

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

Study Guide



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SAMPLE

Questions

SAMPLE

- 1. What does "derm-" or "dermat-" typically refer to?**
 - A. Fingers, toes**
 - B. Lack of, down**
 - C. Skin**
 - D. Right**

- 2. Which term represents EFT when it comes to medical billing practices?**
 - A. Electronic funds transfer**
 - B. Durable Medical Equipment regional carriers**
 - C. Diagnosis related groups**
 - D. (California) Employment Development Department**

- 3. Which act does FELA represent concerning employment liabilities?**
 - A. Final Employee Legal Act**
 - B. Following Employee Liability Assessment**
 - C. Federal Employment Liability Act**
 - D. Financial Equity and Liability Agreement**

- 4. Which organization does CMS represent?**
 - A. Centers of Medicare and Medicaid Services**
 - B. Center for Medical Services**
 - C. Claims Management System**
 - D. Community Medical Support**

- 5. How is coverage determined when both parents have different health insurance plans according to the "birthday rule"?**
 - A. Determines coverage by primary policy only**
 - B. Inflammation**
 - C. Determines coverage by secondary policy only**
 - D. Determines coverage by primary and secondary policies when each parent subscribes to a different health insurance plan**

- 6. Which term represents a "condition"?**
- A. A. Within, into**
 - B. B. Condition**
 - C. C. Ileum (small intestine)**
 - D. D. Uterus, womb**
- 7. What does "Accept Assignment" mean in medical billing?**
- A. Voluntary process that a healthcare facility undergoes**
 - B. Provider accepts payment in full from the patient**
 - C. Provider accepts as payment in full whatever is paid on the claim by the payer**
 - D. Document that acknowledges patient responsibility for payment**
- 8. What does an "Accounts Receivable Aging Report" show in medical billing?**
- A. Payment correction resulting in additional payment(s) to the provider**
 - B. Document that acknowledges patient responsibility for payment**
 - C. The appearance of a pathologic condition due to a chemical substance**
 - D. Shows the status of outstanding claims from each payer**
- 9. Which term is represented by the abbreviation CAT?**
- A. Consumer Directed Health Plan**
 - B. Certified Coding Specialist**
 - C. Common Access Card**
 - D. Computerized Axial Tomography**
- 10. Which term is represented by the abbreviation GPWW in healthcare billing and coding?**
- A. General Equivalency Mapping**
 - B. Group Practice Without Walls**
 - C. Home Assessment Validation and Entry**
 - D. Health Affairs**

Answers

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

SAMPLE

Explanations

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1. What does "derm-" or "dermat-" typically refer to?

- A. Fingers, toes**
- B. Lack of, down**
- C. Skin**
- D. Right**

The term "derm-" or "dermat-" is derived from the Greek word "derma," which means skin. In medical terminology, it is commonly used as a prefix in words related to skin conditions and treatments. For example, dermatology is the branch of medicine that focuses on the diagnosis and treatment of skin disorders. Therefore, identifying "skin" as the correct answer aligns perfectly with the etymological roots and the context of medical terminology. This understanding is crucial for professionals in the healthcare field, including certified billers, as it aids in accurate coding and billing for dermatological services.

2. Which term represents EFT when it comes to medical billing practices?

- A. Electronic funds transfer**
- B. Durable Medical Equipment regional carriers**
- C. Diagnosis related groups**
- D. (California) Employment Development Department**

The term that represents EFT in medical billing practices is "Electronic funds transfer." This refers to the digital movement of money from one bank account to another without the physical exchange of cash or checks. In the context of medical billing, EFT facilitates the direct deposit of payments from insurance companies to healthcare providers' accounts, streamlining the reimbursement process and reducing the chances of delays and errors associated with paper checks. Using electronic funds transfer is particularly beneficial in healthcare as it enhances efficiency, improves cash flow for providers, and allows for quicker access to funds. It is a critical component of modern medical billing practices, as it contributes to timely payments and helps ensure that healthcare organizations can operate smoothly. This process is widely adopted across the industry to modernize and enhance the efficiency of financial transactions. The other terms listed do not align with the definition of transferring funds electronically. Durable Medical Equipment regional carriers refer to specific payers for durable medical equipment claims. Diagnosis related groups are used for classifying inpatient stays and establishing payment rates. The Employment Development Department pertains to employment services and benefits rather than financial transactions in medical billing.

3. Which act does FELA represent concerning employment liabilities?

- A. Final Employee Legal Act**
- B. Following Employee Liability Assessment**
- C. Federal Employment Liability Act**
- D. Financial Equity and Liability Agreement**

The correct answer is the Federal Employment Liability Act. This act was established to protect railroad workers who are injured on the job, ensuring they can seek damages for their injuries resulting from the negligence of their employers. It represents a significant legal framework allowing employees in the railroad industry to hold their employers accountable for workplace safety violations, thereby enhancing protections for workers in that sector. The other options do not correspond to any existing legislation relevant to employment liabilities and therefore do not provide any accepted legal protections or frameworks like the Federal Employment Liability Act does. They may include terms that sound plausible but do not represent actual laws or acts governing employment liabilities.

4. Which organization does CMS represent?

- A. Centers of Medicare and Medicaid Services**
- B. Center for Medical Services**
- C. Claims Management System**
- D. Community Medical Support**

The correct answer is centered on the known acronym CMS, which stands for the Centers for Medicare and Medicaid Services. This governmental agency within the United States Department of Health and Human Services oversees major healthcare programs, including Medicare and Medicaid, as well as the Children's Health Insurance Program (CHIP). Its role is critical in regulating and monitoring healthcare services and providers, ensuring compliance with laws and regulations related to these programs. Understanding this context highlights the significance of CMS in the healthcare system, focusing on the administration of public health insurance programs and policy development. The other options provided do not accurately reflect the official designation or role of the organization in question, which centers primarily on Medicare and Medicaid services essential to public health in the U.S.

5. How is coverage determined when both parents have different health insurance plans according to the "birthday rule"?
- A. Determines coverage by primary policy only
 - B. Inflammation
 - C. Determines coverage by secondary policy only
 - D. Determines coverage by primary and secondary policies when each parent subscribes to a different health insurance plan**

The birthday rule is a guideline used to determine which parent's health insurance plan is considered primary when both parents have insurance coverage for their child. According to this rule, the plan of the parent whose birthday falls earlier in the calendar year is deemed the primary coverage. This means that the child's medical expenses will first be billed to that parent's insurance, before any claims are submitted to the other parent's insurance. The chosen answer accurately reflects that both parents' policies can come into play. It highlights that when parents have different health insurance plans, both primary and secondary coverage can be determined based on the birthday rule. This approach ensures that the child is covered efficiently and maximizes the benefits from both insurance plans. Understanding the implications of this rule is critical for healthcare providers and billers to ensure proper billing and to avoid claim denials. This also helps in coordinating benefits to ensure that the maximum coverage is utilized for medical expenses.

6. Which term represents a "condition"?
- A. A. Within, into
 - B. B. Condition**
 - C. C. Ileum (small intestine)
 - D. D. Uterus, womb

The term that represents a "condition" is indeed the one referring directly to "condition." In medical terminology, the concept of a condition often relates to a state of health—whether it pertains to a disease, disorder, or any other medical issue affecting an individual's well-being. This term is broadly applicable across various contexts in healthcare, helping to convey specific health-related circumstances clearly. The other options refer to specific anatomical structures or prepositions rather than conditions. For instance, the ileum is part of the small intestine, and the uterus refers to a reproductive organ. The terms related to location, such as "within" or "into," do not denote a state of health but rather indicate spatial relationships. Thus, the direct reference of the chosen term as "condition" makes it the most appropriate answer within the given choices.

7. What does "Accept Assignment" mean in medical billing?

- A. Voluntary process that a healthcare facility undergoes**
- B. Provider accepts payment in full from the patient**
- C. Provider accepts as payment in full whatever is paid on the claim by the payer**
- D. Document that acknowledges patient responsibility for payment**

The concept of "Accept Assignment" in medical billing refers to the agreement between a provider and a payer regarding the payment for services rendered. Specifically, when a provider accepts assignment, they agree to accept the payment amount determined by the payer as full payment for the services provided. This means that the provider will not bill the patient for any additional amount beyond what the payer has paid, effectively limiting the patient's financial responsibility to only any applicable copayments or deductibles. In this context, the option indicating that the provider accepts whatever is paid on the claim by the payer as full payment correctly captures the essence of this agreement. It emphasizes that the provider acknowledges the payer's determined payment amount, and the patient is not liable for more than what the insurance agrees to pay. The other options focus on different aspects of billing processes that do not align with the specific definition of "Accept Assignment." Therefore, the chosen answer accurately reflects the provider's responsibility and the financial agreement established with the payer in the context of medical billing.

8. What does an "Accounts Receivable Aging Report" show in medical billing?

- A. Payment correction resulting in additional payment(s) to the provider**
- B. Document that acknowledges patient responsibility for payment**
- C. The appearance of a pathologic condition due to a chemical substance**
- D. Shows the status of outstanding claims from each payer**

The Accounts Receivable Aging Report is a crucial tool in medical billing that provides a snapshot of the outstanding balances owed by patients and insurance companies. This report categorizes these amounts based on the length of time they have been outstanding. By showing the status of outstanding claims from each payer, it enables billing personnel to identify which claims are overdue and to prioritize follow-up actions. This helps in managing cash flow and ensuring timely payments, which is essential for the financial health of a healthcare facility. The other choices do not accurately describe the purpose of an Accounts Receivable Aging Report. For instance, while payment corrections could affect accounts receivable, they do not directly relate to the aging or status of outstanding claims. Similarly, acknowledging patient responsibility for payments is important in billing practice but does not encompass the broad overview that an aging report provides. The reference to a pathologic condition due to a chemical substance is unrelated to accounts receivable and is more relevant to medical diagnoses rather than billing practices. Thus, the correct choice reflects the primary function of the report in managing the financial aspects of healthcare services.

9. Which term is represented by the abbreviation CAT?

- A. Consumer Directed Health Plan**
- B. Certified Coding Specialist**
- C. Common Access Card**
- D. Computerized Axial Tomography**

The abbreviation CAT stands for Computerized Axial Tomography. This term refers to a medical imaging technique that uses computer-processed combinations of many X-ray measurements taken from different angles to produce cross-sectional images of specific areas of the body. This advanced imaging technology is crucial in medical diagnostics as it allows health care providers to see detailed internal structures of patients, which is vital for diagnosing and planning treatment for various conditions. Understanding the purpose and application of Computerized Axial Tomography is key for professionals in the healthcare billing field, as it impacts coding and billing practices related to imaging services. Accurate coding of such services is necessary to ensure proper reimbursement and to comply with health insurance regulations. The other options represent different concepts and fields. For instance, Consumer Directed Health Plans focus on giving consumers more control over their healthcare decisions; Certified Coding Specialist refers to a credential for coding professionals; and Common Access Card is used for identification in secure environments, particularly government facilities. Each of these terms, while relevant in healthcare, does not correspond to the abbreviation CAT in the context of medical imaging.

10. Which term is represented by the abbreviation GPWW in healthcare billing and coding?

- A. General Equivalency Mapping**
- B. Group Practice Without Walls**
- C. Home Assessment Validation and Entry**
- D. Health Affairs**

The correct answer is indeed the term represented by the abbreviation GPWW, which stands for Group Practice Without Walls. This term refers to a type of medical practice structure where multiple healthcare providers operate independently but collaborate to offer patient care, often sharing resources and facilities without being physically located in the same building. This model can enhance the efficiency of care delivery, reduce overhead costs, and provide patients with access to a broader range of services, while allowing providers the autonomy of their individual practices. Understanding this term is important in the context of healthcare billing, as it influences how services are billed, how reimbursements are processed, and how collaborations between different practices are managed in billing systems. The other terms, while relevant in their own contexts, do not correspond to the abbreviation GPWW: - General Equivalency Mapping pertains to the process of translating medical coding systems but does not relate specifically to group practices. - Home Assessment Validation and Entry deals with home healthcare but is not relevant to the grouping of independent practices. - Health Affairs refers to a journal focused on health policy issues rather than a practice structure in healthcare billing.