

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

Study Guide



Everything you need from our exam experts!

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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 is considered inappropriate conduct in the medical coding and billing field?**
 - A. Providing incorrect information**
 - B. Revealing patient information**
 - C. Accepting payment in full for less than the amount due**
 - D. Making deception and lies**

- 2. Which term refers to all activities associated with patient accounts and follow-up?**
 - A. Referrals**
 - B. Coding**
 - C. Collections**
 - D. Billing**

- 3. Patient accounts receivable can generally be classified under which category?**
 - A. Consumer collections**
 - B. Commercial collections**
 - C. Bad debt collections**
 - D. Medicare collections**

- 4. What is a key function of a clearinghouse in medical billing?**
 - A. To provide legal advice on billing practices**
 - B. To verify patient eligibility for services**
 - C. To act as an intermediary for processing claims electronically**
 - D. To audit billing discrepancies**

- 5. What is an essential action that collections specialists may perform in their role?**
 - A. Draft legal contracts for the practice**
 - B. File insurance claims**
 - C. Create patient payment plans**
 - D. Train new office staff**

- 6. What is a plan that lets patients pay bills over time rather than a single payment called?**
- A. Budgeting plan**
 - B. Payment plan**
 - C. Debt consolidation**
 - D. Installment plan**
- 7. What is a key benefit of transparent billing practices?**
- A. Increases confusion among patients**
 - B. Enhances patient trust and satisfaction**
 - C. Reduces the number of services billed**
 - D. Decreases the efficiency of claim processing**
- 8. What is Ambulatory Payment Classification (APC)?**
- A. A system for inpatient billing**
 - B. A payment system for hospital outpatient services based on procedures performed**
 - C. A type of insurance plan**
 - D. A management system for medical records**
- 9. What aspect do sound financial policies aim to clarify for patients?**
- A. Payment methods only**
 - B. The patient's rights regarding insurance claims**
 - C. The patient's responsibilities for payment**
 - D. The quality of healthcare services provided**
- 10. The Truth in Lending Act includes regulations on what aspect of payment plans?**
- A. The ability to transfer debts freely**
 - B. Charging finance charges or late fees**
 - C. Waiving all fees regardless of the situation**
 - D. Providing loans with no interest**

Answers

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

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Explanations

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1. What is considered inappropriate conduct in the medical coding and billing field?

- A. Providing incorrect information**
- B. Revealing patient information**
- C. Accepting payment in full for less than the amount due**
- D. Making deception and lies**

Revealing patient information is considered inappropriate conduct in the medical coding and billing field due to strict privacy regulations, particularly those outlined by the Health Insurance Portability and Accountability Act (HIPAA). This law mandates that patient information must be kept confidential and secure, and unauthorized disclosure can lead to legal consequences for both the individual and the medical facility involved. Maintaining patient confidentiality is critical to building trust in the healthcare system, and any breach can significantly harm both patients and providers. While providing incorrect information, accepting improper payment amounts, and engaging in deception are all unethical behaviors, revealing patient information directly breaches legal and ethical standards, making it a critical focus area in medical compliance training. Therefore, understanding the importance of patient confidentiality is paramount for anyone working in medical coding and billing.

2. Which term refers to all activities associated with patient accounts and follow-up?

- A. Referrals**
- B. Coding**
- C. Collections**
- D. Billing**

The term that refers to all activities associated with patient accounts and follow-up is collections. This encompasses the processes involved in collecting payments from patients for services rendered, including monitoring accounts that are past due, sending out reminders, and communicating with patients regarding their balances. Effective collections ensure that healthcare providers receive timely reimbursements for their services, which is a crucial aspect of financial management within a healthcare setting. In contrast, referrals typically involve directing a patient to a different healthcare provider for specialized services; coding pertains to the assignment of medical codes to diagnoses and procedures for billing purposes; and billing specifically refers to the generation of invoices and statements for services rendered. While these terms are related to the financial aspects of patient accounts, collections is the most comprehensive in terms of activities that include follow-up on outstanding amounts owed by patients.

3. Patient accounts receivable can generally be classified under which category?

- A. Consumer collections**
- B. Commercial collections**
- C. Bad debt collections**
- D. Medicare collections**

Patient accounts receivable are primarily classified as consumer collections because they involve money owed to healthcare providers by patients for services rendered. This category encompasses individuals who are responsible for paying their medical bills, either through direct payment or through insurance. The nature of patient accounts receivable means that they are personal obligations, distinguishing them from commercial collections, which involve businesses owed money. Additionally, bad debt collections would pertain to those accounts where payment is no longer expected, rather than ongoing accounts receivable. Medicare collections are specific to claims involving Medicare insurance payments rather than the broader category of patient payments. Thus, classifying patient accounts receivable under consumer collections is the most accurate representation of how these transactions are categorized in the healthcare billing and coding system.

4. What is a key function of a clearinghouse in medical billing?

- A. To provide legal advice on billing practices**
- B. To verify patient eligibility for services**
- C. To act as an intermediary for processing claims electronically**
- D. To audit billing discrepancies**

A key function of a clearinghouse in medical billing is to act as an intermediary for processing claims electronically. Clearinghouses play a crucial role in the healthcare billing cycle by receiving claims from healthcare providers, formatting them according to specific payer requirements, and then transmitting them to the appropriate insurance companies. This electronic processing streamlines the claim submission process and can help reduce errors related to billing codes and formats, which can lead to quicker reimbursement for providers. By functioning as a bridge between healthcare providers and payers, clearinghouses not only facilitate smoother communication but also enhance efficiency in handling claims. This role is essential in modern medical billing operations, where electronic claims processing is the standard and ensures that healthcare providers receive timely payment for their services.

5. What is an essential action that collections specialists may perform in their role?

- A. Draft legal contracts for the practice**
- B. File insurance claims**
- C. Create patient payment plans**
- D. Train new office staff**

Collections specialists play a vital role in managing a healthcare practice's revenue cycle, and one of their essential functions is to create patient payment plans. This task is crucial because it facilitates the collection of outstanding balances owed by patients while also ensuring that the patients can afford to pay their bills. By developing structured payment plans, collections specialists help patients manage their healthcare costs, improving patient satisfaction and increasing the likelihood that the healthcare provider will receive payment in a timely manner. This not only aids in the financial stability of the practice but also fosters better relationships with patients who may struggle to make a lump-sum payment. In contrast, the other options, while important to the overall administration of a healthcare practice, do not fall within the primary responsibilities of a collections specialist. Drafting legal contracts typically involves a legal expert or someone in a higher administrative role, filing insurance claims is primarily the duty of medical billers, and training new office staff is usually handled by a practice manager or a senior staff member. Each of these roles has distinct responsibilities that do not overlap with the core focus of collections specialists.

6. What is a plan that lets patients pay bills over time rather than a single payment called?

- A. Budgeting plan**
- B. Payment plan**
- C. Debt consolidation**
- D. Installment plan**

The term for a plan that allows patients to pay their bills over time instead of making a single upfront payment is known as a payment plan. This concept is widely used in medical billing to enable patients to manage their healthcare costs more effectively. A payment plan typically outlines the total amount owed, the duration over which payments will be made, and the amount of each installment. This approach is beneficial for patients who may find it challenging to cover the entire cost of a medical service at once, thereby making healthcare more accessible and facilitating timely payments. While other terms like "budgeting plan," "debt consolidation," and "installment plan" might seem relevant, they do not specifically capture the purpose of allowing patients to directly manage their medical bills over time. A budgeting plan usually involves managing finances in a broader sense rather than targeting payments for specific bills. Debt consolidation refers to combining multiple debts into one loan, aiming to simplify repayment, often at a lower interest rate. An installment plan can be a synonym for a payment plan but is more commonly associated with specific agreements for larger purchases or loans, not necessarily medical payments. Therefore, payment plan is the most precise term for the context of managing medical bills.

7. What is a key benefit of transparent billing practices?

- A. Increases confusion among patients
- B. Enhances patient trust and satisfaction**
- C. Reduces the number of services billed
- D. Decreases the efficiency of claim processing

Transparent billing practices play a crucial role in healthcare by enhancing patient trust and satisfaction. When patients clearly understand the costs associated with their care, including what services they are being charged for and why, it fosters an environment of trust. Patients feel more empowered to make informed decisions regarding their healthcare options when they know exactly what to expect financially. This transparency reduces anxiety about unexpected costs and can significantly improve the overall patient experience. Moreover, organizations that adopt transparent billing practices are often viewed more favorably, which can lead to better patient retention and loyalty. The trust established through clear communication regarding billing can enhance the relationship between patients and healthcare providers, which ultimately benefits the entire healthcare experience.

8. What is Ambulatory Payment Classification (APC)?

- A. A system for inpatient billing
- B. A payment system for hospital outpatient services based on procedures performed**
- C. A type of insurance plan
- D. A management system for medical records

Ambulatory Payment Classification (APC) is a payment system specifically designed for hospital outpatient services, categorizing them based on the procedures that are performed. This system enables healthcare facilities to receive reimbursement from Medicare and other payers, ensuring payment reflects the resources used in outpatient care. The APC system simplifies the billing process for various outpatient services by grouping similar procedures that typically require similar levels of resources. It helps to streamline the reimbursement process for providers and can influence the financial management of outpatient services by ensuring that the billing reflects the complexity and care provided during outpatient visits. In contrast, the other options describe different payment systems or concepts. For example, an inpatient billing system relates to the billing of services provided during a patient's stay in a hospital, which is not the focus of APC. An insurance plan pertains to coverage policies and payment structures rather than specific reimbursement methods for outpatient services. A management system for medical records focuses on the organization and storage of health information, which is separate from the payment classification for services.

9. What aspect do sound financial policies aim to clarify for patients?

- A. Payment methods only**
- B. The patient's rights regarding insurance claims**
- C. The patient's responsibilities for payment**
- D. The quality of healthcare services provided**

Sound financial policies are designed to clarify the patient's responsibilities for payment. This includes detailing the financial obligations that patients have when they receive healthcare services, such as co-pays, deductibles, and any balances owed after insurance payments are applied. By outlining these responsibilities, healthcare providers ensure that patients understand what is expected of them financially, which can help avoid confusion and potential disputes over billing later on. While payment methods, patients' rights regarding insurance claims, and the quality of healthcare services are important in the overall healthcare experience, they do not encapsulate the primary focus of sound financial policies. These policies are key in setting clear expectations about payment responsibilities, which aids in fostering transparency and accountability in the patient-provider relationship. Therefore, understanding and communicating these responsibilities is essential for both effective patient care and financial management within healthcare settings.

10. The Truth in Lending Act includes regulations on what aspect of payment plans?

- A. The ability to transfer debts freely**
- B. Charging finance charges or late fees**
- C. Waiving all fees regardless of the situation**
- D. Providing loans with no interest**

The Truth in Lending Act (TILA) primarily focuses on promoting transparency in lending practices, especially regarding the terms and costs associated with credit. One of the key aspects it regulates is the disclosure of finance charges, which includes the interest rates, fees, and other costs associated with a loan. By ensuring that borrowers are fully informed about any finance charges or late fees that may be imposed on their payment plans, the Act seeks to provide consumers with the necessary information to make informed borrowing decisions. This regulation protects consumers by requiring lenders to clearly present all associated costs, thus reducing the risk of unexpected financial burdens. The emphasis on finance charges aligns with the Act's goal of providing clarity and fostering fair practices in credit transactions. In contrast, the other options do not reflect the central provisions of the Truth in Lending Act. The ability to transfer debts freely, waiving all fees, or providing loans with no interest are not key elements addressed by the Act in terms of payment plans.

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://medicalcoderandbiller-mcbc.examzify.com>

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

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