as it highlights the requirement for a considerable time lapse without any consultation or treatment, thereby necessitating a fresh assessment of the patient's health needs upon their return. Other options suggest different time frames or scenarios that either do not align with the official definitions or include criteria that could misclassify patients. For example, the option that refers to an individual who has received services from any physician in the past two years would wrongly categorize patients who have seen other specialists, while the mention of a follow-up appointment clearly describes an established patient scenario. Understanding these distinctions is crucial for accurate patient classification in medical billing and coding practices.

7. Who is considered a policyholder?

- A. A person who receives healthcare benefits
- B. Anyone covered under an insurance plan
- C. A person who owns the insurance policy**
- D. An insurance representative

A policyholder is the individual who owns the insurance policy. This person is responsible for paying the premiums and has the rights and responsibilities outlined in the policy. The policyholder may or may not be the same individual who receives healthcare benefits, as benefits can extend to dependents or other covered individuals under the policy. However, it is the policyholder who has the contractual relationship with the insurance provider. In this context, while anyone covered under an insurance plan may benefit from the services, they do not have ownership of the policy itself, which is why being a policyholder is distinct from simply being a beneficiary of healthcare coverage. An insurance representative, on the other hand, is an individual who sells or manages insurance policies but does not own any policy. Therefore, the emphasis on ownership makes the definition of a policyholder clear and highlights their crucial role in the insurance process.

8. What does Title III of HIPAA address?

- A. Application and Enforcement of Group Health Plan Requirements
- B. Tax related health provisions**
- C. Healthcare Access, Portability and Renewability
- D. Preventing Health Care Fraud and Abuse

Title III of HIPAA specifically addresses healthcare access, portability, and renewability. This title is significant because it establishes standards designed to ensure that individuals maintain their health insurance coverage when they change or lose jobs. This protection is crucial for people who might otherwise face gaps in their health coverage due to employment transitions. The provisions under Title III aim to make it easier for individuals to acquire and retain health insurance, regardless of their employment situation. It also sets forth standards that prevent discrimination in the issuance of health coverage based on health status or medical history, ensuring that people have the ability to get the care they need without excessive barriers. The other options do not align with the focus of Title III. For instance, Title I deals specifically with the application and enforcement of group health plan requirements, while Title II addresses prevention of healthcare fraud and abuse. Understanding these distinctions helps clarify the comprehensive scope of HIPAA and its various titles.

9. What symbol is used in coding to indicate the introduction of a new code?

- A. A bullet**
- B. A plus sign**
- C. A triangle**
- D. Facing triangles**

In medical coding, the symbol used to indicate the introduction of a new code is a bullet. The bullet symbol signifies that the code has been added in the most recent version of the coding manual, such as the Current Procedural Terminology (CPT) or International Classification of Diseases (ICD) codebooks. This is crucial for coders, as it alerts them to new codes that need to be incorporated into their coding practices, ensuring they are using the most up-to-date references and promoting accuracy in medical billing and coding. The other symbols serve different purposes in coding. For instance, a plus sign typically indicates that additional codes may be required to fully describe a procedure or condition, while facing triangles are used to denote changes to existing codes. Understanding these symbols allows medical coders to navigate the coding manuals effectively and maintain compliance with current coding standards.

10. What does a participating physician agree to regarding payment?

- A. Payment sent to the patient**
- B. Accepts assignment**
- C. Demands full upfront payment**
- D. Refuses insurance plans**

A participating physician agrees to accept assignment, meaning they accept the payment terms set by the insurance company as full payment for covered services. When physicians are part of a network of providers for specific insurance plans, they commit to providing services at negotiated rates. This arrangement benefits both the physician and the patient; patients typically pay lower out-of-pocket costs, such as copayments or deductibles, because the physician is contracted to accept a certain fee from the insurer rather than charging the patient directly the full amount that might be billed. In contrast, the other choices illustrate different arrangements that do not involve accepting assignment. For instance, if payment is sent to the patient, the physician may not have any control over how much they get reimbursed, as the patient may not pass the full insurance payment onto the physician. Demanding full upfront payment indicates that the physician is not working within the insurance framework at all, while refusing insurance plans suggests a lack of participation in the network. Acceptance of assignment ensures a smoother process for billing and reimbursement, which is crucial in the healthcare payment landscape.

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://medicalbillingcoding.examzify.com>

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

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