AMCA MEDICAL CODER & BILLER CERTIFICATION (MCBC) 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.

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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!

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Questions

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1. What type of health plan combines a high deductible with a savings account to managed out-of-pocket costs?

A. Health Reimbursement Arrangement (HRA)

B. Consumer Driven Health Plan (CDHP)

C. Flexible Spending Account (FSA)

D. Medicare Part D

2. What term refers to Medicare computer programs that profile average billing patterns for Evaluation and Management (E/M) codes?

A. Cost analysis

B. Profile management

C. Benchmarking

D. Billing analysis

3. What type of insurance provides wage replacement and medical benefits for employees injured at work?

A. Health insurance

B. Worker's compensation

C. Life insurance

D. Disability insurance

4. What does E/M coding primarily assess?

A. Patient Diagnosis

B. Healthcare Outcomes

C. Provider Decision Making

D. Patient's Condition and Treatment Plan

5. What does the acronym NOS stand for in ICD coding?

A. Not Otherwise Specified

B. Not Otherwise Stated

C. National Office of Standards

D. Notable Obvious Symptom

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6. What is the medical term for a blood clot in an artery of the brain?

A. Cerebral thrombosis

B. Brain embolism

C. Arterial occlusion

D. Stroke

7. What is the legal process called when a patient's debt is eliminated by a court?

A. Bankruptcy

B. Debt Relief

C. Credit Rehabilitation

D. Financial Forgiveness

8. Which of the following is NOT a type of managed care organization plan?

A. HMOs

B. PPOs

C. Medicare Supplement Plans

D. POS plans

9. What are the two types of coverage determinations Medicare uses?

A. Local Coverage Determination and National Coverage Determination

B. State Coverage Determination and Federal Coverage Determination

C. Primary Coverage Determination and Secondary Coverage Determination

D. Comprehensive Coverage Determination and Basic Coverage Determination

10. What is the full title of the CPT manual?

A. Current Procedural Terminology

B. Comprehensive Procedures Text

C. Clinical Procedure Titles

D. Coding Procedures Handbook

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Answers

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

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Explanations

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1. What type of health plan combines a high deductible with a savings account to managed out-of-pocket costs?

A. Health Reimbursement Arrangement (HRA)

B. Consumer Driven Health Plan (CDHP)

C. Flexible Spending Account (FSA)

D. Medicare Part D

The correct answer, which refers to a health plan that combines a high deductible with a savings account to manage out-of-pocket costs, is a Consumer Driven Health Plan (CDHP). CDHPs are designed to give consumers more control over their healthcare choices and expenditures. They generally include high deductible health plans paired with either Health Savings Accounts (HSAs) or Health Reimbursement Arrangements (HRAs). The high deductible incentivizes individuals to become more cost-conscious regarding their healthcare services, while the associated savings account allows them to save money tax-free to cover eligible medical expenses, thus helping to manage out-of-pocket costs more effectively. This structure encourages individuals to think critically about their healthcare spending and can lead to more informed healthcare decisions. In contrast, Health Reimbursement Arrangements (HRAs) are employer-funded accounts that reimburse employees for incurred medical expenses, but they do not typically come with high deductible insurance plans. Flexible Spending Accounts (FSAs) allow employees to set aside money pre-tax for medical expenses, but they are not specifically tied to high deductible plans like CDHPs are. Medicare Part D offers prescription drug coverage for Medicare beneficiaries and does not concern out-of-pocket costs in the framework of high deductible health plans.

2. What term refers to Medicare computer programs that profile average billing patterns for Evaluation and Management (E/M) codes?

A. Cost analysis

B. Profile management

C. Benchmarking

D. Billing analysis

The term that refers to Medicare computer programs profiling average billing patterns for Evaluation and Management (E/M) codes is benchmarking. This process involves comparing healthcare providers' billing practices against established standards or averages. By analyzing these profiles, Medicare can identify potential discrepancies or variations in billing practices, helping ensure that providers adhere to appropriate coding and billing guidelines. Benchmarking is crucial for maintaining the integrity of billing processes and enhancing the quality of care. The other terms, while related to the business aspect of healthcare, do not specifically align with the concept of profiling average billing patterns. Cost analysis typically focuses on evaluating the costs associated with services rather than profiling billing. Profile management implies a broader scope of managing data profiles without the specific context of averages and comparisons. Billing analysis, while it examines billing practices, doesn't inherently include the comparative aspect that benchmarking does.

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3. What type of insurance provides wage replacement and medical benefits for employees injured at work?

A. Health insurance

B. Worker's compensation

C. Life insurance

D. Disability insurance

Worker's compensation insurance is specifically designed to provide wage replacement and medical benefits to employees who suffer work-related injuries or illnesses. This insurance covers various costs associated with workplace injuries, including medical treatment, rehabilitation, and a portion of the employee's lost wages while they are unable to work due to their injury. The purpose of worker's compensation is to ensure that employees are not financially burdened by medical expenses or loss of income as a result of a workplace accident. Employers are generally required by law to carry worker's compensation insurance to protect both their employees and themselves from potential lawsuits that could arise from work-related injuries. In contrast, health insurance focuses on covering general medical expenses unrelated to work, life insurance provides financial support to beneficiaries upon the policyholder's death, and disability insurance offers income replacement in the event that an individual is unable to work due to non-work-related illnesses or injuries. These other types of insurance do not specifically address the unique needs of employees injured while performing their job duties, which is the primary function of worker's compensation.

4. What does E/M coding primarily assess?

A. Patient Diagnosis

B. Healthcare Outcomes

C. Provider Decision Making

D. Patient's Condition and Treatment Plan

E/M coding, which stands for Evaluation and Management coding, primarily assesses the patient's condition and treatment plan. This type of coding is integral in the healthcare process because it documents the complexity of the visit based on the patient's symptoms, medical history, and the healthcare provider's assessment, including the decisions made regarding the patient's care. In E/M coding, various elements such as the extent of the examination, history, and clinical decision-making play vital roles in determining the appropriate code. The focus is on how the patient's condition is evaluated during the visit and what treatment plans are established as a result. Therefore, understanding the nuances of the patient's condition and the specific actions taken to manage that condition is essential for appropriate coding. While the other options contain relevant aspects of healthcare, they do not capture the primary focus of E/M coding. For instance, patient diagnosis is an important aspect, but E/M coding is more comprehensive than just diagnosing. Similarly, healthcare outcomes and provider decision-making are parts of the larger picture, but the core element of E/M coding is centered on directly assessing the patient's condition and defining the treatment plan. This distinction highlights the holistic approach of E/M coding in the context of patient management and care delivery.

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5. What does the acronym NOS stand for in ICD coding?

A. Not Otherwise Specified

B. Not Otherwise Stated

C. National Office of Standards

D. Notable Obvious Symptom

The acronym NOS in ICD coding stands for "Not Otherwise Specified." This designation is used when a specific diagnosis does not have a more detailed description or when additional detail is not provided in the medical record. It serves as a placeholder to indicate that a clinician has indicated a condition or diagnosis but has not provided enough specific information to assign a more precise code. The use of NOS codes is important in medical coding as it helps to capture conditions without full specifications while maintaining consistency and clarity in coding practices. The other options don't align accurately with standard terms used in coding. For instance, "Not Otherwise Stated" is not a recognized term in ICD coding; similarly, "National Office of Standards" and "Notable Obvious Symptom" do not apply in this context and do not represent accepted terminology in ICD medical coding practices.

6. What is the medical term for a blood clot in an artery of the brain?

A. Cerebral thrombosis

B. Brain embolism

C. Arterial occlusion

D. Stroke

The medical term for a blood clot that forms in an artery of the brain is "cerebral thrombosis." This term specifically describes the condition where a thrombus, or clot, develops within a cerebral artery, ultimately leading to a reduction or blockage of blood flow to a region of the brain. This can result in significant neurological damage if not promptly addressed. Cerebral thrombosis is distinct in that it refers to the formation of the clot at the site itself, as opposed to other conditions like embolism where a clot may travel from another part of the body and lodge in the brain, causing an obstruction. Stroke is a broader term that encompasses both cerebral thrombosis and other types of strokes, like ischemic and hemorrhagic strokes. Arterial occlusion may describe the blockage of blood flow in an artery but does not specify that it is due to a clot forming in the brain. While "brain embolism" includes clot-related events, it refers to the traveling nature of the clot rather than its formation in the brain itself.

7. What is the legal process called when a patient's debt is eliminated by a court?

A. Bankruptcy

B. Debt Relief

C. Credit Rehabilitation

D. Financial Forgiveness

The legal process where a patient's debt is eliminated by a court is known as bankruptcy. This is a formal procedure governed by federal law, allowing individuals or entities that are unable to repay their debts to seek relief from some or all of their financial obligations. When a court grants bankruptcy relief, it can discharge certain debts, meaning the debtor is no longer legally required to pay them, providing a fresh financial start. In this context, other terms such as debt relief and financial forgiveness may refer to general concepts of alleviating financial burdens but do not represent the specific legal process recognized under U.S. law that bankruptcy does. Credit rehabilitation typically relates to strategies to improve credit scores and does not imply the elimination of debt through a court decision.

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8. Which of the following is NOT a type of managed care organization plan?

A. HMOs

B. PPOs

C. Medicare Supplement Plans

D. POS plans

Medicare Supplement Plans are not classified as managed care organization plans. Managed care organizations, such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Point of Service (POS) plans, are designed to provide healthcare services while controlling costs and improving quality of care through a network of providers and structured plans. Medicare Supplement Plans, or Medigap policies, function differently. Their primary purpose is to cover the gaps in Medicare coverage, such as out-of-pocket expenses that traditional Medicare may not fully encompass. These plans are standardized by Medicare and do not incorporate the managed care principles of network restrictions or coordinated care features that are typical of HMOs, PPOs, and POS plans. Thus, recognizing Medicare Supplement Plans as separate from managed care organizations is essential for understanding various health insurance models.

9. What are the two types of coverage determinations Medicare uses?

A. Local Coverage Determination and National Coverage Determination

B. State Coverage Determination and Federal Coverage Determination

C. Primary Coverage Determination and Secondary Coverage Determination

D. Comprehensive Coverage Determination and Basic Coverage Determination

Medicare utilizes two distinct types of coverage determinations: Local Coverage Determination (LCD) and National Coverage Determination (NCD). Local Coverage Determinations are made by Medicare Administrative Contractors (MACs) and reflect the needs and standards of specific regional Medicare populations. They provide guidance on whether specific services, procedures, or items are covered within a local jurisdiction. This allows for flexibility, as coverage can be tailored to address regional healthcare needs, technological advancements, and varying medical practices. On the other hand, National Coverage Determinations are established by the Centers for Medicare & Medicaid Services (CMS) and apply across the entire country. These determinations outline whether a service or item is covered nationwide, providing a uniform standard for Medicare beneficiaries regardless of their location. NCDs are crucial for ensuring that essential medical services are accessible to all eligible beneficiaries at a national level. Together, these two types of determinations enable Medicare to effectively regulate and adapt its coverage policies based on both local needs and national standards, thereby enhancing patient care and ensuring that necessary medical services are provided to eligible individuals.

10. What is the full title of the CPT manual?

A. Current Procedural Terminology

B. Comprehensive Procedures Text

C. Clinical Procedure Titles

D. Coding Procedures Handbook

The full title of the CPT manual is "Current Procedural Terminology." This title accurately reflects the purpose of the manual, which is to provide a standardized system for coding a wide variety of medical, surgical, and diagnostic services and procedures. The term "Current" signifies that the manual is regularly updated to stay current with medical practices and procedures, while "Procedural" indicates that it focuses specifically on the codes used for procedures rather than other aspects of healthcare. "Terminology" highlights that the manual serves as a reference for the language used in the medical coding community. Understanding this title is crucial for medical coders, as it underpins their ability to accurately document and bill for services rendered in the healthcare system.

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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://amcamedicalcoderbiller.examzify.com

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

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