

NHA BILLING AND CODING SPECIALIST (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. What is meant by coding compliance?**
 - A. Following up with patients regularly
 - B. Adhering to regulations and guidelines in coding
 - C. Implementing new technology
 - D. Recording patient histories accurately
- 2. Which information is required on a patient account record?**
 - A. Name and date of birth of the patient
 - B. Name and address of guarantor
 - C. Insurance policy number
 - D. Contact number of the provider
- 3. If a provider's office fee is \$100 and Medicare Part B allowed is \$85, what amount should the patient be billed assuming the deductible has not been met?**
 - A. \$100
 - B. \$85
 - C. \$15
 - D. \$50
- 4. What does the principal diagnosis code on a claim represent when coding for inpatient?**
 - A. Secondary Diagnosis
 - B. Principal Diagnosis
 - C. Adjudication Code
 - D. Supplemental Diagnosis
- 5. What is a "superbill" in medical billing?**
 - A. A record of patient prescriptions
 - B. A standard invoice listing services rendered during a patient visit
 - C. A summary of patient medical history
 - D. A document for patient referrals

- 6. What does CPT stand for?**
- A. Clinical Procedural Techniques
 - B. Current Procedural Terminology
 - C. Certified Professional Training
 - D. Common Procedural Terms
- 7. In an aging report, which category should ideally contain the lowest percentage of accounts receivable?**
- A. 1-30 days
 - B. 31-60 days
 - C. 61-90 days
 - D. Greater than 120 days
- 8. How can a billing and coding specialist reduce claim denials?**
- A. By submitting claims without verifying information
 - B. By delaying claims submission
 - C. By verifying patient insurance eligibility and ensuring accurate coding before submission
 - D. By simplifying diagnostic codes
- 9. If a CPT code is routinely denied by a third-party payer, what type of review should the specialist perform?**
- A. Prospective review
 - B. Concurrent review
 - C. Retrospective review
 - D. Utilization review
- 10. What coding guidelines must be followed when coding a patient's visit?**
- A. The ICD-10-CM guidelines for clinical documentation
 - B. The Official Guidelines for Coding and Reporting
 - C. The local payer guidelines
 - D. The CMS regulatory requirements

Answers

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

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Explanations

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1. What is meant by coding compliance?

- A. Following up with patients regularly
- B. Adhering to regulations and guidelines in coding**
- C. Implementing new technology
- D. Recording patient histories accurately

Coding compliance refers to the practice of adhering to all applicable regulations, guidelines, and standards when coding medical diagnoses and procedures. This ensures the accuracy and integrity of coded data, which is critical for proper billing, reimbursement, and maintaining the quality of patient care. Following established coding standards, such as those provided by the American Academy of Professional Coders (AAPC) or the American Health Information Management Association (AHIMA), helps prevent coding errors that can lead to legal and financial repercussions for healthcare providers. The other options, while important aspects of healthcare delivery, do not specifically address the principles of coding compliance. For instance, regularly following up with patients focuses on patient care and engagement, while implementing new technology pertains to improving operational efficiency. Similarly, accurately recording patient histories involves clinical documentation but does not directly involve adherence to coding regulations and guidelines.

2. Which information is required on a patient account record?

- A. Name and date of birth of the patient
- B. Name and address of guarantor**
- C. Insurance policy number
- D. Contact number of the provider

The necessary information on a patient account record includes details that facilitate billing, communication, and the management of the patient's account. The name and address of the guarantor is particularly important because the guarantor is the person responsible for the payment of medical bills for the patient, especially if the patient is a minor or not financially responsible for their own healthcare expenses. This information ensures that the billing department can reach the appropriate individual if payments are not made and helps in verifying insurance coverage or financial responsibility. While the name and date of birth of the patient, insurance policy number, and contact number of the provider are all essential pieces of information in the overall context of patient care and billing, the guarantor's information specifically addresses who will handle the finances related to the patient's care. It serves as a critical link between the patient and the billing office, ensuring that billing processes are correctly directed to the responsible party.

3. If a provider's office fee is \$100 and Medicare Part B allowed is \$85, what amount should the patient be billed assuming the deductible has not been met?

- A. \$100
- B. \$85**
- C. \$15
- D. \$50

In this scenario, understanding how charge amounts and allowed amounts work in conjunction with Medicare regulations is key. The provider's office fee of \$100 represents the amount that the provider charges for the service, while the Medicare Part B allowed amount of \$85 reflects the maximum amount that Medicare agrees to pay for that specific service. Since the deductible has not been met, the patient is responsible for the full amount of the allowed charge, which is \$85. Therefore, the patient would be billed this amount, as it is what Medicare considers the reasonable charge for the service provided. If the deductible had been met, the patient would not owe the full allowed amount and may only be responsible for a percentage of it, depending on the specifics of their coverage. However, in this case, since the deductible remains outstanding, the patient incurs the entire allowed amount of \$85.

4. What does the principal diagnosis code on a claim represent when coding for inpatient?

- A. Secondary Diagnosis
- B. Principal Diagnosis**
- C. Adjudication Code
- D. Supplemental Diagnosis

The principal diagnosis code on a claim for inpatient care is the primary condition for which the patient is being treated during their hospitalization. This code reflects the most significant reason the patient was admitted and is crucial for determining the appropriate level of care, resource utilization, and reimbursement from insurers. Accurate coding of the principal diagnosis is essential because it directly affects the hospital's billing and the way reimbursement rates are calculated. This code plays a vital role in data collection for health statistics and research, as it helps identify the common reasons for hospitalizations and informs policy decisions. In contrast, the other options refer to different categories of diagnoses or billing elements that do not represent the principal diagnosis. Secondary diagnoses are additional conditions that coexist with the principal diagnosis and may be relevant for treatment but are not the primary focus of the hospital stay. Adjudication codes pertain to the claims processing phase and are unrelated to diagnosis coding. Supplemental diagnoses provide further information but do not have the same significance as the principal diagnosis code. Thus, the principal diagnosis code is specifically the primary reason for the patient's admission and guides the overall billing process.

5. What is a "superbill" in medical billing?

- A. A record of patient prescriptions
- B. A standard invoice listing services rendered during a patient visit**
- C. A summary of patient medical history
- D. A document for patient referrals

A superbill serves as a detailed invoice that lists the services rendered during a patient visit. It is a crucial document in the medical billing process as it helps to facilitate the billing and coding of healthcare services provided to a patient. The superbill typically includes not only the services performed but also relevant diagnosis codes, procedure codes (CPT codes), and sometimes the pricing for each service. This document is essential for several reasons: it aids healthcare providers in accurately reporting the services they have provided to patients, helps in the proper coding for insurance claims, and streamlines the billing process between the healthcare facility and insurance companies. It is a comprehensive tool that ensures that all services delivered in a clinical setting during a visit are noted and can be efficiently billed. In contrast to the other options presented, a superbill is distinctly focused on billing aspects, whereas records of patient prescriptions, summaries of medical histories, and documents for referrals serve different purposes in the patient care continuum. The superbill's role in coding and billing makes it an indispensable asset for billing and coding specialists.

6. What does CPT stand for?

- A. Clinical Procedural Techniques
- B. Current Procedural Terminology**
- C. Certified Professional Training
- D. Common Procedural Terms

The term CPT stands for Current Procedural Terminology. This is a standardized set of medical codes that physicians and other healthcare providers use to describe the medical, surgical, and diagnostic services and procedures they perform. The primary purpose of CPT coding is to facilitate effective communication among healthcare providers, payers, and researchers by providing a uniform language. By using Current Procedural Terminology, providers can ensure accurate billing, streamline healthcare services, and help maintain comprehensive health records. This standardization is crucial for the reimbursement process and for various administrative functions, making it essential knowledge for billing and coding specialists.

7. In an aging report, which category should ideally contain the lowest percentage of accounts receivable?

- A. 1-30 days
- B. 31-60 days
- C. 61-90 days
- D. Greater than 120 days**

In an aging report, the category that should ideally contain the lowest percentage of accounts receivable is the one representing accounts greater than 120 days. This is because accounts that are older than 120 days are considered long overdue and indicate that the practice has had difficulty collecting payment for those accounts. In a healthy accounts receivable management system, the goal is to collect payments in a timely manner; thus, the older the account gets, the lower the percentage of total receivables it should represent. A high percentage of accounts in the greater than 120 days category signals potential problems with the billing process or customer payment practices, and it could reflect negatively on the financial health of the practice. In contrast, categories like 1-30 days, 31-60 days, and 61-90 days should have higher percentages as they represent newer accounts, indicating that payments are being collected in a timely manner. Ideally, practices aim to keep most of their accounts in the younger aging categories, as these are less likely to result in bad debt and signify effective management of receivables.

8. How can a billing and coding specialist reduce claim denials?

- A. By submitting claims without verifying information
- B. By delaying claims submission
- C. By verifying patient insurance eligibility and ensuring accurate coding before submission**
- D. By simplifying diagnostic codes

The best approach for a billing and coding specialist to reduce claim denials is to verify patient insurance eligibility and ensure accurate coding before submission. This step is crucial because it sets a solid foundation for claims management. When a specialist verifies insurance eligibility, it ensures that the patient has active coverage for the services provided, which minimizes the chance of a denial based on lack of insurance. Accurate coding is equally important, as it communicates to the insurance company the precise nature of the services rendered. If codes are incorrect or do not align with the provided services, claims may be denied. By taking these proactive measures, specialists can address potential issues before claims are submitted, resulting in fewer denials, faster payments, and a smoother billing process overall. This highlights the importance of thorough preparation and verification as critical components in effective claims management.

9. If a CPT code is routinely denied by a third-party payer, what type of review should the specialist perform?

- A. Prospective review
- B. Concurrent review
- C. Retrospective review**
- D. Utilization review

In situations where a CPT code is frequently denied by a third-party payer, conducting a retrospective review is the most appropriate course of action. This type of review allows the billing and coding specialist to analyze previously submitted claims and their outcomes over a specific period. By reviewing past denials, the specialist can identify patterns or common reasons for the denials related to that specific CPT code. A retrospective review involves assessing the documentation, coding accuracy, and compliance with payer guidelines. This can uncover potential issues such as incorrect coding, lack of medical necessity, or failure to meet the criteria set by the insurance provider. By understanding the reasons behind past denials, the specialist can make necessary adjustments and improve future claims submissions, thereby reducing the likelihood of repeated denials and enhancing reimbursement rates. Utilization review, on the other hand, generally focuses on the appropriateness of medical services and ensure they align with healthcare regulations and criteria, rather than specifically addressing coding denials. Prospective and concurrent reviews typically assess services before they occur or during treatment, which does not apply to a situation involving frequent denials of a previously submitted CPT code.

10. What coding guidelines must be followed when coding a patient's visit?

- A. The ICD-10-CM guidelines for clinical documentation
- B. The Official Guidelines for Coding and Reporting**
- C. The local payer guidelines
- D. The CMS regulatory requirements

The Official Guidelines for Coding and Reporting provide the essential framework that coders and billers must follow when documenting and coding a patient's visit. These guidelines are established by the Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), ensuring that coding practices are standardized and compliant across various medical settings. These guidelines cover a wide range of topics, such as proper coding conventions, how to use codes effectively, and how to document patient encounters accurately, which helps ensure that the coded information reflects the services provided and supports reimbursement processes. While the other options provide valuable information in specific contexts, they do not serve the overarching guideline role that the Official Guidelines for Coding and Reporting provide. For example, local payer guidelines may vary significantly by region and insurer, and therefore may not apply universally. Similarly, while the ICD-10-CM guidelines for clinical documentation refer specifically to diagnosis codes and clinical documentation standards, they are part of the broader official guidelines but not the complete set. Lastly, CMS regulatory requirements encompass various regulatory aspects and compliance issues but are not as directly focused on the coding process as the Official Guidelines. This makes the Official Guidelines the central point of reference for accurate coding of patient visits.

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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