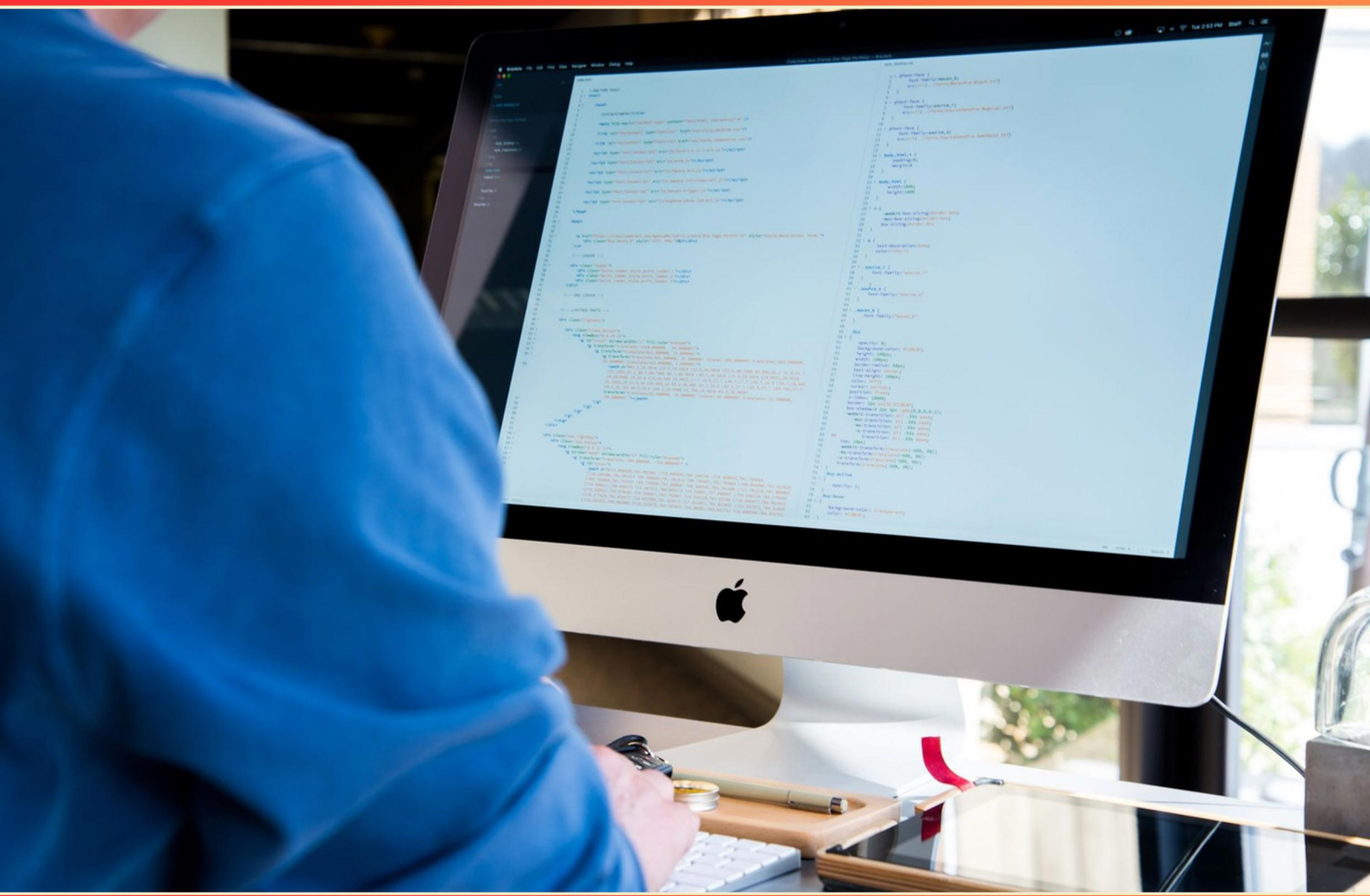
# NHA CERTIFIED BILLING AND CODING SPECIALIST (CBCS) PRACTICE EXAM (SAMPLE)

## STUDY GUIDE



## SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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. If block 13 is left blank when submitting a claim, what is the expected outcome?

A. The third party payer reimburses the patient and the patient is responsible for reimbursing the provider

B. The payer reimburses the provider directly

C. The claim is rejected

D. The patient is billed only after payer pays

2. Given billed $170, allowed $150, deductible unmet $50, copayment $20, what is the patient's responsibility?

A. $50

B. $20

C. $70

D. $100

3. What term describes a service that was approved by the payer before it was performed?

A. Precertification

B. Preauthorization

C. Preapproval

D. Prior authorization

4. A billing and coding specialist submitted a claim to Medicare electronically. No errors were found by the billing software or clearinghouse. Which describes this claim?

A. Clean claim

B. Denied claim

C. Fraudulent claim

D. Duplicate claim

5. If a patient's employer has not submitted a premium, what claim status should the payer issue?

A. Denied

B. Pending

C. Approved

D. On hold

**6. Which is allowed when billing procedural codes?**

A. Use two-digit CPT modifiers to indicate a procedure is performed

B. Bill withoutModifiers

C. Use only CPT codes without modifiers

D. Use only one CPT code per procedure

**7. What color is acceptable on the CMS-1500 claim form?**

A. RED

B. BLUE

C. GREEN

D. BLACK

**8. A billing and coding specialist can ensure appropriate insurance coverage for an outpatient procedure by first using which process?**

A. Precertification

B. Preauthorization

C. Referral

D. Copayment verification

**9. A provider receives reimbursement from a third-party payer accompanied by which document?**

A. EOB

B. Remittance advice

C. Check stub

D. Payment voucher

**10. Which initiative did CMS implement in 1996 to detect inappropriate and improper codes?**

A. National Correct Code Initiative (NCCI)

B. HIPAA

C. Medicare Integrity Program

D. ICD-10 transition

# Answers

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

# Explanations

**1. If block 13 is left blank when submitting a claim, what is the expected outcome?**

A. The third party payer reimburses the patient and the patient is responsible for reimbursing the provider

B. The payer reimburses the provider directly

C. The claim is rejected

D. The patient is billed only after payer pays

*Block 13 indicates whether the patient has assigned benefits to the provider. When this field is left blank, there is no assignment on file. Without an assignment, the insurer processes and pays the claim to the patient rather than directly to the provider. The patient then has the responsibility to reconcile or reimburse the provider for services rendered. That's why the outcome described—payment going to the patient and the patient paying the provider—best fits leaving that block blank. If the patient had signed an assignment of benefits, the payer would typically reimburse the provider directly. The other scenarios—payment being rejected or the patient only being billed after the payer pays—don't reflect the plain effect of leaving the assignment block empty.*

**2. Given billed $170, allowed $150, deductible unmet $50, copayment $20, what is the patient's responsibility?**

A. $50

B. $20

C. $70

D. $100

*The main idea is how patient cost-sharing works with the allowed amount. Use the allowed amount (not the billed amount) to determine what the insurer and patient owe. Since the deductible is unmet, the patient must pay the full deductible amount first, which is 50. The copayment of 20 is an additional fixed amount the patient pays at the time of service. Add these together: 50 + 20 = 70 for the patient's responsibility. The insurer would then pay the remaining portion of the allowed amount: 150 minus 70 equals 80. So the patient's total responsibility is 70.*

**3. What term describes a service that was approved by the payer before it was performed?**

A. Precertification

B. Preauthorization

C. Preapproval

D. Prior authorization

*The key idea here is getting approval from the payer before performing a service to confirm coverage and medical necessity. This upfront review is done through preauthorization. It means the payer evaluates the requested service in advance and agrees to pay for it if it meets their criteria, helping prevent unexpected denials after the service is done. Some plans use similar terms like precertification or prior authorization, but in this context, the term that best matches "approved before the service was performed" is preauthorization.*

**4. A billing and coding specialist submitted a claim to Medicare electronically. No errors were found by the billing software or clearinghouse. Which describes this claim?**

A. Clean claim

B. Denied claim

C. Fraudulent claim

D. Duplicate claim

*A clean claim is a submission that contains all required information with accurate data and no errors that would block processing. When the billing software and clearinghouse flag nothing, the claim has passed automated edits and is ready for adjudication by the payer. It means the patient and provider details are correct, codes are valid, and the claim is complete. Even though it's clean, payment still depends on the payer's coverage rules and medical necessity. A denied claim would indicate the payer found an issue after review, a fraudulent claim involves intentional misrepresentation, and a duplicate claim is a repeated submission for the same service that would typically be detected by the system.*

**5. If a patient's employer has not submitted a premium, what claim status should the payer issue?**

A. Denied

B. Pending

C. Approved

D. On hold

*Coverage is valid only when the employer has submitted the premium and the enrollment is active. If the premium has not been submitted, there is no active coverage to pay the claim, so the payer should deny the claim with a reason indicating lack of premium/payment or ineligibility due to nonpayment. A denied status reflects that the claim cannot be adjudicated for payment until the enrollment issue is resolved. Other statuses imply there is still processing or a temporary hold, but they do not represent a final determination of ineligibility due to missing premium. Therefore, denial is the correct outcome in this scenario.*

**6. Which is allowed when billing procedural codes?**

A. Use two-digit CPT modifiers to indicate a procedure is performed

B. Bill withoutModifiers

C. Use only CPT codes without modifiers

D. Use only one CPT code per procedure

*CPT modifiers provide additional details about a procedure by appending a two-digit code to the procedure code. They describe exactly what happened during the encounter—such as procedures performed on both sides, separate or distinct services, or different components of a service—which helps communicate the actual work done and guides correct reimbursement. Using these modifiers when applicable is allowed and often necessary to reflect the service accurately. Without modifiers, payers may miss important nuances and reimbursement can be misaligned. While modifiers aren't needed for every case, they are essential when the situation calls for them. And you're not limited to a single CPT code per procedure—multiple codes can be reported for different procedures or components performed in the same encounter.*

## 7. What color is acceptable on the CMS-1500 claim form?

A. RED

B. BLUE

C. GREEN

D. BLACK

*The key idea here is that the CMS-1500 professional claim form should be printed in black ink. Black ink provides the strongest contrast on white paper, which makes the information most legible for both human reviewers and the scan/processing systems that payer offices use. When colored inks are used, scanners and automated readers can misread or fail to capture the data correctly, leading to delays or rejections. So, black ink is the standard and acceptable color for submitting the CMS-1500 form; other colors don't meet the typical submission requirements.*

## 8. A billing and coding specialist can ensure appropriate insurance coverage for an outpatient procedure by first using which process?

A. Precertification

B. Preauthorization

C. Referral

D. Copayment verification

*Securing payer approval before the service is performed ensures the outpatient procedure will be covered under the patient's plan. This precertification step confirms with the insurer that the procedure is medically necessary and that benefits will apply, guiding the coder to the correct billing path and helping prevent denial or unexpected patient charges. In many plans, precertification is required for outpatient procedures, making it the first proactive action to verify coverage and approval. A similar term, preauthorization, is used in some plans but serves the same purpose only in certain contexts, while a referral relates to needing a provider note to see a specialist and does not by itself guarantee coverage. Copayment verification checks what the patient will owe at the time of service but does not establish coverage or medical necessity.*

## 9. A provider receives reimbursement from a third-party payer accompanied by which document?

A. EOB

B. Remittance advice

C. Check stub

D. Payment voucher

*Remittance advice is the document that accompanies reimbursement from a third-party payer to a provider. It details how each claim was processed—what was billed, what was allowed, the actual payment, any adjustments or denials, and the reason codes. This information lets the provider post the payment accurately and reconcile the accounts. An Explanation of Benefits is typically sent to the patient to show benefits usage and patient responsibility, not the provider's payment details. The check stub shows basic payment information from the payer, and a payment voucher isn't the standard communication for claim-level payment details.*

**10. Which initiative did CMS implement in 1996 to detect inappropriate and improper codes?**

A. National Correct Code Initiative (NCCI)

B. HIPAA

C. Medicare Integrity Program

D. ICD-10 transition

*CMS safeguards against improper coding rely on the National Correct Coding Initiative, introduced in 1996 to detect inappropriate and improper code usage by applying structured edits that determine which codes can be billed together and how modifiers should be used. These NCCI Edits identify disallowed code pairings and modifier applications, helping to prevent duplicate or conflicting claims and reduce improper payments. The other options don't fit this specific 1996 measure: HIPAA focuses on privacy and security of health information, ICD-10 transition updates the coding language, and while the Medicare Integrity Program addresses fraud and abuse, it isn't the targeted 1996 initiative for automatic detection of improper code combinations.*

# 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://nhacbcs.examzify.com

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