

# Certified Billing and Coding Specialist (CBCS) Practice Exam (Sample)

## Study Guide



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**SAMPLE**

## **Questions**

- 1. What does Electronic Data Interchange (EDI) refer to?**
  - A. The process of communicating with patients**
  - B. The transfer of electronic information in a standard format**
  - C. The sharing of paper documents between providers**
  - D. The use of online patient scheduling systems**
- 2. What is a crossover claim?**
  - A. A claim submitted to Medicare only**
  - B. A claim submitted by individuals with both primary and secondary insurance**
  - C. A claim that will be denied by all insurers**
  - D. A claim for emergency services only**
- 3. What is the purpose of generating an aging report each month in a medical practice?**
  - A. To increase patient visits**
  - B. To indicate which claims are outstanding**
  - C. To assess staff performance**
  - D. To determine patient eligibility**
- 4. What information is recorded in Block 33a of the CMS-1500 form?**
  - A. Claim amount**
  - B. National Provider Identification Number**
  - C. Patient ID number**
  - D. Referring physician's name**
- 5. Which tier would include providers and facilities that are out of the network?**
  - A. Tier 3**
  - B. Tier 2**
  - C. Tier 1**
  - D. Tier 4**

- 6. What does precertification entail?**
- A. A review that determines if a procedure can be performed safely**
  - B. Approval for medication coverage by health insurance**
  - C. A written verification of a patient's illness**
  - D. A decision made by a specialist**
- 7. What does a subscriber number represent?**
- A. Verification of benefits**
  - B. Unique code used to identify a subscriber's policy**
  - C. A reference number for claims**
  - D. Identifier for healthcare providers**
- 8. What does implied consent refer to in a medical context?**
- A. A verbal agreement to treatment**
  - B. A situation where no agreement is given**
  - C. A patient performing a routine action indicating consent**
  - D. A written consent form signed by the patient**
- 9. What is the main focus of formulary management in healthcare?**
- A. To manage the costs of prescription drugs**
  - B. To determine hospital service availability**
  - C. To enforce healthcare policies**
  - D. To regulate the number of physicians**
- 10. What information should be included in Block 24E of the CMS-1500 claim form?**
- A. Diagnosis codes**
  - B. Modifiers**
  - C. Place of service**
  - D. Rendering provider**

## **Answers**

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

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## **Explanations**

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## 1. What does Electronic Data Interchange (EDI) refer to?

- A. The process of communicating with patients
- B. The transfer of electronic information in a standard format**
- C. The sharing of paper documents between providers
- D. The use of online patient scheduling systems

Electronic Data Interchange (EDI) specifically refers to the transfer of electronic information in a standard format between different entities, such as healthcare providers, insurers, and other organizations. This process allows for the seamless exchange of critical data, such as patient records, billing information, and insurance claims, without the need for human intervention or paper forms. EDI promotes efficiency and accuracy in communication, reducing the chances of errors and delays that can occur with manual processes. The standard formats used in EDI, such as ANSI X12, ensure consistency and clarity in the data being transmitted, making it easier for various systems to interpret and process the information correctly. The other options pertain to different aspects of healthcare communication and operations but do not capture the specific function of EDI. Communicating with patients, sharing paper documents, and using online scheduling systems are important elements of healthcare management; however, they do not reflect the standardized electronic exchange of information that characterizes EDI.

## 2. What is a crossover claim?

- A. A claim submitted to Medicare only
- B. A claim submitted by individuals with both primary and secondary insurance**
- C. A claim that will be denied by all insurers
- D. A claim for emergency services only

A crossover claim refers to the process in which a healthcare claim is initially submitted to one insurance provider, such as Medicare, the primary payer, and then automatically forwarded to a secondary insurance provider for consideration of additional payment. This scenario occurs when an individual has both primary and secondary insurance coverage. The primary insurer processes the claim first, and any remaining balances eligible for coverage are sent directly to the secondary insurer. This mechanism streamlines the billing process for both providers and patients, ensuring that the individual receives appropriate coverage for their healthcare services. The other options do not align with the definition of a crossover claim. Submitting a claim solely to Medicare does not cover the aspect of having dual coverage, and denying claims does not pertain to the process of crossover claims. Additionally, claims concerning only emergency services do not specifically define a crossover claim either, as crossover claims can encompass a wide range of healthcare services beyond emergencies.

**3. What is the purpose of generating an aging report each month in a medical practice?**

- A. To increase patient visits**
- B. To indicate which claims are outstanding**
- C. To assess staff performance**
- D. To determine patient eligibility**

Generating an aging report each month in a medical practice serves the primary purpose of indicating which claims are outstanding. An aging report categorizes accounts receivable based on the amount of time they have been outstanding, typically organized by specific time frames (e.g., 0-30 days, 31-60 days, 61-90 days, etc.). This report helps medical billers and coders identify claims that have not been paid within a reasonable period. By tracking aging accounts, the practice can efficiently manage its revenue cycle, follow up on unpaid claims in a timely manner, and ensure cash flow is maintained. It also allows the practice to recognize patterns in the payment behavior of insurance companies and adjust their billing practices where necessary. This proactive approach ensures that outstanding claims are addressed before they become stale or require additional follow-up, ultimately supporting the financial health of the practice.

**4. What information is recorded in Block 33a of the CMS-1500 form?**

- A. Claim amount**
- B. National Provider Identification Number**
- C. Patient ID number**
- D. Referring physician's name**

Block 33a of the CMS-1500 form is designated for the National Provider Identifier (NPI) number. This block is crucial because it ensures that the provider's identification is correctly submitted for billing purposes. The NPI is a unique identification number for healthcare providers in the United States, which is essential for processing claims and ensuring proper payment by insurance companies. The inclusion of the NPI in this specific block helps to streamline the claims process by providing a standardized method to identify healthcare providers, thereby reducing the risk of errors or confusion regarding provider identity. This is particularly important in an environment where multiple providers may offer similar services, as it allows for accurate attribution of services rendered. Filling out Block 33a correctly is vital for reimbursement from insurance companies and for compliance with various health regulations. Other options pertain to different types of information not recorded in this particular block, like the claim amount, patient ID number, or referring physician's name, which are captured in other sections of the form.

**5. Which tier would include providers and facilities that are out of the network?**

- A. Tier 3**
- B. Tier 2**
- C. Tier 1**
- D. Tier 4**

The correct answer is associated with the tier that includes providers and facilities that operate outside of the established network. In many health insurance plans, tiered structures are used to categorize providers based on their network status and the costs associated with using them. Typically, Tier 1 represents in-network providers, offering the lowest out-of-pocket costs for patients. Tier 2 often includes preferred out-of-network providers, which may offer some level of coverage at a higher cost to the patient. Tier 3 is commonly designated for out-of-network providers who do not have any agreement with the insurance plan, making it the tier where patients have the highest out-of-pocket expenses. Therefore, this tier is crucial for identifying providers and facilities that are outside the insurance network, which aligns with the nature of the question. Understanding the tiering system in health insurance is essential for effective billing and coding, as it directly impacts reimbursement rates and patient costs. Recognizing where out-of-network providers fall within this system allows billing and coding specialists to accurately advise patients on their potential financial responsibilities and facilitate proper claims processing.

**6. What does precertification entail?**

- A. A review that determines if a procedure can be performed safely**
- B. Approval for medication coverage by health insurance**
- C. A written verification of a patient's illness**
- D. A decision made by a specialist**

Precertification is a process that involves a review by a health insurance company to determine whether a specific medical procedure or service is medically necessary, appropriate, and safe to be performed for a particular patient. This process often takes place before the service is delivered, ensuring that any requested medical treatment meets the insurer's criteria for coverage. In scenarios where a procedure is being considered, the insurance company will assess factors such as the patient's medical condition, the necessity of the procedure, and whether there are alternative treatments that should be tried first. This helps to ensure that the patient receives appropriate care while managing costs for both the patient and the insurance provider. While other options refer to important aspects of healthcare processes, they do not accurately describe the precertification process. For instance, medication coverage involves different prior authorization processes, while a written verification of a patient's illness and decisions made by specialists relate to other aspects of patient management and communication but do not specifically define precertification.

## 7. What does a subscriber number represent?

- A. Verification of benefits
- B. Unique code used to identify a subscriber's policy**
- C. A reference number for claims
- D. Identifier for healthcare providers

A subscriber number represents a unique code used to identify a subscriber's policy with an insurance company. This number is crucial in medical billing and coding, as it links the individual receiving services to their specific health insurance plan. It ensures that claims are processed correctly and that the provider can verify coverage and benefits associated with that subscriber. Having a unique subscriber number allows healthcare providers to efficiently track and manage claims, so they can receive reimbursement for services rendered. It helps to reduce errors in billing and ensures seamless communication between the healthcare provider and the insurance company regarding the patient's coverage and eligibility for benefits. While verification of benefits and references for claims are important processes in healthcare billing, these actions rely on the subscriber number to facilitate accurate tracking and processing. Additionally, the identifier for healthcare providers refers to a separate identification system, such as the National Provider Identifier (NPI), which is not related to the subscriber's insurance policy.

## 8. What does implied consent refer to in a medical context?

- A. A verbal agreement to treatment
- B. A situation where no agreement is given
- C. A patient performing a routine action indicating consent**
- D. A written consent form signed by the patient

Implied consent in a medical context refers to situations where a patient's actions indicate that they agree to a treatment or procedure, even if they have not explicitly stated so verbally or in writing. For instance, if a patient presents themselves for a routine examination or a medical procedure and follows through with the actions involved, such as rolling up their sleeve for a blood draw, this behavior suggests that they consent to the care being provided. This concept is important in healthcare because it allows for necessary medical actions to be taken promptly, particularly in situations where obtaining explicit consent may not be feasible, such as emergencies. Patients generally understand that by engaging in routine medical visits and actions, they are giving their consent implicitly. Additionally, implied consent is widely accepted for procedures that are understood to have low risk and for which the patient has a reasonable expectation of the benefits.

**9. What is the main focus of formulary management in healthcare?**

- A. To manage the costs of prescription drugs**
- B. To determine hospital service availability**
- C. To enforce healthcare policies**
- D. To regulate the number of physicians**

Formulary management primarily focuses on managing the costs of prescription drugs within the healthcare system. A formulary is essentially a list of medications that are approved for use, typically by a specific health plan or provider organization. By managing this list, healthcare organizations strive to control prescription drug expenses while ensuring that patients have access to necessary medications. This process involves evaluating the effectiveness, safety, and cost-effectiveness of medications to make informed decisions about which drugs to include in the formulary. Furthermore, formulary management can involve negotiating prices with drug manufacturers and determining co-payment structures for patients, all aimed at reducing overall drug expenditure for the healthcare provider and the patient. Other choices relate to different areas of healthcare management. For instance, determining hospital service availability addresses operational service issues rather than the financial aspect of medications. Enforcing healthcare policies involves regulatory compliance and governance but is not specifically about drug management. Regulating the number of physicians pertains to workforce management and supply, which again differs from the focus on drug costs and formulary management.

**10. What information should be included in Block 24E of the CMS-1500 claim form?**

- A. Diagnosis codes**
- B. Modifiers**
- C. Place of service**
- D. Rendering provider**

Block 24E of the CMS-1500 claim form is designated for modifiers that provide additional details regarding the procedure or service provided. Modifiers are essential because they can alter the meaning of a procedure code or indicate that a service or procedure was performed under specific circumstances that may affect reimbursement. By using modifiers effectively, healthcare providers ensure that payers have all the necessary information to process the claim accurately. In contrast, other elements such as diagnosis codes, place of service, and rendering provider information have specific blocks they correspond to on the CMS-1500 form. For instance, diagnosis codes are typically placed in Block 21, place of service is included in Block 24B, and the rendering provider's name would be recorded in Block 24J. Understanding the proper placement of different types of information on the CMS-1500 form is crucial for accurate claim submissions and successful reimbursement.