

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

## Study Guide



**Everything you need from our exam experts!**

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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. What is the role of the encounter form in the medical billing process?**
  - A. To assign diagnosis codes**
  - B. To summarize the clinical history of the patient**
  - C. To collect information for follow-up appointments**
  - D. To compile information for billing and insurance claims**
- 2. What are the main goals of ICD-10-PCS?**
  - A. To compile patient demographics and improve billing software**
  - B. To enhance coding accuracy, reduce training effort, and improve physician communication**
  - C. To focus exclusively on outpatient procedures and diagnoses**
  - D. To replace all previous coding systems with a single code set**
- 3. What does a self-insured health plan typically depend on for financial management?**
  - A. Third-party insurance premiums**
  - B. Employer's financial reserves and risk management**
  - C. Government assistance programs**
  - D. Private health insurance market rates**
- 4. What is the primary purpose of the CMS-1500 claim form?**
  - A. To submit claims for payment by Medicare**
  - B. To track patient demographics**
  - C. To document medical history**
  - D. To record patient vital signs**
- 5. What standardized formats are used in the electronic filing of claims?**
  - A. ISO standards**
  - B. HIPAA standard transactions**
  - C. ICD coding standards**
  - D. CMS regulation formats**

- 6. What does an insurance carrier typically do upon receiving a claim?**
- A. Immediately issue payment without review**
  - B. Process, verify information, and determine eligibility for coverage**
  - C. Reject all claims over a certain amount**
  - D. Only cover claims that are submitted electronically**
- 7. What is one reason Medicaid is considered the payer of last resort?**
- A. It covers only emergency visits**
  - B. It requires prior authorization for all services**
  - C. It is intended for low-income individuals**
  - D. It only covers catastrophic events**
- 8. What does Medicare Advantage (MA) offer?**
- A. A combination of Medicare Parts A and B benefits**
  - B. Only hospital coverage**
  - C. Covers outpatient treatments exclusively**
  - D. Standalone prescription drug coverage**
- 9. What does a Category I CPT code cover?**
- A. Hospital inpatient coding only**
  - B. Physicians' services and hospital outpatient coding**
  - C. Emergency and urgent care services**
  - D. Pharmaceutical coding**
- 10. What does the 837 format primarily relate to?**
- A. Provider enrollment**
  - B. Electronic claims submission**
  - C. Patient intake forms**
  - D. Prescription processing**



## **Answers**

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

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## **Explanations**

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## **1. What is the role of the encounter form in the medical billing process?**

- A. To assign diagnosis codes**
- B. To summarize the clinical history of the patient**
- C. To collect information for follow-up appointments**
- D. To compile information for billing and insurance claims**

The encounter form plays a crucial role in the medical billing process by compiling information needed for billing and insurance claims. This form, often referred to as a superbill, contains key details about the patient's visit, including the services provided, the diagnoses made during the visit, and any relevant procedures that were performed. By consolidating this information, the encounter form ensures that the medical office can accurately bill the patient and submit claims to insurance providers. The encounter form is essential for ensuring that all necessary data is captured accurately, so that billing can proceed smoothly and billing errors can be minimized. This includes not only the diagnoses and procedures but also other necessary billing codes and patient details, which are critical for processing insurance claims efficiently. Therefore, its primary function is to provide a comprehensive package of information that supports the financial aspects of patient care.

## **2. What are the main goals of ICD-10-PCS?**

- A. To compile patient demographics and improve billing software**
- B. To enhance coding accuracy, reduce training effort, and improve physician communication**
- C. To focus exclusively on outpatient procedures and diagnoses**
- D. To replace all previous coding systems with a single code set**

The main goals of ICD-10-PCS are closely aligned with enhancing coding accuracy, reducing training effort, and improving communication between healthcare providers. This system was developed specifically for the standardized classification of procedures performed in inpatient settings. Enhanced coding accuracy ensures that medical procedures are accurately documented, which ultimately supports better patient care and a more reliable database for health statistics. By reducing the training required for coders, the implementation of ICD-10-PCS allows for a more efficient transition to the coding system, enabling coders to familiarize themselves more quickly with the new standards. Additionally, improving communication among physicians becomes pivotal as the intricacies of procedures can be captured more comprehensively with the detailed coding structure of ICD-10-PCS, helping to convey the nature and complexity of procedures performed. The other options do not capture the holistic goals of ICD-10-PCS. For instance, compiling patient demographics and improving billing software does not convey the primary focus of this particular coding system. Additionally, focusing exclusively on outpatient procedures would misrepresent the purpose of ICD-10-PCS, which applies to inpatient procedures. Finally, while it did intend to update coding practices, it did not aim to completely replace all previous coding systems with a single code set, as there are various coding

**3. What does a self-insured health plan typically depend on for financial management?**

- A. Third-party insurance premiums**
- B. Employer's financial reserves and risk management**
- C. Government assistance programs**
- D. Private health insurance market rates**

A self-insured health plan operates differently from traditional insurance models, where the employer assumes the financial risk for providing health care benefits to its employees. This means that instead of paying a premium to a third-party insurer, the employer sets aside funds to cover medical claims incurred by employees. As such, financial management of a self-insured health plan significantly relies on the employer's financial reserves and effective risk management strategies. In this model, employers must accurately estimate healthcare expenses, maintain sufficient reserves to cover potential claims, and implement cost-control measures such as wellness programs or negotiating directly with healthcare providers. This approach not only allows for flexibility in benefit design but can also result in cost savings over time if managed properly. Understanding these aspects is crucial for a Certified Billing and Coding Specialist since it impacts how claims are processed, the expected costs associated with healthcare services, and the financial planning required to support self-insured plans.

**4. What is the primary purpose of the CMS-1500 claim form?**

- A. To submit claims for payment by Medicare**
- B. To track patient demographics**
- C. To document medical history**
- D. To record patient vital signs**

The primary purpose of the CMS-1500 claim form is to submit claims for payment by Medicare as well as other insurance payers. This standardized form is crucial for billing purposes because it contains the necessary information healthcare providers must present to insurance companies to receive reimbursement for services rendered. The form captures vital details such as the patient's insurance information, the services provided, and relevant codes, ensuring that claims are processed efficiently and correctly. While tracking patient demographics, documenting medical history, and recording patient vital signs are important components of patient care and medical records, these functions are not the main focus of the CMS-1500 form. Instead, the structure of the form is tailored specifically to facilitate communication between healthcare providers and payers regarding the payment for medical services.

**5. What standardized formats are used in the electronic filing of claims?**

- A. ISO standards**
- B. HIPAA standard transactions**
- C. ICD coding standards**
- D. CMS regulation formats**

The correct choice focuses on HIPAA standard transactions, which play a crucial role in the electronic filing of claims within the healthcare industry. HIPAA, or the Health Insurance Portability and Accountability Act, set forth a series of regulations that include standardized formats for electronic data interchange (EDI). These standards ensure that healthcare providers, payers, and other entities can exchange data reliably and securely. Specifically, HIPAA established standardized transaction codes for various types of healthcare transactions, including claims submissions, eligibility inquiries, payment remittances, and more. These standardized formats help streamline administrative processes, reduce errors, and enhance the efficiency of healthcare operations by providing a consistent framework for data communication. Other options, while relevant in their contexts, do not specifically address the standardized formats for electronic claims filing as precisely as HIPAA standards do. ISO standards pertain to a wide range of industrial and technological guidelines, ICD coding standards relate primarily to the classification of diseases and health conditions, and CMS regulation formats refer more broadly to compliance regulations rather than the specific electronic claim filing processes dictated by HIPAA.

**6. What does an insurance carrier typically do upon receiving a claim?**

- A. Immediately issue payment without review**
- B. Process, verify information, and determine eligibility for coverage**
- C. Reject all claims over a certain amount**
- D. Only cover claims that are submitted electronically**

When an insurance carrier receives a claim, the typical procedure is to process the claim by verifying the information submitted and determining the eligibility for coverage. This involves checking the details against the policy provisions, ensuring that the claim is valid and that the services provided fall under the patient's coverage. The processing phase ensures that every aspect of the claim is legitimate, which helps in preventing fraud and ensuring that only eligible claims receive payment. This thorough verification process guards against incorrect or fraudulent claims and allows the insurance carrier to maintain financial responsibility. Claims must adhere to specific guidelines and criteria set by the insurer, and this step is critical in ensuring compliance with those regulations. The other options provided do not accurately reflect the standard practices of insurance carriers. For example, issuing payment immediately without review would compromise the quality assurance needed to manage risk effectively. Rejecting all claims over a certain amount is also not typical, as claims are evaluated on their merits rather than their monetary value. Similarly, the requirement for electronic submission is not a universal standard across all insurance carriers, as many still accept paper claims under certain conditions.

**7. What is one reason Medicaid is considered the payer of last resort?**

- A. It covers only emergency visits**
- B. It requires prior authorization for all services**
- C. It is intended for low-income individuals**
- D. It only covers catastrophic events**

Medicaid is considered the payer of last resort primarily because it is designed to provide healthcare coverage to low-income individuals and families. This means that before Medicaid pays for any healthcare services, other sources of payment must first be exhausted. This could include private insurance, Medicare, or other public programs that provide financial assistance for healthcare costs. The intent behind this is to ensure that Medicaid serves its primary purpose of supporting those who may not have the means to afford healthcare otherwise, without unnecessarily depleting its resources by being the first option for payment. While the other options do mention aspects that may relate to Medicaid, they do not capture the core principle of the program's functioning as the payer of last resort. For instance, Medicaid does not only cover emergency visits, it's not universally subject to prior authorization for all services, and it does not strictly limit coverage to catastrophic events. These factors do not define the fundamental aspect of Medicaid's operational framework as much as its role in prioritizing coverage for the financially vulnerable.

**8. What does Medicare Advantage (MA) offer?**

- A. A combination of Medicare Parts A and B benefits**
- B. Only hospital coverage**
- C. Covers outpatient treatments exclusively**
- D. Standalone prescription drug coverage**

Medicare Advantage (MA) plans, also known as Medicare Part C, are designed to provide an alternative way to receive the benefits included in Medicare Parts A (hospital insurance) and B (medical insurance). These plans are offered by private insurance companies that contract with Medicare to provide all the benefits of original Medicare, often including additional services. By choosing a Medicare Advantage plan, beneficiaries gain both hospital and outpatient medical coverage under one plan, which can simplify their healthcare management. These plans typically also incorporate additional benefits not covered by original Medicare, such as vision, dental, and wellness programs, making them a comprehensive health insurance option for many seniors. Standalone prescription drug coverage is typically offered separately through Medicare Part D but is not a defining feature of Medicare Advantage plans. While some MA plans may include prescription drug coverage, it is not guaranteed that all MA plans do; thus, it is essential for beneficiaries to review specific plan details. Outpatient treatments and hospital coverage are generally both encompassed in the MA plans, not limited to just one aspect of care.

## 9. What does a Category I CPT code cover?

- A. Hospital inpatient coding only
- B. Physicians' services and hospital outpatient coding**
- C. Emergency and urgent care services
- D. Pharmaceutical coding

A Category I CPT code covers a wide range of procedures and services primarily related to physicians' services and hospital outpatient coding. These codes are utilized to describe services provided by healthcare professionals, including evaluation and management services, surgical procedures, radiological services, and other specific clinical activities performed by physicians, which are critical for billing and documentation purposes in outpatient and professional settings. This classification ensures proper communication about the level and type of medical services being delivered, allowing healthcare providers to more accurately claim reimbursement from insurers. By encompassing both physicians' services and hospital outpatient coding, Category I codes serve a broad spectrum of healthcare scenarios, which is essential in efficient healthcare delivery and understanding healthcare billing workflows.

## 10. What does the 837 format primarily relate to?

- A. Provider enrollment
- B. Electronic claims submission**
- C. Patient intake forms
- D. Prescription processing

The 837 format refers to the specific file format used for the electronic submission of healthcare claims. This format is established by the X12 standards set by the Accredited Standards Committee (ASC). Utilizing the 837 format enables healthcare providers and payers to exchange claims information in an efficient, standardized manner. It facilitates the streamlining of the claims process, helping to reduce the time it takes for claims to be processed and reimbursed, which is vital in the healthcare billing and coding environment. This standardized electronic approach enhances accuracy and reduces errors associated with paper claims, making it a critical component in the modern healthcare system. In contrast, the other options listed pertain to different areas of healthcare management. Provider enrollment involves registering and verifying a provider's credentials within a health plan or organization, patient intake forms are used to collect patient information upon their arrival for services, and prescription processing relates to the management of medication orders and pharmacy services. None of these directly involve the electronic claim submission process that the 837 format addresses.



## 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](mailto:hello@examzify.com).**

**Or visit your dedicated course page for more study tools and resources:**

**<https://certifiedbillingandcodingspecialist.examzify.com>**

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