

MEDICAL BILLING AND CODING: ROLES, PROCESSES, AND SKILLS PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE**

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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. HCPCS Level II codes are used for which of the following?**
 - A. They are used for products, supplies, and services not in CPT
 - B. They replace CPT codes for procedures
 - C. They are ICD-10-CM diagnosis codes
 - D. They are only used in inpatient hospital billing
- 2. What is a recommended method for maintaining compliance with coding changes?**
 - A. Participate in ongoing education and training on coding updates.
 - B. Rely on outdated manuals.
 - C. Swap to nonstandard coding to speed processing.
 - D. Avoid any changes to the billing system.
- 3. If a coder assigns diagnoses or procedures without adequate documentation, what is a likely result?**
 - A. The claim will be denied automatically.
 - B. The service will be billed at a higher rate.
 - C. The claim may be denied or delayed due to lack of supported documentation.
 - D. The patient will be billed for the full amount.
- 4. Which Medicare coverage determination specifies coverage for a specific item or service within a local jurisdiction?**
 - A. Local Coverage Determination
 - B. National Coverage Determination
 - C. Coding Clinic guidance
 - D. Advanced Beneficiary Notice
- 5. What is the significance of documentation of services in medical billing?**
 - A. It is optional for patient care and reimbursement
 - B. It is vital for good patient care and proper reimbursement
 - C. It delays processing
 - D. It is used only for legal defense

- 6. Which statement best describes the significance of interdepartmental information flow in health care organizations?**
- A. It is optional for operations.
 - B. It only affects patient scheduling, not finances.
 - C. It primarily supports patient satisfaction surveys.
 - D. It is vital for the overall revenue cycle and operational efficiency.
- 7. Which statement best captures medicolegal responsibilities in billing?**
- A. They protect patient privacy and ensure accurate, authorized sharing of information.
 - B. They necessitate disclosing more patient data to sponsors.
 - C. They require nothing beyond invoice generation.
 - D. They ensure compliance with privacy laws and proper handling of information in billing processes.
- 8. What is the impact of using updated coding guidelines on payer reimbursements?**
- A. It reduces the total number of claims submitted.
 - B. It ensures compliance but not necessarily the payment outcome.
 - C. It helps ensure accurate billing and reduces denial risk.
 - D. It guarantees higher reimbursements regardless of coding.
- 9. What should an insurance billing specialist do if they encounter vague information?**
- A. Verify the information with the physician for accuracy.
 - B. Guess the information.
 - C. Leave the claim unchanged.
 - D. Document as uncertain.
- 10. CPT/HCPCS codes are used to bill what types of items?**
- A. Procedures and supplies
 - B. Diagnoses only
 - C. Medical devices only
 - D. Administrative services

Answers

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

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Explanations

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1. HCPCS Level II codes are used for which of the following?

- A. They are used for products, supplies, and services not in CPT**
- B. They replace CPT codes for procedures
- C. They are ICD-10-CM diagnosis codes
- D. They are only used in inpatient hospital billing

HCPCS Level II codes cover items and services that CPT doesn't include, expanding the coding system to report products, supplies, and certain services such as drugs, durable medical equipment, prosthetics and orthotics, ambulance services, and other non-physician items. They complement CPT (Level I) and are commonly used by Medicare and other payers across outpatient, supplier, and various care settings. They are not ICD-10-CM diagnosis codes, which specify diagnoses, and they aren't limited to inpatient hospital billing—their use spans multiple settings where those items and services are billed. So the best description is that HCPCS Level II codes are used for products, supplies, and services not in CPT.

2. What is a recommended method for maintaining compliance with coding changes?

- A. Participate in ongoing education and training on coding updates.
- B. Rely on outdated manuals.**
- C. Swap to nonstandard coding to speed processing.
- D. Avoid any changes to the billing system.

Staying compliant with coding changes relies on ongoing education and training on coding updates. Codes, guidelines, and payer policies shift each year, so regularly engaging in formal updates ensures you learn new codes, understand revised rules, and apply them accurately in documentation and claims. This proactive approach reduces denials, supports proper reimbursement, and keeps your practice ready for audits. Relying on outdated manuals risks using obsolete codes and instructions, which leads to incorrect coding and increased compliance risk. Swapping to nonstandard coding would violate coding standards and payer requirements, inviting audits and denials. Avoiding changes to the billing system leaves your processes out of date with current edits and rules, causing errors and noncompliance.

3. If a coder assigns diagnoses or procedures without adequate documentation, what is a likely result?

- A. The claim will be denied automatically.
- B. The service will be billed at a higher rate.
- C. The claim may be denied or delayed due to lack of supported documentation.**
- D. The patient will be billed for the full amount.

The main idea is that documentation backs up what was coded and billed. When diagnoses or procedures aren't adequately documented, there isn't enough evidence to support the codes and charges, so the payer can't verify medical necessity or accuracy. That means the claim may be denied or delayed while the missing information is requested or reviewed. Think of documentation as the proof a payer needs to justify each code and the corresponding payment. Without it, processing can't move forward smoothly, leading to denial or hold-ups. A few other outcomes aren't as likely. Claims aren't automatically denied every time; some may be reviewed and later approved once documentation is provided. Billing at a higher rate wouldn't happen simply due to lack of documentation—payers reimburse based on what's documented and medically necessary, so lacking documentation could lower or deny payment rather than raise it. As for billing the patient in full, that would depend on the payer's determination and the patient's coverage, but the standard risk when documentation is inadequate is denial or delay, not an automatic full out-of-pocket charge.

4. Which Medicare coverage determination specifies coverage for a specific item or service within a local jurisdiction?

- A. Local Coverage Determination**
- B. National Coverage Determination
- C. Coding Clinic guidance
- D. Advanced Beneficiary Notice

Local Coverage Determination specifies whether Medicare will cover a specific item or service within a local jurisdiction, as determined by the local Medicare Administrative Contractor. It sets the coverage rules for that region, including the medical necessity criteria, required documentation, and any coding or billing limitations. This local decision ensures coverage reflects regional practice patterns and payer policies, while nationwide coverage determinations apply across the country. National Coverage Determination is nationwide and not local; Coding Clinic guidance provides coding advice rather than coverage decisions; Advanced Beneficiary Notice informs beneficiaries about potential noncoverage before a service is provided, not whether the service is covered.

5. What is the significance of documentation of services in medical billing?

- A. It is optional for patient care and reimbursement
- B. It is vital for good patient care and proper reimbursement**
- C. It delays processing
- D. It is used only for legal defense

Documentation of services is the factual basis that ties what was done to why it was necessary and to how it should be billed. When notes clearly describe the service, the clinical rationale (medical necessity), and the outcomes, coders can assign the correct CPT/HCPSC and ICD-10-CM codes, which supports accurate and justifiable reimbursement. This record also underpins continuity of care, allowing other clinicians to understand the treatment plan and decisions. Without thorough documentation, claims are prone to denials, delays, or incorrect payments, and compliance issues can arise. It isn't merely for legal defense; it directly affects both the quality of patient care and the likelihood of proper, timely reimbursement.

6. Which statement best describes the significance of interdepartmental information flow in health care organizations?

- A. It is optional for operations.
- B. It only affects patient scheduling, not finances.
- C. It primarily supports patient satisfaction surveys.
- D. It is vital for the overall revenue cycle and operational efficiency.**

Coordinating information across departments keeps data consistent as patients move from intake and care through coding, billing, and discharge. When this flow is timely and accurate, charges are captured correctly, claims are submitted promptly, and denials drop, all of which strengthens the revenue cycle. At the same time, operational efficiency improves because teams aren't working with outdated or duplicated information, supporting smoother schedules, better resource use, and continuous care. Overall, interdepartmental information flow is vital for both the revenue cycle and day-to-day operations in a health care organization. It isn't optional and it impacts more than just scheduling or patient satisfaction surveys.

7. Which statement best captures medicolegal responsibilities in billing?

- A. They protect patient privacy and ensure accurate, authorized sharing of information.
- B. They necessitate disclosing more patient data to sponsors.
- C. They require nothing beyond invoice generation.
- D. They ensure compliance with privacy laws and proper handling of information in billing processes.**

Medicolegal responsibilities in billing revolve around protecting patient information and complying with privacy and security laws. The best statement captures that billing professionals must adhere to privacy laws and handle patient data properly throughout the billing process, including who has access, how data is stored and shared, and how disclosures are documented. This goes beyond simply issuing invoices and includes data accuracy, confidentiality, proper documentation, and ongoing regulatory compliance (such as HIPAA, breach notification, and audit readiness). The other options don't fit as well: one mentions privacy and authorized sharing but omits the broader legal obligation to follow privacy laws and proper billing workflows; another suggests disclosing more data to sponsors, which would violate confidentiality; the last implies nothing beyond invoice generation, ignoring the legal duties tied to data protection and governance.

8. What is the impact of using updated coding guidelines on payer reimbursements?

- A. It reduces the total number of claims submitted.
- B. It ensures compliance but not necessarily the payment outcome.
- C. It helps ensure accurate billing and reduces denial risk.**
- D. It guarantees higher reimbursements regardless of coding.

Using updated coding guidelines keeps coding aligned with the latest definitions, rules, and payer policies. When the most current codes, sequencing, and modifiers are applied, the billed charges more accurately reflect what was documented and performed. This reduces common denial reasons tied to coding errors, such as outdated codes, incorrect code relationships, or unsupported service combinations, thereby lowering denial risk. While following updates supports accurate billing and can improve what the payer pays when documentation and coverage align, it does not guarantee higher reimbursements in all cases, since payment still depends on payer policies, medical necessity, and contractual terms.

9. What should an insurance billing specialist do if they encounter vague information?

- A. Verify the information with the physician for accuracy.**
- B. Guess the information.
- C. Leave the claim unchanged.
- D. Document as uncertain.

When information is vague, confirm details with the physician to ensure accuracy in coding and billing. Verifying the exact service, diagnosis, and items billed ensures the codes reflect what was actually performed, supporting proper reimbursement and compliance with payer rules. It helps prevent denials or audits that can arise from guesswork or incomplete documentation. Guessing the information can lead to incorrect codes or diagnoses, which risks improper reimbursement and potential compliance issues. Leaving the claim unchanged when details are missing perpetuates uncertainty and can delay payment or result in incorrect billing. Documenting as uncertain without obtaining clarification doesn't resolve the ambiguity and leaves the claim lacking the specifics needed for accurate submission.

10. CPT/HCPCS codes are used to bill what types of items?

A. Procedures and supplies

B. Diagnoses only

C. Medical devices only

D. Administrative services

CPT/HCPCS codes are used to bill procedures and supplies. CPT codes describe the medical procedures and clinician services performed, such as surgeries, office visits, imaging, and anesthesia. HCPCS Level II codes extend billing to items like durable medical equipment, prosthetics and orthotics, disposable supplies, drugs, and certain services not covered by CPT alone. Diagnoses are coded with ICD-10-CM, not CPT/HCPCS, and administrative services aren't items billed with these codes. So the best fit is procedures and supplies.

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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://medbillingcodingrolesprocess.examzify.com>

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

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