CERTIFIED BILLING AND CODING SPECIALIST CBCS-B PRACTICE TEST (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. Who bears the responsibility for paying the deductible?

A. The insurer

B. The employer

C. The patient

D. The provider

2. On a CMS-1500 claim, which identifier uniquely identifies the treating provider?

A. Tax Identification Number

B. Social Security Number

C. National Provider Identifier

D. Medical License Number

3. Which code sets are used for diagnoses and procedures in outpatient coding?

A. ICD-10-CM for diagnoses and CPT/HCPCS for procedures

B. ICD-10-CM for diagnoses and ICD-10-PCS for procedures

C. ICD-9-CM for diagnoses and CPT for procedures

D. ICD-10-CM for both diagnoses and procedures

4. Which section of the medical record is used to determine the correct Evaluation and Management code used for billing and coding?

A. Assessment and plan

B. Progress notes

C. Plan of care

D. History and physical

5. Which statement best defines a medical consultation for billing purposes?

A. A routine checkup

B. A service performed by a nurse

C. A hospital discharge evaluation

D. A physician's opinion or advice requested by another physician or agency

6. After a third-party payer validates a claim, which of the following takes place next?

A. Claim adjudication

B. Payment posting

C. Denied claim notification

D. Patient statement generation

7. Which modifier is commonly used to indicate store-and-forward telemedicine?

A. -GT

B. -GQ

C. -GZ

D. -GR

8. When posting a payment, which item should be included?

A. Patient's responsibility

B. Insurance policy number

C. Provider's license

D. Date of birth

9. Which form must the patient or their representative sign to allow the release of protected health information?

A. A consent form

B. An authorization

C. A waiver

D. A patient agreement

10. Which type of services does the CMS-1500 form primarily bill?

A. Professional services provided by physicians

B. Inpatient hospital services

C. Pharmacy prescriptions

D. Dental procedures

Answers

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

Explanations

1. Who bears the responsibility for paying the deductible?

A. The insurer

B. The employer

C. The patient

D. The provider

A deductible is the amount the insured must pay out of pocket before the health plan starts paying benefits. Because of that, the patient bears the responsibility for paying the deductible. After the deductible is met, the insurer contributes according to the policy terms, often with coinsurance or copays until the out-of-pocket maximum is reached. The employer funds the plan but does not directly pay the deductible for individual services in the usual billing flow, and the provider typically collects the deductible at the point of service to apply toward the patient's responsibility.

2. On a CMS-1500 claim, which identifier uniquely identifies the treating provider?

A. Tax Identification Number

B. Social Security Number

C. National Provider Identifier

D. Medical License Number

The main concept is using a standard, unique identifier to identify the provider who rendered the service on a CMS-1500 claim. The National Provider Identifier (NPI) is a 10-digit number assigned to individual clinicians and organizations through the National Plan and Provider Enumeration System (NPPES). It is used on HIPAA-standard claims to clearly identify the treating provider across all payers, ensuring consistent and accurate processing. This is why the NPI is the correct choice: it uniquely identifies providers in a national system, unlike the Tax Identification Number (which identifies a business entity), the Social Security Number (personal data not intended for claims), or a medical license number (which varies by state and does not serve as a universal payer identifier).

3. Which code sets are used for diagnoses and procedures in outpatient coding?

A. ICD-10-CM for diagnoses and CPT/HCPCS for procedures

B. ICD-10-CM for diagnoses and ICD-10-PCS for procedures

C. ICD-9-CM for diagnoses and CPT for procedures

D. ICD-10-CM for both diagnoses and procedures

In outpatient coding, the way you separate codes is by purpose: diagnoses are captured with ICD-10-CM, while the procedures and services you perform are coded with CPT or HCPCS. CPT covers most outpatient procedures and services, while HCPCS Level II handles additional items and services not included in CPT, such as certain supplies and durable medical equipment. ICD-10-PCS, on the other hand, is used for inpatient hospital procedures, not outpatient encounters. ICD-9-CM is outdated and no longer used for new codes. So the correct pairing—ICD-10-CM for diagnoses and CPT/HCPCS for procedures—reflects current outpatient coding practice.

4. Which section of the medical record is used to determine the correct Evaluation and Management code used for billing and coding?

A. Assessment and plan

B. Progress notes

C. Plan of care

D. History and physical

Evaluating and coding for E/M services relies on the data documented about the patient's history and the physical examination. The History and Physical section captures the full history (history of present illness, review of systems, past medical, family and social history) and the detailed physical findings from the examination. This information directly supports the level of service billed, especially for new patient visits, because more extensive history and a broader exam justify higher codes. The assessment and plan show the diagnoses and management decisions, and progress notes provide updates, but they don't by themselves supply the complete history and exam data used to determine the code. The plan of care isn't the factor used to set the E/M level. So the History and Physical is the section that most determines the correct E/M code.

5. Which statement best defines a medical consultation for billing purposes?

A. A routine checkup

B. A service performed by a nurse

C. A hospital discharge evaluation

D. A physician's opinion or advice requested by another physician or agency

The key idea here is what constitutes a medical consultation for billing: it's when a physician provides an opinion or advice that is requested by another physician or by a health care agency about a patient's condition. That requested expert input is what differentiates a consultation from other types of encounters. So the statement that describes a physician's opinion or advice requested by another physician or agency best defines a medical consultation for billing. It's not a routine checkup (preventive care), not a service performed by a nurse (nursing care), and not a hospital discharge evaluation (part of discharge planning). In billing terms, the consultation occurs specifically because one clinician or entity asks for another physician's expert input on the patient.

6. After a third-party payer validates a claim, which of the following takes place next?

A. Claim adjudication

B. Payment posting

C. Denied claim notification

D. Patient statement generation

After a third-party payer validates a claim, the next step is adjudication. Adjudication is the payer's processing phase where they apply contract terms, eligibility, coverage, coding rules, and benefit limits to determine how much, if anything, will be paid. It results in a payment decision (paid, partially paid, or denied) and often a remittance advice that explains the calculation. Payment posting happens only after adjudication confirms the payment amount, or after a denial is determined, and patient statement generation typically occurs after payment posting or once any patient responsibility is known. So adjudication is the immediate next step because it sets the actual payment or denial outcome that drives the rest of the workflow.

7. Which modifier is commonly used to indicate store-and-forward telemedicine?

A. -GT

B. -GQ

C. -GZ

D. -GR

Store-and-forward telemedicine means sending patient data (such as images or records) to a clinician at a different location for review later, rather than during a live session. The modifier that communicates this asynchronous approach is -GQ. It signals that the service was delivered via store-and-forward technology. In contrast, real-time interactive telemedicine uses -GT to indicate live audio-video communication, so that modifier wouldn't apply to store-and-forward. The other modifiers cover different telemedicine scenarios and don't reflect the asynchronous workflow.

8. When posting a payment, which item should be included?

A. Patient's responsibility

B. Insurance policy number

C. Provider's license

D. Date of birth

The important point is that payment posting should capture the amount the patient is responsible for after any insurer payment. This portion updates the patient's balance and reflects what remains for the patient to pay, such as copays, coinsurance, and deductibles. The insurance policy number, provider's license, and date of birth serve for verification or identification, but they aren't used to record payments. Including the patient's responsibility keeps the account accurate and supports proper cash flow.

9. Which form must the patient or their representative sign to allow the release of protected health information?

A. A consent form

B. An authorization

C. A waiver

D. A patient agreement

Releasing protected health information to someone outside the care team requires an authorization. This written form names who will receive the information, what specific PHI can be disclosed, the purpose of the disclosure, and when it expires, and it must be signed by the patient or their representative. An authorization gives explicit permission for the outside party to access the PHI, which is the formal control mechanism for disclosures beyond routine uses. By contrast, a consent is typically a general permission for the provider to use PHI for treatment, payment, and healthcare operations within the practice and isn't the standard document used to release records to outside entities. A waiver would remove protections, which isn't the proper tool for authorizing release, and a patient agreement isn't the recognized form for this purpose.

10. Which type of services does the CMS-1500 form primarily bill?

A. Professional services provided by physicians

B. Inpatient hospital services

C. Pharmacy prescriptions

D. Dental procedures

Professional services billed on the CMS-1500 form. This form is the standard for claims filed by individual practitioners (like physicians and other clinicians) for the services they personally render in outpatient or office settings—think office visits, consultations, and procedures performed by a clinician. Inpatient hospital charges are billed on a different form (UB-04), pharmacy claims use the NCPDP format, and dental procedures are typically billed with dental claim forms or CDT codes. So the CMS-1500 is used primarily for professional services provided by physicians and other clinicians.

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://cbcsb.examzify.com

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