NWCA Medical Billing and Coding 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

1. When are post-operative visits billable separately within the global period?

A. Post-operative visits are not billed separately unless the visit is for an unrelated condition or an exception applies.

B. Post-operative visits are always billed separately within the global period.

C. Post-operative visits are never billed during the global period.

D. Global period does not apply to post-operative visits.

2. For a claim from September 2013 that needs rebilling, which coding system should be used?

A. ICD-10-CM

B. CPT

C. HCPCS

D. ICD-9-CM

3. Which statement about UB-04 is true?

A. It is used to bill professional services.

B. It is used for dental clinics only.

C. It is used to bill hospital outpatient services only.

D. It is used to bill institutional providers (hospitals) for inpatient and outpatient services.

4. What are CPT codes used for?

A. To report diagnoses

B. To report procedures/services performed by physicians and other qualified professionals

C. To report HCPCS Level II non-physician services

D. To code patient demographics

5. Radiation oncology is a form of cancer treatment that uses which to shrink of kill malignant neoplasms

A. Low-energy non-ionizing radiation

B. Surgical incisions

C. High-energy ionizing radiation

D. Chemotherapy drugs

6. How should you determine the correct E/M code for an office visit under current guidelines?

A. Evaluate history, exam, and medical decision making (or time); select the correct E/M level (e.g., 99202-99215) per CPT guidelines and document accordingly.

B. The patient's age should drive the code selection.

C. Always use the highest level code for every visit.

D. Code based on payer's preferred level only.

7. When coding multiple Anesthesia services for the same patient during the same encounter, which approach is correct?

A. Only the most complex anesthesia procedure code with the highest base unit value

B. The sum of all anesthesia base units

C. The least complex anesthesia code

D. The code with the highest base units regardless of complexity

8. For a procedure with no specific CPT code in Category I or Category III, which coding option should be used?

A. Unlisted codes

B. Category I codes

C. HCPCS Level II codes

D. Modifier codes

9. What best describes the relationship between CPT codes and HCPCS Level II codes?

A. CPT codes report procedures and services by physicians; HCPCS Level II codes report non-physician services, supplies, equipment, and certain drugs not included in CPT

B. CPT codes are for diagnoses; HCPCS Level II for procedures

C. They are the same system

D. CPT codes are used only in inpatient settings

10. What is an 'allowable' amount?

A. The maximum amount a payer will reimburse for a service or procedure; patient responsibility may include deductible, copay, or coinsurance.

B. The provider's billed charge.

C. The amount after discounts.

D. The amount charged by the patient.

Answers

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

Explanations

1. When are post-operative visits billable separately within the global period?

A. Post-operative visits are not billed separately unless the visit is for an unrelated condition or an exception applies.

B. Post-operative visits are always billed separately within the global period.

C. Post-operative visits are never billed during the global period.

D. Global period does not apply to post-operative visits.

The global period bundles postoperative care into the surgical charge, so visits related to the surgery aren't billed separately. They can be billed separately only if the patient comes in for a problem unrelated to the surgery (a separate/new issue) or there's another payer-supported exception. In that case, you'd typically bill an evaluation and management service for the unrelated problem, sometimes using modifier -24 to indicate a separate E/M service during the global period. This is why the correct understanding is that post-operative visits aren't billed separately within the global period unless they're for an unrelated condition or an allowed exception.

2. For a claim from September 2013 that needs rebilling, which coding system should be used?

A. ICD-10-CM

B. CPT

C. HCPCS

D. ICD-9-CM

The key idea is that the rebilled claim must use the coding system that was in effect at the time of service. In September 2013, ICD-9-CM was the standard for diagnostic codes (with CPT/HCPCS used for procedures). ICD-10-CM/ICD-10-PCS were not yet adopted in the U.S. until later, so they wouldn't be used for a 2013 claim. Therefore, rebill the claim with ICD-9-CM codes for diagnoses (and CPT/HCPCS for procedures if applicable).

3. Which statement about UB-04 is true?

A. It is used to bill professional services.

B. It is used for dental clinics only.

C. It is used to bill hospital outpatient services only.

D. It is used to bill institutional providers (hospitals) for inpatient and outpatient services.

UB-04 is the standard claim form used by institutional providers, such as hospitals, to bill for facility-based services. It covers both inpatient stays and hospital outpatient services, which is why it's the form hospitals use to submit inpatient and outpatient claims. This form is designed for facility claims, while professional services are billed on the CMS-1500 (or its electronic equivalent), and dental clinics typically use different processes. So the statement that UB-04 is used to bill institutional providers (hospitals) for inpatient and outpatient services is the correct description.

4. What are CPT codes used for?

A. To report diagnoses

B. To report procedures/services performed by physicians and other qualified professionals

C. To report HCPCS Level II non-physician services

D. To code patient demographics

At the heart of CPT coding is describing the procedures and services performed by physicians and other qualified professionals for billing purposes. This set standardizes what was done in terms of medical, surgical, radiology, pathology, and laboratory services, making it possible for payers to determine reimbursement. Diagnoses are tracked with ICD-10-CM codes, not CPT codes, which is why CPT codes alone don't report the reason for the encounter. Non-physician services and supplies are typically coded with HCPCS Level II codes, which sit alongside CPT for billing certain items and services that CPT doesn't cover. An example helps tie it together: a physician performing a colonoscopy would use a CPT procedure code; the reason for the colonoscopy—such as a finding of colorectal polyps—would be coded with ICD-10-CM; a supply like a wheelchair would be HCPCS Level II; demographics like age or gender aren't coded with CPT. So, CPT codes are used to report procedures and services performed by physicians and other qualified professionals.

5. Radiation oncology is a form of cancer treatment that uses which to shrink of kill malignant neoplasms

A. Low-energy non-ionizing radiation

B. Surgical incisions

C. High-energy ionizing radiation

D. Chemotherapy drugs

Radiation oncology relies on high-energy ionizing radiation to shrink or kill malignant neoplasms. Ionizing radiation has enough energy to remove electrons from atoms, creating damage to DNA. Cancer cells are especially vulnerable because they divide rapidly and often have less robust DNA repair, so DNA damage from the radiation leads to cell death or permanent failure to replicate. High-energy forms include X-rays, gamma rays, and particle beams used in external beam or brachytherapy. Low-energy non-ionizing radiation doesn't ionize DNA and isn't used to treat cancer in this way. Surgical incisions are a physical removal method, not a radiation approach, and chemotherapy uses chemical agents rather than radiation.

6. How should you determine the correct E/M code for an office visit under current guidelines?

A. Evaluate history, exam, and medical decision making (or time); select the correct E/M level (e.g., 99202-99215) per CPT guidelines and document accordingly.

B. The patient's age should drive the code selection.

C. Always use the highest level code for every visit.

D. Code based on payer's preferred level only.

The key idea is that office E/M coding is driven by what you document about three elements: history, examination, and medical decision making, with a possible alternative based on the total time spent on the encounter if counseling/coordination dominates. You determine the level of service by the depth of the documented history, the extent of the exam, and the complexity of MDM (or by the total time when time-based criteria apply), and then choose the CPT code in the 99202–99215 range that matches that level. Documentation must support the chosen level. Context helps: the history can be documented as problem-focused, expanded problem-focused, detailed, or comprehensive; the exam as corresponding levels; and MDM as straightforward, low, moderate, or high complexity. If the visit's primary value is counseling and coordination, you may base the level on total time rather than the three components. In any case, the code should reflect what is actually documented, not age, not a default to the highest code, and not payer preference.

7. When coding multiple Anesthesia services for the same patient during the same encounter, which approach is correct?

A. Only the most complex anesthesia procedure code with the highest base unit value

B. The sum of all anesthesia base units

C. The least complex anesthesia code

D. The code with the highest base units regardless of complexity

When multiple anesthesia services are provided in a single patient encounter, you report only one anesthesia code—the one that represents the most complex procedure, i.e., the code with the highest base unit value. Base units reflect the inherent complexity and resource use of the anesthesia service, so selecting the single most complex procedure avoids double-counting base units and keeps the coding aligned with the actual work performed. The total anesthesia time for the encounter remains a separate factor that accounts for the overall duration, but the base units come from the most complex service, not a sum of all services. This is why choosing the most complex code with the highest base units is the correct approach. Sums of base units across multiple procedures aren't used, and picking the least complex or simply the highest-base-unit code without regard to the actual procedure performed would misrepresent the services rendered.

8. For a procedure with no specific CPT code in Category I or Category III, which coding option should be used?

A. Unlisted codes

B. Category I codes

C. HCPCS Level II codes

D. Modifier codes

When a procedure isn't represented by a specific CPT code in Category I or Category III, you use an unlisted code. These codes act as placeholders for services that don't have an exact match in the CPT system. They signal to the payer that the procedure is new, rare, or not yet assigned a standard code, and they require detailed documentation to justify the service. Why this is the best choice: An unlisted CPT code is designed specifically for situations with no precise match. It ensures you can bill for the service while providing the payer with enough information to determine appropriate value and payment through the accompanying operative report or description. The documentation should cover what was done, why it was needed, any equipment or materials used, duration, and technique, so the payer can evaluate the service adequately. Why the other options don't fit here: Using a Category I or Category III code would only be appropriate if there was a precise code that matched the procedure. Since none exists, those codes wouldn't accurately reflect the service. HCPCS Level II codes cover items, supplies, and certain non-physician services rather than a general procedure when no CPT match exists. Modifiers simply modify the meaning of an existing code and cannot stand alone in place of a missing procedure code. In short, unlisted codes are intended for when no exact CPT code is available, with thorough documentation to support payment.

9. What best describes the relationship between CPT codes and HCPCS Level II codes?

A. CPT codes report procedures and services by physicians; HCPCS Level II codes report non-physician services, supplies, equipment, and certain drugs not included in CPT

B. CPT codes are for diagnoses; HCPCS Level II for procedures

C. They are the same system

D. CPT codes are used only in inpatient settings

CPT codes describe procedures and services performed by physicians, while HCPCS Level II codes cover non-physician services, supplies, equipment, and certain drugs not included in CPT. This split exists so billing can capture both the professional services provided by clinicians and the wide range of items and non-physician services used in care, such as durable medical equipment, ambulance services, and drugs not represented in CPT. CPT codes are five-digit codes developed and maintained for reporting physician procedures and related services, used across outpatient and inpatient settings. HCPCS Level II codes are alphanumeric codes (beginning with a letter) used by CMS and payers to report non-physician items and services, including DME, supplies, prosthetics, and many drugs. On a claim, you'll often see CPT codes for the clinician's procedures and Level II codes for the associated equipment, supplies, or non-physician services.

10. What is an 'allowable' amount?

A. The maximum amount a payer will reimburse for a service or procedure; patient responsibility may include deductible, copay, or coinsurance.

B. The provider's billed charge.

C. The amount after discounts.

D. The amount charged by the patient.

The main idea is what the term allowable amount means in medical billing. The allowable amount is the maximum sum a payer will reimburse for a service under a patient's plan. This amount comes from the negotiated rate between the insurer and the provider. Patient cost-sharing—deductible, copay, or coinsurance—is typically calculated from this allowed amount, not from the provider's entire billed charge. So, the correct description is that the payer won't reimburse more than this maximum amount, and the patient owes any remaining cost-sharing amounts based on that figure. The other options describe different price points (the full billed charge, amounts after discounts, or what the patient pays) and aren't what is meant by allowable amount.

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://nwcamedicalbillingcoding.examzify.com

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