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.

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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. The bone marrow or stem cell services/procedures category falls under which subheading?

A. General

B. Surgical

C. Diagnostic

D. Therapeutic

2. 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

3. In CPT coding, how should percutaneous coronary intervention (PCI) be coded?

A. PCI is coded using ICD-10-CM codes only

B. Use CPT codes for PCI describing the intervention; ensure correct pairing with diagnostic studies and apply NCCI edits if needed

C. PCI is not coded separately

D. PCI uses radiology codes only

4. Differentiate CPT and HCPCS Level II codes in terms of what they cover?

A. CPT codes cover physician services and procedures; HCPCS Level II codes cover supplies, devices, and non-physician services

B. CPT codes cover supplies; HCPCS Level II covers physician services

C. CPT covers hospital inpatient diagnoses

D. CPT and HCPCS Level II are the same

5. 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.

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6. Which CPT code would represent Dr Christian Conover's initial hospital observation service on August 15?

A. 99222

B. 99221

C. 99358

D. 99223

7. What is a 'denial' and what are common reasons for denials in medical billing?

A. A denial is a payer's rejection of a claim; common reasons include missing/invalid codes, lack of medical necessity, insufficient documentation, duplicate claims, or eligibility issues.

B. A denial is an approval for payment.

C. A denial is a request for more patient information only.

D. A denial is a penalty fee charged to the provider.

8. What does unbundling mean in coding, and why is it discouraged?

A. Using one code for every step of a procedure.

B. Creating new codes for every variation.

C. Coding separate component procedures that would typically be included in one comprehensive CPT code.

D. Combining multiple procedures into a single CPT code.

9. Which procedure uses a lighted flexible tube with an attached lens to view the inside of the respiratory system?

A. Endoscopy

B. Laryngoscopy

C. Bronchoscopy

D. Colonoscopy

10. What is the medical term for age-related loss of near vision?

A. Myopia

B. Presbyopia

C. Hyperopia

D. Astigmatism

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Answers

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

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Explanations

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1. The bone marrow or stem cell services/procedures category falls under which subheading?

A. General

B. Surgical

C. Diagnostic

D. Therapeutic

Bone marrow or stem cell services/procedures are categorized as General because this grouping covers broad, non–body-system–specific activities that support care rather than being limited to a single diagnostic test, a surgical operation, or a direct therapeutic procedure. The marrow/stem cell workflow includes collection, processing, storage, and related administrative or cross-cutting services that enable treatment but aren't themselves a specific diagnostic test, a surgical procedure, or a direct treatment step. While individual aspects like a transplant can be therapeutic or surgical in nature, the overall category described fits under General, which is designed for these broad, supportive services.

2. 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.

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3. In CPT coding, how should percutaneous coronary intervention (PCI) be coded?

A. PCI is coded using ICD-10-CM codes only

B. Use CPT codes for PCI describing the intervention; ensure correct pairing with diagnostic studies and apply NCCI edits if needed

C. PCI is not coded separately

D. PCI uses radiology codes only

When coding PCI, the CPT procedure codes that describe the interventional work are used. ICD-10-CM diagnoses identify why the procedure was done, not the procedure itself, so they don't replace the CPT codes for the intervention. Pair the PCI CPT codes with any relevant diagnostic studies as appropriate, and apply NCCI edits to ensure proper bundling and to avoid improper unbundling. Radiology codes by themselves aren't used to report PCI, and PCI is not coded only with ICD-10-CM.

4. Differentiate CPT and HCPCS Level II codes in terms of what they cover?

A. CPT codes cover physician services and procedures; HCPCS Level II codes cover supplies, devices, and non-physician services

B. CPT codes cover supplies; HCPCS Level II covers physician services

C. CPT covers hospital inpatient diagnoses

D. CPT and HCPCS Level II are the same

CPT codes report the professional services and procedures provided by physicians and other qualified health care professionals. They describe what was done during the encounter or procedure—think office visits, surgeries, imaging studies, and other clinician-performed services. HCPCS Level II codes cover items and services that CPT doesn't describe. They're used for supplies, devices, and non-physician services, such as durable medical equipment (like walkers and wheelchairs), prosthetics and orthotics, certain drugs and biologicals (often shown with J-codes), ambulance services, and other miscellaneous items and services used in patient care. So the main difference is that CPT focuses on the clinician's procedures and services, while HCPCS Level II covers the tangible goods and many non-physician services used in care.

5. 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.

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6. Which CPT code would represent Dr Christian Conover's initial hospital observation service on August 15?

A. 99222

B. 99221

C. 99358

D. 99223

Hospital observation visits use a distinct set of E/M codes from inpatient admissions. For the initial observation encounter, CPT codes range from 99218 to 99220, with 99218 representing the baseline initial observation evaluation, and 99219–99220 reflecting higher complexity or longer time. The code 99221 is reserved for initial hospital inpatient care (admission as an inpatient), not observation. Without additional detail showing higher complexity, the typical initial observation code would be 99218 (and 99219 or 99220 only if the documentation shows greater complexity or time). So, for an initial hospital observation service, the correct approach is to use an observation code from 99218–99220 rather than 99221. The other options, such as 99358 (prolonged services) and 99223 (a higher-level inpatient initial encounter), do not represent an initial observation visit.

7. What is a 'denial' and what are common reasons for denials in medical billing?

A. A denial is a payer's rejection of a claim; common reasons include missing/invalid codes, lack of medical necessity, insufficient documentation, duplicate claims, or eligibility issues.

B. A denial is an approval for payment.

C. A denial is a request for more patient information only.

D. A denial is a penalty fee charged to the provider.

A denial is a payer's rejection of a submitted claim, meaning payment will not be made for that claim. This most often happens when the codes used are missing or invalid, the service isn't considered medically necessary under the payer's guidelines, the documentation is incomplete or doesn't justify the service, there are duplicate claims for the same service, or the patient isn't eligible for coverage. Understanding these common triggers helps you prevent denials by ensuring accurate coding, complete supporting documentation, and correct patient eligibility, and it also guides the steps for appealing a denial if needed. The other options describe an approval, a request for information that doesn't reject payment, or a penalty fee, which are not denials.

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8. What does unbundling mean in coding, and why is it discouraged?

A. Using one code for every step of a procedure.

B. Creating new codes for every variation.

C. Coding separate component procedures that would typically be included in one comprehensive CPT code.

D. Combining multiple procedures into a single CPT code.

Unbundling is the practice of billing separate codes for the individual components of a procedure that would normally be described by one comprehensive CPT code. This is discouraged because it can inflate reimbursement and misrepresent the work performed; payer rules and coding guidelines, such as NCCI edits, are designed to prevent paying for the parts separately when a single code already covers the entire procedure. If the components truly are distinct and necessary to bill separately, documentation and payer guidelines must support it, but in general you should use the single code that captures the whole procedure. The option that describes coding separate component procedures that would typically be included in one comprehensive CPT code best captures this concept. The other options describe practices that don't align with unbundling: using one code for every step is not about separating components under a single code; creating new codes for every variation refers to code creation, not separating existing components; and combining multiple procedures into one code is bundling, the opposite of unbundling.

9. Which procedure uses a lighted flexible tube with an attached lens to view the inside of the respiratory system?

A. Endoscopy

B. Laryngoscopy

C. Bronchoscopy

D. Colonoscopy

Endoscopy is the general technique that uses a lighted flexible tube with a camera or lens to look inside hollow organs and passages. For the respiratory system, this umbrella term covers looking into airways and related structures, with specific procedures like bronchoscopy (viewing the bronchial tubes) and laryngoscopy (viewing the larynx). The device described—an illuminated flexible tube with a lens—defines an endoscope itself, so the broader term endoscopy best fits the description. Colonoscopy is not related to the respiratory system, as it views the colon.

10. What is the medical term for age-related loss of near vision?

A. Myopia

B. Presbyopia

C. Hyperopia

D. Astigmatism

Presbyopia is the gradual loss of the eye's ability to focus on close objects as we age. It happens when the lens becomes stiffer and the ciliary muscles lose some flexibility, making near tasks like reading harder unless you hold material farther away or use reading glasses. This normal aging change typically becomes noticeable in the 40s or 50s and is distinct from other refractive errors: myopia is difficulty seeing distant objects, hyperopia is difficulty seeing near objects from birth or a young age, and astigmatism is caused by an irregular corneal shape that blurs vision at all distances. Treatments include reading glasses, multifocal or progressive lenses, contact lenses, or surgical options if desired.

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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://nwcamedicalbillingcoding.examzify.com

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

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