NHA BILLING AND CODING SPECIALIST (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 equation determines how patient responsibility is calculated when posting payments from an explanation of benefits (EOB)?

A. Charges + Payment - Adjustment = Patient Responsibility

B. Charges - Payment + Adjustment = Patient Responsibility

C. Charged - Payment - Adjustment = Patient Responsibility

D. Payment - Charges = Patient Responsibility

2. What does a modifier signify in medical billing?

A. Additional services provided

B. Unbundled codes

C. Modifiers indicate changes in service

D. Payment adjustments only

3. After coding a claim, what should a specialist do if they notice an error in demographic information?

A. Resubmit the claim with corrections

B. Ignore the error

C. Contact the patient for clarification

D. File a complaint with the insurance

4. What is a common requirement for Medicaid eligibility?

A. Higher income than Medicare

B. Being a U.S. citizen

C. Having a college degree

D. Being permanently disabled

5. What does a signature approving assignment of benefits on a CMS-1500 claim form indicate?

A. The patient will pay for all costs upfront.

B. The payer should send reimbursement directly to the provider.

C. The patient must receive all services in-network.

D. The provider can charge the patient additional fees.

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6. Which document is typically used to request pre-authorization for a service?

A. Insurance card

B. Health history form

C. Referral form

D. Pre-authorization form

7. A patient has met a Medicare deductible of $150. The patient's coinsurance is 20% and the allowed amount is $600. What is the patient's out-of-pocket expense?

A. $80

B. $120

C. $150

D. $200

8. In coding, what does the term "modifier" mean?

A. A three-digit code for procedures

B. A two-digit code that provides additional information about a service or procedure

C. A code that indicates a location

D. A prefix for specialty codes

9. Which of the following is NOT a requirement for submitting insurance claims?

A. Patient's Social Security Number

B. Provider's National Provider Identifier (NPI)

C. Diagnosis Codes

D. Patient's Employment Status

10. What does the term "Global period" refer to in surgical coding?

A. The time frame before surgery

B. The duration during which follow-up care is included in the procedure fee

C. The waiting time for surgery approval

D. The recovery time after surgery

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Answers

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

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Explanations

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1. What equation determines how patient responsibility is calculated when posting payments from an explanation of benefits (EOB)?

A. Charges + Payment - Adjustment = Patient Responsibility

B. Charges - Payment + Adjustment = Patient Responsibility

C. Charged - Payment - Adjustment = Patient Responsibility

D. Payment - Charges = Patient Responsibility

The equation that correctly determines how patient responsibility is calculated from an explanation of benefits (EOB) is derived by considering the relationships between charges, payments made by the insurance, and any adjustments that may need to be applied. In this context, the patient responsibility is calculated by taking the total charges for services rendered and subtracting both the payments made by the insurance and any adjustments applied. This results in the final amount that the patient is responsible for paying. Using this understanding, the correct equation is calculated as follows: 1. Start with the total charges incurred by the patient. 2. Subtract any payments that have been made on behalf of the patient by their insurance provider. 3. Additionally, account for any adjustments, which may include discounts, write-offs, or any other modifications to the total bill. The correct representation is therefore: Charged - Payment - Adjustment = Patient Responsibility. This equation clearly shows that the patient's financial obligation arises from the initial charges reduced by the contributions of the insurance and any adjustments applied.

2. What does a modifier signify in medical billing?

A. Additional services provided

B. Unbundled codes

C. Modifiers indicate changes in service

D. Payment adjustments only

A modifier in medical billing serves as a two-digit code that provides additional information about a procedure or service performed. It is used to indicate changes in the standard definition of the procedure, which may be due to various factors such as the complexity of the procedure, the site of service, or specific circumstances that affected how the service was provided. For instance, a modifier might be used to denote that a procedure was altered in some way without changing the fundamental service performed. Modifiers help convey nuances that are crucial for accurate billing and coding. They ensure that insurance payers have a clearer understanding of what transpired during a visit, which can affect reimbursement, compliance, and the overall representation of the healthcare provider's services. The use of modifiers prevents misunderstandings regarding services rendered and allows for proper payment based on the specifics of each case.

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3. After coding a claim, what should a specialist do if they notice an error in demographic information?

A. Resubmit the claim with corrections

B. Ignore the error

C. Contact the patient for clarification

D. File a complaint with the insurance

The appropriate action after noticing an error in demographic information on a coded claim is to resubmit the claim with corrections. Accurate demographic information is crucial in medical billing and coding, as it ensures that the claim is processed smoothly and that the payment is directed to the correct provider and patient. Errors in demographic details, such as the patient's name, date of birth, or insurance specifics, can lead to claim denials or delays in reimbursement. By resubmitting the claim with the corrected information, the billing specialist facilitates the resolution of the issue, allowing the insurance payer to review and process the claim correctly. This proactive approach helps maintain billing integrity and fosters a better relationship with both patients and insurance companies, ultimately supporting timely reimbursement for services rendered. In contrast, options like ignoring the error or filing a complaint would not address the core issue, and contacting the patient for clarification may unnecessarily delay the claim resolution process. Therefore, resubmitting the claim ensures the information is accurate and compliant with billing standards.

4. What is a common requirement for Medicaid eligibility?

A. Higher income than Medicare

B. Being a U.S. citizen

C. Having a college degree

D. Being permanently disabled

A common requirement for Medicaid eligibility is being a U.S. citizen. Medicaid is a state and federally funded program designed to provide healthcare coverage for low-income individuals and families, including specific groups such as children, pregnant women, elderly individuals, and those with disabilities. Generally, to qualify for Medicaid, applicants must be U.S. citizens or meet specific immigration status requirements. This citizenship requirement ensures that the funds are allocated to those who are legal residents of the country. While other factors such as income level, household size, and specific circumstances like disability may determine the eligibility of applicants, citizenship remains a fundamental criterion across nearly all states.

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5. What does a signature approving assignment of benefits on a CMS-1500 claim form indicate?

A. The patient will pay for all costs upfront.

B. The payer should send reimbursement directly to the provider.

C. The patient must receive all services in-network.

D. The provider can charge the patient additional fees.

A signature approving the assignment of benefits on a CMS-1500 claim form indicates that the payer should send reimbursement directly to the provider. This is a critical aspect of the claims process, as it allows healthcare providers to receive payments directly from insurance companies rather than requiring upfront payments from the patient. When a patient signs this assignment of benefits, they are essentially giving permission for their insurance company to pay the provider directly for the services rendered. This is advantageous for both the patient and the provider because it streamlines the billing process and alleviates the financial burden on the patient at the time of service. The other options do not accurately reflect what the assignment of benefits entails. For example, it does not indicate that the patient will pay for all costs upfront, nor does it imply that all services must be provided in-network—these factors are governed by different rules and agreements. Additionally, the assignment of benefits does not grant the provider the ability to charge the patient additional fees beyond what is agreed upon with the insurance provider. Thus, the core purpose of this signature is to facilitate direct reimbursement from the payer to the provider.

6. Which document is typically used to request pre-authorization for a service?

A. Insurance card

B. Health history form

C. Referral form

D. Pre-authorization form

The pre-authorization form is a specific document designed for the purpose of requesting approval from an insurance company before a certain medical service, procedure, or medication is provided to a patient. This form includes important details such as the patient's information, the service being requested, relevant medical history, and sometimes supporting documentation from the healthcare provider. The insurance company reviews this information to determine whether the proposed service meets their coverage criteria and to ensure that it is medically necessary. In health care billing and coding, understanding the necessity of pre-authorization is crucial, as many insurance plans require it to control costs and manage care. By successfully completing and submitting a pre-authorization form, healthcare providers can receive assurance or approval from the insurance carrier, allowing for the service to be conducted smoothly for the patient. While an insurance card provides essential identification and access to coverage details, and the health history form contains the patient's medical history, neither directly serves the purpose of seeking pre-approval. A referral form is typically used to guide a patient to another health care provider but does not request authorization for services on its own. Thus, the pre-authorization form is the correct choice as it is explicitly designed for this process.

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7. A patient has met a Medicare deductible of $150. The patient's coinsurance is 20% and the allowed amount is $600. What is the patient's out-of-pocket expense?

A. $80

B. $120

C. $150

D. $200

To determine the patient's out-of-pocket expense in this scenario, we begin by considering the Medicare deductible and coinsurance. The patient has already met the deductible of $150, so this amount will not be deducted from the allowed amount again. The allowed amount for the service performed is $600. After the deductible is met, the patient's responsibility includes the coinsurance, which is 20% of the allowed amount. To calculate this, we first determine 20% of $600: 20% of $600 equals $120 (calculated as $600 x 0.20). Since the patient has already satisfied the deductible, their out-of-pocket expense will be based solely on the 20% coinsurance amount of $120. Thus, the patient's total out-of-pocket expense is the coinsurance of $120. This sum reflects the calculated share of costs for the service after the deductible has been met, making it the right answer in this case.

8. In coding, what does the term "modifier" mean?

A. A three-digit code for procedures

B. A two-digit code that provides additional information about a service or procedure

C. A code that indicates a location

D. A prefix for specialty codes

The term "modifier" in coding specifically refers to a two-digit code that provides additional information about a service or procedure. Modifiers are used to clarify certain aspects of the procedure that may affect how the service is billed or processed. For example, a modifier can indicate that a procedure was performed under special circumstances, such as a bilateral procedure or a service that was provided more than once. Modifiers are essential in ensuring accurate billing and coding because they convey specific details to payers that may not be clear from the standard procedure codes alone. This helps prevent billing errors and ensures that the healthcare provider receives appropriate reimbursement for their services. Understanding the role of modifiers is crucial for billing and coding specialists as they navigate the complexities of healthcare coding. This knowledge enables them to enhance communication with insurance companies and improve the accuracy of claims submissions.

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9. Which of the following is NOT a requirement for submitting insurance claims?

A. Patient's Social Security Number

B. Provider's National Provider Identifier (NPI)

C. Diagnosis Codes

D. Patient's Employment Status

Submitting insurance claims requires specific information to ensure that claims are processed accurately and efficiently. The requirement for the patient's employment status is not necessary for the submission of insurance claims, making it the correct answer in this context. In contrast, each of the other options represents critical components of a claim submission. The patient's Social Security Number may be needed to verify their identity or for specific insurance requirements, although some healthcare practices may use alternate identifiers. The provider's National Provider Identifier (NPI) is essential because it uniquely identifies healthcare providers in billing processes. Diagnosis codes are vital since they provide the rationale for the services rendered and support medical necessity during the claim review. Thus, the omission of the patient's employment status from the requisite information for submitting claims highlights the focus on more critical data that directly pertains to the provision and reimbursement of healthcare services.

10. What does the term "Global period" refer to in surgical coding?

A. The time frame before surgery

B. The duration during which follow-up care is included in the procedure fee

C. The waiting time for surgery approval

D. The recovery time after surgery

The term "global period" in surgical coding refers to the duration during which follow-up care is included in the procedure fee. In surgical coding, the global period specifies the timeframe that encompasses pre-operative, surgical, and post-operative care. This includes the typical care and follow-up services that are necessary after surgery, which means that the surgeon or healthcare provider does not bill separately for these services as they are bundled into the fee for the surgical procedure. Understanding the global period is essential for proper coding and billing, as it helps ensure that providers are reimbursed accurately while avoiding unnecessary charges for services that fall within this defined period. Therefore, the correct answer highlights the comprehensive nature of care associated with a surgical procedure, which aims for continuity and efficiency in patient management.

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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://nhabillingcoding.examzify.com

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

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