

CERTIFIED BILLING AND CODING SPECIALIST (CBCS) PRACTICE EXAM (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

**VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE**

[https://
certifiedbillingandcodingspecialist.examzify.com](https://certifiedbillingandcodingspecialist.examzify.com)



Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.

ALL RIGHTS RESERVED.

No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.

Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.

SAMPLE

Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	16

SAMPLE

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

SAMPLE

- 1. 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
- 2. What is typically found in Block 21 of the CMS-1500 claim form?**
 - A. Insurance information
 - B. Diagnosis codes
 - C. Patient name
 - D. Provider signature
- 3. What defines a dirty claim?**
 - A. A claim that is accurate and complete
 - B. A claim that is inaccurate, incomplete, or contains other errors
 - C. A claim submitted only for emergency services
 - D. A claim that has been processed and approved
- 4. CPT codes are primarily used to describe what?**
 - A. Healthcare facility accreditation statuses
 - B. Healthcare services rendered by providers
 - C. Patient demographics and insurance information
 - D. Clinical outcomes of treatment
- 5. What does the process of abstracting involve?**
 - A. Creating new patient records from scratch
 - B. Reviewing health records to code medical documentation
 - C. Training coders on specific documentation standards
 - D. Categorizing procedures for insurance reimbursement

6. What is the primary characteristic of a Health Maintenance Organization (HMO)?

- A. Patients can see any physician without restrictions
- B. Patients are required to use a list of approved providers, except in emergencies
- C. It allows direct access to specialists without referrals
- D. It only covers surgical procedures

7. Which block on the CMS-1500 form indicates the date of service?

- A. Block 1
- B. Block 24A
- C. Block 22
- D. Block 33

8. What is the primary purpose of a referral in healthcare?

- A. A written recommendation to a specialist
- B. A request for a patient's medication
- C. A notification of a patient's discharge
- D. An appeal for insurance coverage

9. Which of the following best describes what the MS-DRG Grouper takes into account?

- A. The hospital's geographic location
- B. The level of services provided and severity of illness
- C. Patient demographics only
- D. Outpatient versus inpatient coding rules

10. What process occurs after a third-party payer validates a claim?

- A. Claim submission
- B. Claim rejection
- C. Claim adjudication
- D. Claim approval

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. 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.

2. What is typically found in Block 21 of the CMS-1500 claim form?

- A. Insurance information
- B. Diagnosis codes**
- C. Patient name
- D. Provider signature

Block 21 of the CMS-1500 claim form is designated for diagnosis codes. This section is critical because it allows healthcare providers to specify the patient's diagnoses relevant to the services rendered. By listing the diagnosis codes here, it enables insurance companies to understand the medical necessity of the services provided and facilitates the adjudication process. The formatting in Block 21 adheres strictly to coding guidelines, and the codes entered here directly correlate with the Current Procedural Terminology (CPT) codes used in Block 24, ensuring a clear link between the provided services and the reasons for those services based on the given diagnoses. This linkage is essential in claims processing, as it provides the insurance payer with the context needed to approve the claim.

3. What defines a dirty claim?

- A. A claim that is accurate and complete
- B. A claim that is inaccurate, incomplete, or contains other errors**
- C. A claim submitted only for emergency services
- D. A claim that has been processed and approved

A dirty claim refers to a claim that is inaccurate, incomplete, or contains errors in any form. When a claim has issues such as incorrect patient information, wrong procedure codes, or missing documentation, it may be deemed "dirty." This classification is crucial because dirty claims can lead to delays in payment, denial of claims, or even audits, complicating the billing process for healthcare providers. In the context of billing and coding, it's essential to ensure that all claims submitted are clean and free from errors to facilitate timely reimbursement. Therefore, recognizing and addressing the characteristics of dirty claims helps in maintaining the efficiency of the billing process and ensuring that healthcare providers receive compensation for their services without unnecessary hindrances. Accurate and complete claims contribute to a streamlined process, while dirty claims necessitate rework and resubmission, which can be both time-consuming and costly for practices.

4. CPT codes are primarily used to describe what?

- A. Healthcare facility accreditation statuses
- B. Healthcare services rendered by providers**
- C. Patient demographics and insurance information
- D. Clinical outcomes of treatment

CPT codes, or Current Procedural Terminology codes, are specifically designed to describe healthcare services and procedures performed by healthcare providers. These codes provide a standardized way to communicate the types of services rendered during a patient encounter, facilitating billing and documentation processes in healthcare. CPT codes categorize a wide range of services, including surgical procedures, evaluation and management services, and various non-surgical procedures. Their primary purpose is to ensure that providers can accurately bill for the services they perform, which is crucial for the reimbursement process from insurance companies and other payers. While healthcare facility accreditation statuses, patient demographic and insurance information, and clinical outcomes are all important components of healthcare administration and patient care, they do not fall under the scope of what CPT codes represent. CPT codes focus exclusively on the procedures and services provided to patients, making them essential for billing and coding specialists in the healthcare industry.

5. What does the process of abstracting involve?

- A. Creating new patient records from scratch
- B. Reviewing health records to code medical documentation**
- C. Training coders on specific documentation standards
- D. Categorizing procedures for insurance reimbursement

The process of abstracting refers specifically to the thorough examination and review of health records in order to extract relevant medical information necessary for coding. Abstracting is crucial in the coding process because it involves gathering key details such as diagnoses, procedures, and other clinical data from patient records. This information is then used to assign the appropriate codes according to medical coding systems (like ICD, CPT, or HCPCS), which are essential for insurance claims, statistical analysis, and patient care management. In contrast, creating new patient records from scratch does not fall under the abstracting process, as abstracting involves reviewing existing records rather than generating new documentation. Training coders on specific documentation standards, while important, relates more to educating individuals rather than extracting data from health records. Lastly, categorizing procedures for insurance reimbursement is an outcome of the coding process, but it does not encompass the act of abstracting health information from patient records. Thus, the correct choice highlights the core activity associated with abstracting in the context of medical billing and coding.

6. What is the primary characteristic of a Health Maintenance Organization (HMO)?

- A. Patients can see any physician without restrictions
- B. Patients are required to use a list of approved providers, except in emergencies**
- C. It allows direct access to specialists without referrals
- D. It only covers surgical procedures

The primary characteristic of a Health Maintenance Organization (HMO) is that patients are required to use a list of approved providers, except in emergencies. This model emphasizes a network of healthcare providers who offer services to members at reduced costs, allowing for more managed and coordinated care. By requiring members to choose from a designated panel of providers, HMOs aim to control healthcare costs and ensure that patients receive care that is not only affordable but also suitable for their specific health needs. In this structure, if a patient wishes to see a specialist, they typically must go through their primary care physician and obtain a referral, adhering to the HMO guidelines. This helps streamline the process and keeps management centralized, allowing for better tracking of patient care and outcomes. Other options, such as unrestricted access to any physician or direct access to specialists without referrals, do not align with the HMO model. These scenarios are more characteristic of Preferred Provider Organizations (PPOs) or other healthcare plan structures that promote greater flexibility in provider choice. Additionally, the assertion that HMOs only cover surgical procedures is misleading, as they cover a range of medical services, including preventive care, outpatient care, and hospitalization, not just surgical services.

7. Which block on the CMS-1500 form indicates the date of service?

- A. Block 1
- B. Block 24A**
- C. Block 22
- D. Block 33

Block 24A on the CMS-1500 form is specifically designated for the "Date(s) of Service." This block allows healthcare providers to enter the exact date when the services were performed for the patient. Accurate documentation of the date of service is crucial for billing purposes, as it helps to ensure that claims are processed correctly and timely, aligning with insurance coverage periods and certain billing guidelines. Other blocks serve different purposes: Block 1 is for the insured's information, Block 22 is for the resubmission of claims or to indicate the original claim number, and Block 33 is where the provider's billing information and NPI (National Provider Identifier) can be entered. Understanding the specific use of each block is essential for accurately completing the CMS-1500 form and facilitating proper claim submissions to insurance companies.

8. What is the primary purpose of a referral in healthcare?

A. A written recommendation to a specialist

B. A request for a patient's medication

C. A notification of a patient's discharge

D. An appeal for insurance coverage

The primary purpose of a referral in healthcare is to provide a written recommendation to a specialist. Referrals are crucial in the healthcare process, as they facilitate access to specialized care that a primary care provider deems necessary for the patient's condition. When a physician identifies a need for a specialist's expertise—due to complex conditions, specialized testing, or treatment options—they create a referral that ensures the patient receives appropriate care. This communication helps coordinate treatment, ensures continuity of care, and allows for comprehensive management of the patient's health. The other options represent different functions in the healthcare system. Requests for a patient's medication are more related to pharmaceutical management rather than referrals. Notifications of a patient's discharge pertain to the conclusion of inpatient care and the transition back to outpatient management. Appeals for insurance coverage involve addressing denied claims or requesting additional benefits, which do not relate to making specialized medical recommendations.

9. Which of the following best describes what the MS-DRG Grouper takes into account?

A. The hospital's geographic location

B. The level of services provided and severity of illness

C. Patient demographics only

D. Outpatient versus inpatient coding rules

The MS-DRG Grouper, or Medicare Severity Diagnosis Related Group Grouper, is a tool used to classify hospital cases into one of the groups that fund Medicare inpatient hospital services. It takes into account several critical factors when determining how to categorize a patient's hospital stay and the associated reimbursement. The correct choice focuses on the level of services provided and the severity of illness, which are essential elements in determining the appropriate DRG assignment. The grouper assesses the diagnosis, various procedures performed during the hospital stay, the presence of comorbidities or complications, and the overall complexity of the case. This ensures that hospitals are appropriately reimbursed based on the resource intensity of the care provided to patients with different conditions. This approach reflects the reality that patients with more severe illnesses or those requiring more complex care will generally involve higher costs for the hospital and thus warrant a higher reimbursement level. By considering both the services rendered and the severity of each patient's condition, the MS-DRG system aims to create a fair and equitable payment model. In contrast, factors such as the hospital's geographic location, patient demographics, or the distinction between outpatient and inpatient services do not directly influence the MS-DRG classification as directly as the severity and complexity of care do.

10. What process occurs after a third-party payer validates a claim?

- A. Claim submission
- B. Claim rejection
- C. Claim adjudication
- D. Claim approval

After a third-party payer validates a claim, the next step in the process is claim adjudication. During this phase, the payer reviews the claim in detail to determine whether it meets their guidelines for payment, which includes assessing the accuracy of the information, appropriateness of the services rendered, and verification of patient eligibility and coverage for the services. Claim adjudication involves various outcomes such as approval, partial payment, or denial based on the terms of the insurance policy. This process is crucial as it determines the financial responsibility of both the payer and the patient. Effective adjudication ensures that claims are processed efficiently and accurately, facilitating proper reimbursement for the healthcare provider while ensuring that the payer adheres to their policies and contractual obligations. In contrast, claim submission is the initial step where claims are sent to the payer, claim rejection is when a claim fails to meet the criteria set by the payer resulting in it not being processed, and claim approval occurs when the claim is found acceptable for payment, which is a result of the adjudication process rather than a step that follows it.

SAMPLE

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://certifiedbillingandcodingspecialist.examzify.com>

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

SAMPLE