

NHA Billing and Coding Specialist (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. A patient has requested a copy of the remittance advice for a claim. What action should the specialist take?**
 - A. Send the entire remittance advice**
 - B. Remove all information other than what pertains to the patient**
 - C. Provide a summary of the remittance advice**
 - D. Request the patient to provide documentation**

- 2. If a claim for an appendectomy was denied after reporting two units, which coding edits should the specialist review before resubmitting?**
 - A. Edit for duplicate billing.**
 - B. Medically unlikely edits.**
 - C. Modifier edits.**
 - D. Insurance policy exclusions.**

- 3. What should a billing and coding specialist do when a patient is upset about a claim denial from a 3rd party payer?**
 - A. Call the insurance company to seek clarification.**
 - B. Inform the patient of the reason for the denial.**
 - C. Advise the patient to pay the bill immediately.**
 - D. Reassure the patient that the issue will resolve itself.**

- 4. Which code set is predominantly utilized for outpatient procedures?**
 - A. ICD codes**
 - B. HCPCS codes**
 - C. CPT codes**
 - D. DRG codes**

- 5. For which of the following reasons should a claim be resubmitted?**
 - A. The claim was paid incorrectly.**
 - B. The claim requires an attachment to support medical necessity.**
 - C. The patient changed insurance plans.**
 - D. The procedure was coded incorrectly.**

- 6. How often is the ICD-10-CM coding system updated?**
- A. Every month**
 - B. Annually**
 - C. Every two years**
 - D. Every quarter**
- 7. What is the primary purpose of a remittance advice?**
- A. To provide a guide for coding.**
 - B. To communicate payment information to providers.**
 - C. To inform patients about their bills.**
 - D. To document medical necessity.**
- 8. What type of insurance code is specifically designed for new technologies and procedures?**
- A. ICD Codes**
 - B. CPT Codes**
 - C. Category I Codes**
 - D. Category III Codes**
- 9. Which coding system is used for durable medical equipment (DME)?**
- A. ICD-10**
 - B. CPT**
 - C. HCPCS Level II**
 - D. HCPCS Level I**
- 10. What is the purpose of conducting an internal review in a provider's office?**
- A. To increase patient satisfaction**
 - B. To verify that the medical records and billing records match**
 - C. To educate staff on compliance**
 - D. To reduce billing errors**

Answers

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

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Explanations

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1. A patient has requested a copy of the remittance advice for a claim. What action should the specialist take?

- A. Send the entire remittance advice**
- B. Remove all information other than what pertains to the patient**
- C. Provide a summary of the remittance advice**
- D. Request the patient to provide documentation**

The appropriate action for the billing and coding specialist when a patient requests a copy of the remittance advice is to remove all information other than what pertains to the patient before sending it. This is essential for maintaining patient privacy and confidentiality, as remittance advices often contain sensitive information about other patients and detailed financial arrangements that are not relevant to the individual making the request. By sending only the patient-specific information, the specialist ensures compliance with regulations like the Health Insurance Portability and Accountability Act (HIPAA), which governs the sharing of patient information. This approach protects the patient's rights while still providing the necessary information related to their claim. Thus, maintaining confidentiality while fulfilling the patient's request is fundamental to the role of a billing and coding specialist.

2. If a claim for an appendectomy was denied after reporting two units, which coding edits should the specialist review before resubmitting?

- A. Edit for duplicate billing.**
- B. Medically unlikely edits.**
- C. Modifier edits.**
- D. Insurance policy exclusions.**

The assertion that the specialist should review medically unlikely edits before resubmitting the claim for an appendectomy reflects an important aspect of coding and billing practices. Medically unlikely edits (MUEs) are guidelines established by payers to identify situations where a service or procedure is considered unlikely to be performed more than a specified number of times for a single patient in a given period. In this case, reporting two units for an appendectomy may trigger a review under these edits since it is medically unlikely for a patient to require two appendectomies at once. By examining these edits, the billing specialist can determine if the claim was denied due to the number of units reported exceeding what the payer considers medically necessary or reasonable. This review is a critical step to ensure that the claim aligns with established medical standards and guidelines before resubmission. In contrast, evaluating the other options would not directly address the potential reason for the denial in this specific case. Duplicate billing reviews are important but focus on whether the same service has been billed multiple times inappropriately within the same billing period. Modifier edits would be relevant if modifiers were necessary to clarify the circumstances under which the appendectomy was performed. Insurance policy exclusions refer to services that a particular insurance plan does not cover,

- 3. What should a billing and coding specialist do when a patient is upset about a claim denial from a 3rd party payer?**
- A. Call the insurance company to seek clarification.**
 - B. Inform the patient of the reason for the denial.**
 - C. Advise the patient to pay the bill immediately.**
 - D. Reassure the patient that the issue will resolve itself.**

Informing the patient of the reason for the denial is the most appropriate response in this situation. By explaining the specific issues that led to the denial, the billing and coding specialist helps the patient understand the circumstances surrounding their claim. This transparency can alleviate some of the patient's frustration and helps to build trust in the process. Understanding the reason for the denial empowers the patient with knowledge about their situation, which could facilitate informed discussions on how to proceed. It also allows the specialist to guide the patient on next steps, whether that's appealing the decision or addressing any outstanding issues. Acknowledging the patient's concerns and providing clear information helps mitigate anxiety and keeps the lines of communication open between the patient and the office.

- 4. Which code set is predominantly utilized for outpatient procedures?**
- A. ICD codes**
 - B. HCPCS codes**
 - C. CPT codes**
 - D. DRG codes**

CPT codes are predominantly utilized for outpatient procedures because they are specifically designed to describe medical, surgical, and diagnostic services provided to patients in an outpatient setting. The Current Procedural Terminology (CPT) system, developed by the American Medical Association, includes codes that reflect the nature of the services performed, such as evaluations, consultations, surgeries, and other treatment modalities that occur outside of an inpatient hospital environment. In contrast, ICD codes (International Classification of Diseases) are primarily used for diagnosis coding, reflecting the conditions or diseases being treated, rather than the procedures performed. HCPCS codes (Healthcare Common Procedure Coding System) include a broader category of services and supplies, often used for items not covered by CPT, such as certain non-physician services and durable medical equipment. DRG codes (Diagnosis-Related Groups) are utilized for inpatient hospital billing and reflect classifications of inpatient stays; they determine reimbursement for hospital services rather than outpatient procedures. Therefore, CPT codes are essential for detailing the specific procedures and services rendered in outpatient care, making them the correct choice for this question.

5. For which of the following reasons should a claim be resubmitted?

A. The claim was paid incorrectly.

B. The claim requires an attachment to support medical necessity.

C. The patient changed insurance plans.

D. The procedure was coded incorrectly.

A claim should be resubmitted when it requires additional documentation to support the medical necessity of the services provided. In situations where the insurer requires specific information before making a determination on payment, failing to include this documentation can delay processing or result in a denial. Resubmitting the claim with the necessary attachments allows the payer to reassess the claim with a complete understanding of the patient's condition and the need for the services billed. While there are other scenarios that might warrant resubmission, such as correcting code errors or addressing changes in the patient's insurance, the specific focus in this case is on providing the required support for medical necessity, which is crucial for justifying the services billed to the insurance company.

6. How often is the ICD-10-CM coding system updated?

A. Every month

B. Annually

C. Every two years

D. Every quarter

The ICD-10-CM coding system is updated annually to reflect changes in medical knowledge, coding guidelines, and the healthcare landscape. This annual update process ensures that the codes remain relevant and accurate, allowing for proper classification of medical conditions and procedures. Updates typically occur on October 1st each year, which is the date when new codes are implemented. Such frequent updates are crucial for maintaining the integrity of clinical data and improving health analytics. In this context, monthly, bi-annual, or quarterly updates would not provide the necessary consistency needed for coding practices, as more frequent updates could lead to confusion among healthcare providers and coding specialists, while longer intervals might not adequately capture new developments in medicine and healthcare.

7. What is the primary purpose of a remittance advice?

- A. To provide a guide for coding.**
- B. To communicate payment information to providers.**
- C. To inform patients about their bills.**
- D. To document medical necessity.**

The primary purpose of a remittance advice is to communicate payment information to providers. This document serves as a notification of the payment amount and outlines how the payment was determined, including adjustments, denials, and any patient responsibilities. It provides healthcare providers with detailed information regarding what services were reimbursed and what claims have been processed, enabling them to reconcile their records and understand the financial aspects of the care rendered. While coding guidance, patient billing notifications, and documentation of medical necessity are important in the healthcare process, they are not the main function of a remittance advice. The focus of this document is specifically on the financial transactions between insurers and providers, making it a crucial element in the billing and reimbursement cycle.

8. What type of insurance code is specifically designed for new technologies and procedures?

- A. ICD Codes**
- B. CPT Codes**
- C. Category I Codes**
- D. Category III Codes**

The correct answer is D, Category III Codes. These codes are specifically designed to represent new and emerging technologies, procedures, and services that may not yet be widely used or accepted in clinical practice. They provide a way for healthcare providers to report innovative treatments and interventions that are still in the developmental stage or have not yet been assigned a permanent code in the standard coding systems. Category III Codes help facilitate data collection and research on these new procedures, allowing for better tracking of their effectiveness and outcomes. They play a crucial role in ensuring that healthcare providers can receive reimbursement for services rendered using novel technologies, thereby encouraging the advancement of medical practices. In contrast, ICD Codes are primarily used for diagnosing diseases and conditions, while CPT Codes (specifically Category I Codes) are used for established medical services and procedures. Category III Codes complement these by focusing on those that are new and not yet classified under the standard Category I Codes.

9. Which coding system is used for durable medical equipment (DME)?

A. ICD-10

B. CPT

C. HCPCS Level II

D. HCPCS Level I

The coding system used for durable medical equipment (DME) is HCPCS Level II. This system is specifically designed to standardize the coding of services and supplies that are not included in the CPT codes. HCPCS Level II codes encompass a wide range of items, including DME such as wheelchairs, oxygen equipment, and other medical supplies necessary for patient care outside a hospital setting. Using HCPCS Level II codes ensures clarity and consistency in billing for these items. It allows healthcare providers to communicate more effectively with payers about the services provided, ensuring that proper reimbursement can be obtained for DME. By contrast, CPT codes are primarily focused on procedures and services rendered by healthcare professionals, and ICD-10 is used for diagnosis coding, which does not specifically address equipment or supplies. Therefore, HCPCS Level II is the correct and appropriate choice for coding durable medical equipment.

10. What is the purpose of conducting an internal review in a provider's office?

A. To increase patient satisfaction

B. To verify that the medical records and billing records match

C. To educate staff on compliance

D. To reduce billing errors

Conducting an internal review in a provider's office primarily serves the purpose of ensuring that medical records and billing records are accurate and consistent with each other. This verification process is critical for maintaining the integrity of patient data, preventing discrepancies that could lead to claim denials or delays in reimbursement. Accurate documentation is essential for proper billing and coding, as it supports the services rendered during patient visits. When medical records align with billing records, it enhances the overall efficiency of the revenue cycle management within the practice. While increasing patient satisfaction, educating staff on compliance, and reducing billing errors are valuable outcomes that may result from a thorough internal review process, the immediate and primary goal lies in matching medical and billing records. By focusing on this objective, healthcare providers can ensure compliance with regulations and guidelines, thus safeguarding against potential audits and legal issues related to improper billing practices.

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://nhabillingcoding.examzify.com>

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

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