

# CPB (Certified Professional Biller) Certification Practice Exam (Sample)

## Study Guide



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## **Questions**

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- 1. What does HCPCS stand for?**
  - A. Healthcare reimbursement Account**
  - B. Health Insurance portability and accountability Act of 1996**
  - C. Health Care Provider Coding System**
  - D. Healthcare Common Procedure Coding System**
- 2. What is the universal claim form used by physician's offices?**
  - A. Centers of Medicare and Medicaid Services-150 (CMS-1500)**
  - B. Internal Revenue Service Form W-2**
  - C. Department of Motor Vehicles Form DLF45**
  - D. Social Security Administration Form SSA-10**
- 3. CLIA signifies the acronym for which regulatory act?**
  - A. Clinical Laboratory Implementation Act**
  - B. Certified Laboratory Improvement Act**
  - C. California Laboratory Investigation Act**
  - D. Clinical Laboratory Improvement Act**
- 4. What determines the reimbursement rates for severity of illness and risk of mortality under the ARP-DRG system?**
  - A. Minor and moderate subclasses**
  - B. Major and extreme subclasses**
  - C. Superficial and deep subclasses**
  - D. Minute and significant subclasses**
- 5. What is the full form of EPO as used in healthcare administration?**
  - A. Electronic Media Claim**
  - B. Exclusive Provider Organization**
  - C. Electronic Health Record**
  - D. Employer Group Health Plan**

- 6. What is provided by a cafeteria plan, as per the text?**
- A. Health Insurance Plans**
  - B. Retirement Plans**
  - C. Meal Plans**
  - D. Health Benefit Plans and Extra Coverage Options**
- 7. Interpreting a medical term with the suffix "-emia," what does it relate to?**
- A. Bad, painful**
  - B. Blood condition**
  - C. Red**
  - D. Pain**
- 8. What do the prefixes "gyn-, gyne-, gynec-" relate to?**
- A. record**
  - B. women, female**
  - C. instrument for reading**
  - D. blood**
- 9. Which acronym represents Hospital Payment Monitoring Program?**
- A. Home Health Resource Group**
  - B. Health Personnel Shortage Area**
  - C. Hospital Payment Monitoring Program**
  - D. Health Plan Employer Data and Information Set**
- 10. What does a breach of confidentiality refer to?**
- A. Unwanted Patient Calls**
  - B. Unauthorized Release of Patient Information**
  - C. Coding Errors**
  - D. Lost Medical Records**

## **Answers**

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

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## **Explanations**

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## **1. What does HCPCS stand for?**

- A. Healthcare reimbursement Account**
- B. Health Insurance portability and accountability Act of 1996**
- C. Health Care Provider Coding System**
- D. Healthcare Common Procedure Coding System**

The abbreviation HCPCS stands for Healthcare Common Procedure Coding System. This is a standardized coding system used in the United States to identify medical procedures, supplies, products, and services provided to patients. It is essential for billing and documentation purposes, as it helps ensure that healthcare providers are reimbursed correctly for their services. The HCPCS is organized into two levels: Level I consists of the Current Procedural Terminology (CPT) codes, which are developed and maintained by the American Medical Association, while Level II codes cover non-physician services and supplies, such as ambulance services and durable medical equipment, which are not included in the CPT. This coding system is critical for health care billing, as it offers a standardized method for reporting and claiming services. In contrast, the other options do not represent the correct full form of HCPCS. Healthcare reimbursement accounts pertain to financial management in healthcare rather than coding. The Health Insurance Portability and Accountability Act of 1996, while significant for health information privacy and data security, is unrelated to the coding system. Finally, Health Care Provider Coding System, while seemingly close, is not the officially recognized term and does not capture the essence of the commonality and procedure aspects emphasized in the correct full form.

## **2. What is the universal claim form used by physician's offices?**

- A. Centers of Medicare and Medicaid Services-150 (CMS-1500)**
- B. Internal Revenue Service Form W-2**
- C. Department of Motor Vehicles Form DLF45**
- D. Social Security Administration Form SSA-10**

The correct answer is the Centers of Medicare and Medicaid Services-1500 (CMS-1500) form. This universal claim form is specifically designed for billing professional services provided by physicians and other healthcare professionals. The CMS-1500 form is widely accepted by insurance companies and is used to submit claims for reimbursement of medical services rendered to patients. It provides necessary information regarding the patient's care, the provider's details, diagnoses, and procedures performed, ensuring a standardized format that facilitates the claims process. The other options, such as the IRS Form W-2, are unrelated to medical billing as they pertain to the reporting of wages and tax information. The Department of Motor Vehicles Form DLF45 is not associated with healthcare; it is typically related to vehicle registration or licensing. Similarly, the Social Security Administration Form SSA-10 is a form used for disability benefits applications, not for healthcare billing. Therefore, the CMS-1500 form is the only choice that specifically addresses the needs of physicians' offices in the realm of medical billing.

**3. CLIA signifies the acronym for which regulatory act?**

- A. Clinical Laboratory Implementation Act**
- B. Certified Laboratory Improvement Act**
- C. California Laboratory Investigation Act**
- D. Clinical Laboratory Improvement Act**

The acronym CLIA stands for the Clinical Laboratory Improvement Amendments, which is reflected in the correct choice. This act was enacted to establish standards for laboratory testing and ensure the accuracy of laboratory results. CLIA regulations apply to all clinical laboratories in the United States, mandating that they meet specific quality standards through licensing and certification. The act is primarily concerned with the process of laboratory testing for human specimens and encompasses a wide range of testing, which includes those performed in hospitals, private laboratories, and physician offices. It promotes the usability of the laboratory services without compromising the quality of care provided to patients. The other options offered do not correctly represent the full name or intent of the regulatory framework associated with CLIA, which emphasizes the improvement and quality assurance of clinical laboratory services.

**4. What determines the reimbursement rates for severity of illness and risk of mortality under the ARP-DRG system?**

- A. Minor and moderate subclasses**
- B. Major and extreme subclasses**
- C. Superficial and deep subclasses**
- D. Minute and significant subclasses**

The correct answer reflects the fact that the ARP-DRG (All Patient Refined Diagnosis Related Groups) system categorizes patients based on the severity of their illness and the risk of mortality. The system specifically utilizes major and extreme subclasses to determine reimbursement rates effectively. Major subclasses correspond to a higher level of severity and indicate that a patient's condition requires more intensive resources and care, which justifies higher reimbursement rates. Extreme subclasses represent cases that pose the highest risk of mortality and indicate that the treatment and care needed are significantly more complex and resource-intensive. This hierarchy ensures that reimbursement is aligned with the intensity of the medical services required, thus providing a more equitable and accurate payment structure for healthcare providers based on the needs of their patients. The other terminology options listed do not align with the designations used in the ARP-DRG system and do not reflect the necessary granularity required for proper classification, which reinforces why major and extreme subclasses are essential for determining reimbursement rates accurately.

**5. What is the full form of EPO as used in healthcare administration?**

- A. Electronic Media Claim**
- B. Exclusive Provider Organization**
- C. Electronic Health Record**
- D. Employer Group Health Plan**

The full form of EPO in healthcare administration is Exclusive Provider Organization. This term describes a type of managed care health insurance plan that offers a network of healthcare providers to its members. The key feature of an EPO is that it requires members to use the services of providers that are within this network for coverage, except in an emergency. This structure incentivizes cost control and encourages members to seek care within the network to avoid higher out-of-pocket expenses. In contrast, the other options represent different concepts within healthcare administration. Electronic Media Claim refers to the method of submitting claims electronically rather than on paper. Electronic Health Record pertains to the digital version of a patient's paper chart, containing their comprehensive health history. An Employer Group Health Plan is a health insurance plan that an employer offers to employees, often encompassing more than just the exclusive provider model. Each of these terms, while relevant in the healthcare context, serves a distinct purpose and accurately reflects its specific role within the industry.

**6. What is provided by a cafeteria plan, as per the text?**

- A. Health Insurance Plans**
- B. Retirement Plans**
- C. Meal Plans**
- D. Health Benefit Plans and Extra Coverage Options**

A cafeteria plan offers flexibility to employees by allowing them to choose from a variety of benefits to suit their individual needs. This can include health benefit plans, which encompass various types of medical coverage, as well as additional options like dental and vision insurance, flexible spending accounts, and other non-cash benefits. The key aspect of a cafeteria plan is that it provides a menu of choices, allowing employees to tailor their benefits package according to their personal circumstances, which often results in increased satisfaction and better alignment with individual needs. The concept of cafeteria plans stems from the idea of providing choices rather than a one-size-fits-all approach. Therefore, the designation of "Health Benefit Plans and Extra Coverage Options" effectively captures the essence of what cafeteria plans provide, as they encompass a range of health-related benefits along with the possibility to select additional options based on employee preferences.

**7. Interpreting a medical term with the suffix "-emia," what does it relate to?**

- A. Bad, painful**
- B. Blood condition**
- C. Red**
- D. Pain**

The suffix "-emia" in medical terminology specifically refers to a condition related to blood. It is often used to indicate the presence of a particular substance in the blood or a disease involving the blood. For instance, "anemia" refers to a deficiency of red blood cells or hemoglobin in the blood, while "hyperglycemia" refers to an excess of glucose in the blood. This suffix serves as a critical component in the formation of various medical terms that denote different blood-related conditions. Therefore, when interpreting a medical term that includes "-emia," it is clear that it deals with a condition affecting the blood, confirming that "blood condition" is the accurate interpretation. Other options do not align with the established meaning of this suffix, which is specifically associated with hematology and related medical conditions.

**8. What do the prefixes "gyn-, gyne-, gynec-" relate to?**

- A. record**
- B. women, female**
- C. instrument for reading**
- D. blood**

The prefixes "gyn-, gyne-, gynec-" are derived from Greek origins and specifically relate to women or female. This is evident in various medical terms such as "gynecology," which is the branch of medicine that focuses on women's health, particularly the reproductive system. Understanding these prefixes is crucial in medical billing and coding as they provide context for diagnoses and procedures related to female patients. Other options do not align with the meaning of these prefixes. For example, "record" pertains generally to documentation terminology, while "instrument for reading" refers to tools, such as a thermometer or sphygmomanometer, used for measurement or observation. The option concerning blood relates to hematological terms but does not connect to the concept of women or females. Hence, the emphasis on prefixes associated with gender is essential for accurate interpretation of medical terminology and billing processes relevant to female healthcare.

**9. Which acronym represents Hospital Payment Monitoring Program?**

- A. Home Health Resource Group**
- B. Health Personnel Shortage Area**
- C. Hospital Payment Monitoring Program**
- D. Health Plan Employer Data and Information Set**

The correct answer is indeed the acronym that stands for Hospital Payment Monitoring Program, which captures the focus and intent of monitoring hospital payments to ensure accuracy, compliance, and efficiency in billing practices. This program is essential in the healthcare billing process as it helps in identifying any discrepancies or areas for improvement in hospital payments, ultimately contributing to better financial performance and quality patient care. By focusing on the specific terms in the acronym, it's clear that it aligns directly with the subject matter of billing and hospital finance. The other choices, while related to healthcare, represent different areas entirely. Home Health Resource Group pertains to home health payment systems, Health Personnel Shortage Area refers to geographic areas with a shortage of health professionals, and Health Plan Employer Data and Information Set (HEDIS) relates to data about health plan performance and quality measures. Each of these terms serves a distinct purpose in healthcare but does not align with the function of monitoring hospital payments.

**10. What does a breach of confidentiality refer to?**

- A. Unwanted Patient Calls**
- B. Unauthorized Release of Patient Information**
- C. Coding Errors**
- D. Lost Medical Records**

The correct answer, which pertains to a breach of confidentiality, is the unauthorized release of patient information. Breach of confidentiality involves disclosing sensitive patient information without the appropriate consent or authority. This is a critical issue in healthcare, as maintaining patient confidentiality is a fundamental ethical principle and a legal requirement under regulations like HIPAA (Health Insurance Portability and Accountability Act). When patient information is released without consent, it can lead to a loss of trust between patients and healthcare providers, potential identity theft, and violations of privacy laws which can result in legal consequences for the entity responsible for the breach. The other options, while related to healthcare communication and record-keeping, do not specifically address the concept of confidentiality. Unwanted patient calls may involve issues of communication but do not inherently violate confidentiality. Coding errors pertain to inaccuracies in billing and do not relate to patient privacy. Lost medical records can pose risks but are not characterized as a breach of confidentiality unless they lead to unauthorized access to patient information.