

MEDICAL BILLING AND CODING CERTIFICATE PRACTICE EXAM (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

**VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE**

<https://medicalbillingcoding.examzify.com>



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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 percentage of costs does Medicare typically cover for services?**
 - A. 50%
 - B. 70%
 - C. 80%
 - D. 90%

- 2. Which of the following is NOT a direct HIPAA National Identifier?**
 - A. Patients
 - B. Healthcare providers
 - C. Insurance claim forms
 - D. Health plans

- 3. What does self-insurance in a workplace entail?**
 - A. Employers pay directly for employees' medical bills
 - B. Employees are required to pay their own medical bills
 - C. Insurance companies handle all medical expenses
 - D. Employers purchase insurance from a third party

- 4. What does the term "eponym" refer to in medical terminology?**
 - A. A disease named after the person who discovered it
 - B. An operation described by its medical procedure
 - C. A structure identified by a specific name
 - D. A classification of administrative procedures

- 5. In coding, what does a plus sign symbol represent?**
 - A. New revised text
 - B. Update in code usage
 - C. Add-on codes
 - D. Reduction in services

- 6. Which term describes a group of related codes in medical billing?**
 - A. Sub-category
 - B. Category
 - C. Code also
 - D. Inclusion Notes

- 7. What does detailed medical history level require from the physician?**
- A. Extensive documentation of patient history
 - B. A simple review of symptoms
 - C. Basic information about medical history
 - D. Only symptoms related to the current complaint
- 8. When does the annual update of CPT codes occur?**
- A. December 1
 - B. October 1
 - C. March 1
 - D. November 1
- 9. When a patient is covered under two group plans, which plan is considered primary?**
- A. The plan with the lowest premium
 - B. The most recently acquired plan by the patient
 - C. The plan that has been in effect for the longest period of time
 - D. The plan that offers more extensive coverage
- 10. What character count does a category code typically consist of?**
- A. One character
 - B. Three characters
 - C. Four characters
 - D. Five characters

Answers

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

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Explanations

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1. What percentage of costs does Medicare typically cover for services?

- A. 50%
- B. 70%
- C. 80%**
- D. 90%

Medicare typically covers 80% of the approved costs for most covered services after the beneficiary has met their deductible. This percentage is integral to understanding how Medicare works, particularly the distinction between covered and non-covered services and the financial responsibilities of both the beneficiaries and healthcare providers. The remaining 20% usually falls to the Medicare beneficiary, who may have additional insurance, such as Medigap, to help cover these out-of-pocket costs. This understanding helps practitioners in medical billing and coding accurately process claims and inform patients of their potential liabilities effectively. The other answer options do not reflect Medicare's structure as precisely as 80%, leading to common misunderstandings about the extent of Medicare's coverage for services.

2. Which of the following is NOT a direct HIPAA National Identifier?

- A. Patients
- B. Healthcare providers
- C. Insurance claim forms**
- D. Health plans

The correct answer is that insurance claim forms are not a direct HIPAA National Identifier. Under HIPAA, direct identifiers include specific categories of information that are used to uniquely identify individuals and entities involved in healthcare. These identifiers are designed to protect patient information while ensuring secure access to necessary data. Patients, healthcare providers, and health plans are all considered direct identifiers within the framework of HIPAA. Each of these categories has specific identifiers that facilitate the administration of healthcare and billing processes while safeguarding personal health information. For instance, patients are identified by unique identifiers such as their medical record numbers or Social Security numbers, healthcare providers have NPI (National Provider Identifier) numbers, and health plans have specific identifiers that help to track and manage insurance claims. Insurance claim forms, however, serve as documentation for reimbursement and do not function as identifiers under HIPAA. They contain relevant information necessary for processing claims but are not unique identifiers in themselves. Instead, they rely on the identifiers associated with patients, providers, and health plans for identification purposes. This distinction helps clarify the roles these entities play in the healthcare system and ensures that patient confidentiality is maintained.

3. What does self-insurance in a workplace entail?

- A. Employers pay directly for employees' medical bills
- B. Employees are required to pay their own medical bills
- C. Insurance companies handle all medical expenses
- D. Employers purchase insurance from a third party

Self-insurance in a workplace involves employers assuming the financial risk of providing health benefits to their employees rather than purchasing a traditional insurance policy from an outside insurance company. When an employer pays directly for employees' medical bills, they are taking on these costs themselves, which means they have more control over the healthcare costs and can tailor health benefits to meet the specific needs of their employees. This approach allows businesses to save on premiums that would typically be paid to an insurance carrier, although it also carries the risk of unpredictable medical costs. Employers who self-insure often set aside funds to cover potential claims and may also utilize third-party administrators to help manage claims and process payments. The other options do not accurately represent the concept of self-insurance, as they either suggest that the financial burden falls on employees or rely on third-party insurance companies to manage medical expenses.

4. What does the term "eponym" refer to in medical terminology?

- A. A disease named after the person who discovered it
- B. An operation described by its medical procedure
- C. A structure identified by a specific name
- D. A classification of administrative procedures

The term "eponym" in medical terminology specifically refers to a disease, condition, procedure, or structure that is named after a person, typically a physician or scientist who either discovered it or made significant contributions related to it. For example, Alzheimer's disease is named after Dr. Alois Alzheimer, who first described the condition. This naming convention recognizes the individual's contributions to medical science or treatment. In contrast, the other options refer to different concepts. An operation described by its medical procedure focuses on the method or technique rather than the person associated with it. Naming a structure by a specific name describes anatomical terms that do not involve personal attribution, while a classification of administrative procedures pertains more to organization and billing in healthcare management rather than naming conventions in medical diagnoses or treatments.

5. In coding, what does a plus sign symbol represent?

- A. New revised text
- B. Update in code usage
- C. Add-on codes
- D. Reduction in services

The plus sign symbol in coding specifically indicates that the code is an add-on code. Add-on codes are used to report additional services that are provided in conjunction with a primary procedure. They are not standalone codes; instead, they must be used alongside the primary procedure code to fully capture the scope of the services rendered. This allows for a more accurate representation of the complete service provided to the patient. In the context of medical billing and coding, understanding the significance of the plus sign is crucial for proper code selection and ensuring that all services rendered are correctly billed, which can impact reimbursement. The use of add-on codes helps to clarify that these services enhance or support the primary procedure, thereby fostering clarity and precision in billing practices.

6. Which term describes a group of related codes in medical billing?

- A. Sub-category
- B. Category**
- C. Code also
- D. Inclusion Notes

The term that describes a group of related codes in medical billing is "Category." In the context of medical coding, particularly in systems like the International Classification of Diseases (ICD), codes are organized into categories based on shared characteristics or related conditions. These categories help healthcare providers and billing professionals quickly identify and apply appropriate codes for diagnoses or procedures. For instance, in ICD-10, the codes are grouped into categories such as categories for infectious diseases, cancers, or endocrine disorders, each containing specific codes that relate to that category. This organization aids in accurate documentation, billing, and statistical analysis of medical data. In contrast, sub-category refers to more specific groupings within a category, which are not as broad. "Code also" is a guideline used in coding, indicating that another code may also be applicable, but it does not define a group of related codes. Inclusion notes are additional instructions within coding guidelines that provide clarity on what is included under certain codes, rather than serving as a term for a group of codes.

7. What does detailed medical history level require from the physician?

- A. Extensive documentation of patient history**
- B. A simple review of symptoms
- C. Basic information about medical history
- D. Only symptoms related to the current complaint

The requirement for a detailed medical history level necessitates extensive documentation of the patient's history. This involves a comprehensive collection of information that goes beyond mere symptoms and includes various aspects of the patient's background, such as past medical conditions, family medical history, social history, medications, and other relevant details that could impact the patient's health and treatment plan. This level of detail is crucial for healthcare providers to accurately assess the patient's overall health status, make informed treatment decisions, and ensure continuity of care. While simpler reviews of symptoms or basic information may provide some insights, they are not sufficient for achieving the depth of understanding needed in complex cases. Detailed documentation is essential for compliance with coding and billing regulations, ensuring that care is adequately justified, and optimizing reimbursement for services rendered.

8. When does the annual update of CPT codes occur?

- A. December 1
- B. October 1**
- C. March 1
- D. November 1

The annual update of CPT (Current Procedural Terminology) codes occurs on October 1 each year. This timing aligns with many coding updates that are rolled out by various coding authorities and reflects the need for healthcare professionals to have the most current coding options available at the start of the fourth quarter of the calendar year. The October update ensures that all stakeholders, including healthcare providers, insurers, and coders, have ample time to adapt to the new codes, procedures, and guidelines well before the onset of the new calendar year. This consistent scheduling allows for smooth transitions and the ability to educate those involved in medical billing and coding about the updates and changes made to the codes. Therefore, the response indicating October 1 as the update date is correct, as it is an established norm within the medical coding community.

9. When a patient is covered under two group plans, which plan is considered primary?

- A. The plan with the lowest premium
- B. The most recently acquired plan by the patient
- C. The plan that has been in effect for the longest period of time**
- D. The plan that offers more extensive coverage

In situations where a patient is covered under two group health insurance plans, determining which plan is considered primary is guided by specific coordination of benefits rules. The primary plan is responsible for paying first when a claim is submitted. The most widely used rule to establish primary coverage is based on the duration of the coverage: the plan that has been in effect for the longest period of time is deemed the primary plan. This approach prioritizes continuity and stability in coverage, as the longer a plan has been active, the more established it typically is in its terms and benefits. Choosing the plan based on the lowest premium, the most recently acquired plan, or the plan offering more extensive coverage does not align with the standard practices for coordination of benefits. These factors do not reflect the underlying principles designed to streamline payment responsibilities between multiple insurers. Instead, the length of time a plan has been in force serves a clear and logical rationale for determining which plan takes precedence in paying for healthcare expenses.

10. What character count does a category code typically consist of?

- A. One character
- B. Three characters**
- C. Four characters
- D. Five characters

Category codes in the coding system, specifically in ICD-10 (International Classification of Diseases, 10th Revision), typically consist of three characters. These category codes are foundational in the classification of diseases and health-related conditions. Each three-character code represents a specific category of diagnoses, which can be further specified by additional subcategories or details. In the context of ICD-10, the first character is always a letter that specifies the disease category, followed by two numerical digits that define the specific condition within that category. This structure allows for a concise representation of a wide range of health issues, facilitating effective coding and billing processes in medical practice. Understanding this helps professionals ensure accurate coding for diagnoses, which is crucial for proper insurance claims processing and medical record-keeping. Knowing that category codes are three characters can also guide healthcare providers in correctly interpreting medical records and documentation.

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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