NWCA MEDICAL BILLING AND CODING PRACTICE EXAM (SAMPLE)

STUDY GUIDE

SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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. What is upcoding and downcoding, and why are they problematic?

A. Upcoding assigns a higher-severity code to increase payment; downcoding assigns a lower-severity code; both violate guidelines and can lead to audits and penalties.

B. They are acceptable practices with proper documentation.

C. They refer to coding errors that do not affect payment.

D. They are required to align with payer policies.

2. Who publishes Coding Clinics?

A. A private blog by coders about coding mistakes.

B. Official guidance published by the American Hospital Association to assist coders in resolving coding questions; used as a reference in decision-making.

C. Training module for insurance executives.

D. CMS policy manual for claims processing.

3. How do you use modifiers 25 and 59 differently in a claim?

A. The 25 modifier indicates a separately identifiable E/M service on the same day; the 59 modifier indicates a separate procedure/service that would otherwise be bundled

B. The 25 modifier indicates a separate E/M service; the 59 modifier indicates a separate procedure not bundled

C. Both modifiers indicate different payment adjustments with no distinction

D. They are never used together

4. What is the difference between a primary diagnosis and a secondary diagnosis?

A. The primary diagnosis is the most severe condition.

B. Secondary diagnoses always have no effect on billing.

C. Secondary diagnoses determine the entire billing amount.

D. The primary diagnosis is the main reason for admission or the most significant condition; secondary diagnoses are additional conditions that affect care or billing.

5. In a patient with chronic kidney disease and hypertensive heart disease, if the visit's main focus is kidney disease management, which code is typically listed first?

A. Hypertensive heart disease first

B. CKD first

C. Diabetes first

D. No CKD coding if heart disease present

6. Which CPT code entry was used for Dr. Bruce Prentice on date of service 8/15/yy?

A. 49505-50 , 99213-57

B. 49505-50

C. 99213-57

D. 49505-59 , 99213-50

7. What is the purpose of NCCI edits in medical coding?

A. To increase payment amounts

B. To reduce the number of codes that can be billed

C. To delay claims processing

D. To prevent improper coding sequences and mass bundling of codes, ensuring appropriate pairing or separation of services for payment

8. What two factors are considered when coding burns?

A. Depth only.

B. Surface area only.

C. Depth and total body surface area.

D. Age of patient only.

9. What is the difference between the global surgical package and separate procedures?

A. Global packages include routine postoperative care for a surgery; separate procedures may have their own post-op rules and payments.

B. Global packages exclude postoperative care.

C. Separate procedures are never billed with the main surgery.

D. Global packages are only for diagnostic procedures.

10. Which procedure describes excision of a thyroid lobe along with part of the opposite lobe and the isthmus?

A. Subtotal thyroidectomy

B. Thyroid lobectomy - contralateral (opposite side) subtotal

C. Total thyroidectomy

D. Parathyroidectomy

Answers

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

Explanations

1. What is upcoding and downcoding, and why are they problematic?

A. Upcoding assigns a higher-severity code to increase payment; downcoding assigns a lower-severity code; both violate guidelines and can lead to audits and penalties.

B. They are acceptable practices with proper documentation.

C. They refer to coding errors that do not affect payment.

D. They are required to align with payer policies.

Upcoding and downcoding are forms of misrepresenting the level of service through coding. Upcoding means using a code that reflects a more severe diagnosis or higher complexity of services than what was actually performed and documented, with the aim of getting higher payment. Downcoding means assigning a lower-severity code than the documentation supports, which still misrepresents the true level of service. Both practices violate coding guidelines because the code should accurately reflect what was done and documented in the medical record. When the documentation supports a higher level of care, that higher code should be used; when it supports a lower level, the lower code is appropriate. Deliberate misrepresentation to influence payment undermines payer trust, can lead to audits, recoupment of funds, civil penalties, and even criminal action under fraud and abuse laws. The proper approach is to code exactly what is documented and medically necessary, and to clarify with the clinician if the chart is unclear.

2. Who publishes Coding Clinics?

A. A private blog by coders about coding mistakes.

B. Official guidance published by the American Hospital Association to assist coders in resolving coding questions; used as a reference in decision-making.

C. Training module for insurance executives.

D. CMS policy manual for claims processing.

Coding Clinics are official guidance published by the American Hospital Association to assist coders in resolving coding questions and to serve as a reference in decision-making. This makes them the authoritative source coders consult when a coding scenario isn't clearly answered by standard guidelines, providing consistent interpretation and examples. A private blog by coders isn't an official reference, so it lacks the standardized authority needed for formal coding decisions. A training module for insurance executives isn't the purpose of Coding Clinics, which are aimed at coders and healthcare facilities. The CMS policy manual for claims processing is a separate CMS resource focused on claims rules, not the authoritative coding guidance from the AHA.

3. How do you use modifiers 25 and 59 differently in a claim?

A. The 25 modifier indicates a separately identifiable E/M service on the same day; the 59 modifier indicates a separate procedure/service that would otherwise be bundled

B. The 25 modifier indicates a separate E/M service; the 59 modifier indicates a separate procedure not bundled

C. Both modifiers indicate different payment adjustments with no distinction

D. They are never used together

The main idea is telling payers when two things done in the same encounter are truly distinct and deserve separate payment. Modifier 25 is used with an Evaluation and Management (E/M) code to show that the E/M service is significant and separately identifiable from the procedure performed that same day. In other words, the visit itself is not just pre/post care for the procedure; there's an independent E/M examination or decision-making that warrants separate reimbursement, supported by documentation. Modifier 59, on the other hand, is used to indicate that a procedure or service is distinct from another on the same day and would normally be bundled, so it should be paid separately. It flags that two procedures are not simply part of the same, bundled global service, but are separate enough to merit separate consideration. So the correct characterization is that one modifier signals a separately identifiable E/M on the same day as a procedure, while the other signals a distinct procedure/service that would otherwise be bundled. This distinction helps ensure the right services are paid for on the claim.

4. What is the difference between a primary diagnosis and a secondary diagnosis?

A. The primary diagnosis is the most severe condition.

B. Secondary diagnoses always have no effect on billing.

C. Secondary diagnoses determine the entire billing amount.

D. The primary diagnosis is the main reason for admission or the most significant condition; secondary diagnoses are additional conditions that affect care or billing.

The main idea here is how the two types of diagnoses guide care and billing. The primary diagnosis is the main reason for the patient's admission—the condition that most directly explains why the patient needs to be in the hospital and it largely drives the initial treatment plan and the DRG. Secondary diagnoses are the other active conditions found during the stay that can affect how care is delivered, what resources are used, and how the claim is billed. This distinction is why the correct choice fits best: it states that the primary diagnosis is the main reason for admission or the most significant condition, while secondary diagnoses are additional conditions that affect care or billing. The other statements are not accurate: the primary diagnosis isn't defined by severity alone, secondary diagnoses can influence billing, and billing is not determined by secondary diagnoses alone since reimbursement depends on the combination of diagnoses and procedures within coding rules.

5. In a patient with chronic kidney disease and hypertensive heart disease, if the visit's main focus is kidney disease management, which code is typically listed first?

A. Hypertensive heart disease first

B. CKD first

C. Diabetes first

D. No CKD coding if heart disease present

When the visit is focused on a specific condition, that condition's code is listed first as the main reason for the encounter. If the patient's main focus is kidney disease management, the CKD code (N18.x) should be the first-listed diagnosis. Hypertensive heart disease would then appear as a secondary code if it's relevant to the visit but not the primary focus. The presence of heart disease does not remove CKD coding, and it wouldn't be correct to code diabetes first unless diabetes was the reason for the visit.

6. Which CPT code entry was used for Dr. Bruce Prentice on date of service 8/15/yy?

A. 49505-50 , 99213-57

B. 49505-50

C. 99213-57

D. 49505-59 , 99213-50

When a patient has a surgical procedure and the preoperative evaluation on the same day, you report both the surgery with a bilateral modifier and the preoperative evaluation with a modifier that indicates the decision for surgery. For an open repair of inguinal hernia performed on both sides, the procedure code is the open inguinal hernia repair with the bilateral modifier (-50). On the same day, the preoperative evaluation that leads to the surgical decision is coded as an office/outpatient visit (such as 99213) and given the modifier -57 to show this E/M service was the decision for surgery. Using both codes on the date of service captures both the actual operation and the preoperative decision-making. Relying on only the surgical code misses the preoperative decision, while using only the E/M code misses the surgery itself.

7. What is the purpose of NCCI edits in medical coding?

A. To increase payment amounts

B. To reduce the number of codes that can be billed

C. To delay claims processing

D. To prevent improper coding sequences and mass bundling of codes, ensuring appropriate pairing or separation of services for payment

NCCI edits are designed to ensure proper coding sequences and prevent improper billing by restricting which code pairs can be paid together. They create rules that flag combinations where one code's work is already included in another or where combining codes would result in duplicative payment. In practice, when a listed pair is billed together, payment for the secondary code is denied unless a valid override applies, preventing mass bundling of codes and ensuring services are paired or separated correctly for payment. This isnates that the edits aren't about increasing payments, delaying claims, or shrinking the code set; they're about making sure payment reflects the true services performed and avoids double-payment for the same work.

8. What two factors are considered when coding burns?

A. Depth only.

B. Surface area only.

C. Depth and total body surface area.

D. Age of patient only.

Burn coding uses two key measurements: how deep the burn goes and how much of the body is burned. Depth tells you which tissue layers are damaged—superficial, partial-thickness, or full-thickness—and this drives decisions about treatment and the specific code. The total body surface area (TBSA) shows how extensive the injury is, usually estimated with established charts such as Lund and Browder or the Rule of Nines. Together, depth and TBSA capture both the severity and the extent of the burn, which is why they're the factors used for coding. Depth alone wouldn't reflect how widespread the burn is, and TBSA alone wouldn't indicate tissue involvement, so combining both provides the accurate code. Age or considering surface area by itself aren't used to determine burn codes in isolation, since they don't fully represent severity.

9. What is the difference between the global surgical package and separate procedures?

A. Global packages include routine postoperative care for a surgery; separate procedures may have their own post-op rules and payments.

B. Global packages exclude postoperative care.

C. Separate procedures are never billed with the main surgery.

D. Global packages are only for diagnostic procedures.

Global surgical package rules determine what is bundled into the payment for a surgical procedure. The payment for the surgery typically includes the operation itself plus routine postoperative care during the designated global period (0, 10, or 90 days, depending on the procedure). That means follow-up visits and standard postoperative services are paid as part of that one payment. When another procedure is performed, it may have its own post-operative rules and its own payment separate from the original surgery. If the second procedure is billed as a separate procedure (either because it is truly distinct or has its own global period), it is paid with its own postoperative coverage, independent of the first surgery's global period. In other words, the global package is not a blanket for every intervention during an encounter; separate procedures can be billed and paid separately according to their own global periods. Postoperative care is included in the global package, not excluded. Separate procedures can be billed separately, and global periods apply per procedure rather than universally. Global packages aren't limited to diagnostic work; they apply to surgical procedures as defined by CPT.

10. Which procedure describes excision of a thyroid lobe along with part of the opposite lobe and the isthmus?

A. Subtotal thyroidectomy

B. Thyroid lobectomy - contralateral (opposite side) subtotal

C. Total thyroidectomy

D. Parathyroidectomy

The key idea is understanding how thyroid surgeries are described by how much gland is removed on each side. The scenario specifies removing an entire lobe on one side and taking out part of the opposite lobe along with the isthmus. That pattern fits a lobectomy on one side with a subtotal (partial) resection of the opposite side, which is captured by the phrase thyroid lobectomy with contralateral subtotal. It acknowledges a complete removal on the operated side plus a partial removal on the other side, with the isthmus included in the procedure. A total thyroidectomy would mean removing both lobes completely and the isthmus, which isn't what's described here. Subtotal thyroidectomy generally implies removing tissue from the gland as a whole but doesn't specify a full lobectomy on one side with partial removal on the opposite. Parathyroidectomy targets the parathyroid glands, not the thyroid tissue.

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!