EPIC RESOLUTE PROFESSIONAL BILLING (PB) FUNDAMENTALS 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.

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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!

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Questions

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1. **Which action is NOT typically required to make a coverage effective for past encounters?**

   A. Undo billing for the HAR

   B. Add the coverage in Registration

   C. Notify the insurance provider

   D. Document the reason for the lack of coverage

2. **What is the primary function of an encounter form number?**

   A. To initiate payment processing

   B. To track patient demographics

   C. To document a visit

   D. To manage insurance claims

3. **Which HB HAR statuses allow you to change the primary coverage on an HB HAR?**

   A. Open

   B. DNB

   C. Billed

   D. Closed

4. **What does the three-letter abbreviation known as an INI refer to in the context of a master file?**

   A. Individual Numeric Identifier

   B. Integrated Network Information

   C. Internal Name Identifier

   D. Instrumentation Number Index

5. **What action should be taken if a charge is discovered to be incorrect after posting?**

   A. Ignore it until the next review

   B. Use charge correct to void and edit

   C. Contact the payer immediately

   D. Remove it from the billing system

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6. What does the term 'write-off' refer to in billing?

A. The total amount billed to the insurance

B. The amount a healthcare provider agrees to not collect from the patient

C. The initial estimate of patient charges

D. The fees charged for administrative services

7. What is the purpose of the NRP (Next Responsible Party) Action?

A. To cancel the payment

B. To move the remaining balance to the next party in the visit's filing order

C. To request additional information from the patient

D. To initiate a refund process

8. True or False: Multiple checks can be combined into one cash control group.

A. True

B. False

C. Only if they are from the same payer

D. Only if they are from different payers

9. What role does the Billing Compliance Committee play?

A. To oversee and enforce billing compliance policies and protocols

B. To manage patient care services at the practice

C. To train staff on customer service practices

D. To drive marketing strategies for practice growth

10. What benefit does automated messaging provide in billing practices?

A. Improves patient communication and reduces delays in payment

B. Decreases the workload of the billing department

C. Enhances the accuracy of billing codes

D. Increases the number of services billed monthly

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Answers

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

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Explanations

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1. Which action is NOT typically required to make a coverage effective for past encounters?

A. Undo billing for the HAR

B. Add the coverage in Registration

C. Notify the insurance provider

D. Document the reason for the lack of coverage

The action that does not typically need to be taken to make coverage effective for past encounters is adding the coverage in Registration. When dealing with past encounters, it's crucial to ensure that any required adjustments related to billing or communication with the insurance provider are completed to facilitate the coverage. While it is necessary to undo the billing for the health access record (HAR) to allow for any necessary changes, and notifying the insurance provider is needed to clarify the coverage status, the actual addition of coverage in the Registration may not be necessary for past encounters already delivered. The focus is often on rectifying existing records and billing rather than modifying registration information for encounters that have already occurred. Thus, adding coverage at this stage does not align with the standard procedural requirements to address the past encounter issues effectively.

2. What is the primary function of an encounter form number?

A. To initiate payment processing

B. To track patient demographics

C. To document a visit

D. To manage insurance claims

The primary function of an encounter form number is to document a visit. Encounter forms are vital tools used in healthcare settings to capture important information related to a patient's visit, including the services provided, diagnoses, and instructions given during the appointment. They serve as a way for healthcare providers to systematically record the details that occurred during that specific encounter, ensuring accurate records for effective patient management, billing, and continuity of care. While the other options involve important aspects of healthcare operations, they don't directly align with the primary function of the encounter form number. For instance, initiating payment processing and managing insurance claims are processes that happen after the encounter has been documented, relying on the information captured in the encounter form. Tracking patient demographics is also separate from the core goal of documenting the details of a specific visit. The encounter form number primarily serves to ensure that each visit is accurately recorded and can be referenced appropriately in the patient's health records and billing processes.

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3. Which HB HAR statuses allow you to change the primary coverage on an HB HAR?

A. Open

B. DNB

C. Billed

D. Closed

The status "Open" for an HB HAR (Hospital Billing Health Account Receivable) is vital for making changes, such as modifying the primary coverage. When a HAR is classified as "Open," it indicates that the billing process is still active, allowing changes to be made to its details, including the primary insurance coverage. In the context of a billing system, having an Open HAR means that the account has not been finalized, and adjustments can still be made based on new information or corrections, which includes the ability to update the insurance details. This flexibility is essential during the billing process as it accommodates any updates in patient coverage that may occur before the claim is fully processed or adjudicated. On the other hand, statuses like DNB (Do Not Bill), Billed, or Closed generally signify more final stages in the billing process where changes to insurance or coverage information are restricted or may require additional steps to rectify. For instance, once an HAR is marked as Billed, it indicates that a bill has been sent out and changes to primary coverage could complicate any claims that have already been submitted. Similarly, a Closed status signifies that the account is completed and that adjustments are typically no longer permitted.

4. What does the three-letter abbreviation known as an INI refer to in the context of a master file?

A. Individual Numeric Identifier

B. Integrated Network Information

C. Internal Name Identifier

D. Instrumentation Number Index

The three-letter abbreviation INI stands for Internal Name Identifier. In the context of a master file, this term is essential for distinguishing and identifying individual entries or components within the system. The Internal Name Identifier plays a critical role in how data elements are organized, classified, and referenced throughout the billing process. This identifier helps ensure that every piece of information is accurately linked to its corresponding patient or transaction record, allowing for streamlined operations and efficient data management within the Epic Resolute Professional Billing system. Understanding the significance of the INI can aid users in navigating the system more effectively and ensuring that all identifiers are correctly applied, ultimately promoting the integrity of data captured in the billing workflow.

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5. What action should be taken if a charge is discovered to be incorrect after posting?

A. Ignore it until the next review

B. Use charge correct to void and edit

C. Contact the payer immediately

D. Remove it from the billing system

If a charge is discovered to be incorrect after posting, the appropriate action is to use the charge correction functionality to void and edit the charge. This method allows for the accurate adjustment of billing records, ensuring that financial statements and claims reflect correct information. The charge correction process typically involves voiding the incorrect charge, which effectively removes it from the billing records, and then entering the correct information. This maintains compliance and avoids issues such as claim denials or audit discrepancies, as it provides a clear trail of changes made. Utilizing charge correction helps maintain integrity in billing practices and supports the proper financial management of healthcare services. The ability to correct charges not only safeguards the provider's revenue but also enhances the accuracy of patient accounts and ensures fair billing practices.

6. What does the term 'write-off' refer to in billing?

A. The total amount billed to the insurance

B. The amount a healthcare provider agrees to not collect from the patient

C. The initial estimate of patient charges

D. The fees charged for administrative services

The term 'write-off' in billing specifically refers to the amount a healthcare provider agrees to not collect from the patient. This typically occurs when the provider negotiates a reduced amount with an insurance company or when they determine that the full amount of a bill cannot be collected due to financial hardship or other reasons. By writing off a portion of the bill, the provider acknowledges that they will not pursue further collection from the patient for that amount, which can assist in maintaining a positive relationship with patients who may be facing financial difficulties. In the context of billing practices, a write-off may impact the provider's revenues, but it is essential for ensuring patient care is accessible and that the provider complies with contractual agreements with insurers. It reflects a critical aspect of the financial interactions between healthcare providers and patients, emphasizing the importance of managing costs and maintaining transparency in billing practices.

7. What is the purpose of the NRP (Next Responsible Party) Action?

A. To cancel the payment

B. To move the remaining balance to the next party in the visit's filing order

C. To request additional information from the patient

D. To initiate a refund process

The NRP (Next Responsible Party) Action is designed to facilitate the billing process when the initial payer is not responsible for the remaining balance after a claim has been processed. When a claim is submitted and partially paid or denied, the NRP action allows the system to automatically move the remaining balance to the next party in the visit's filing order. This could involve transitioning the balance from one insurance company to another or to a patient, depending on the established hierarchy of responsibility for the claim. Utilizing the NRP action ensures that billing efficiently accounts for all possible payers, reducing the likelihood of missed payments and streamlining the revenue cycle process. This is particularly useful in scenarios where multiple insurance plans may be involved for a single visit, as it allows for a structured approach to determining which entity should take financial responsibility after the primary payer's action.

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8. True or False: Multiple checks can be combined into one cash control group.

A. True

B. False

C. Only if they are from the same payer

D. Only if they are from different payers

The correct answer is that multiple checks can indeed be combined into one cash control group. This is a common practice in professional billing contexts, as it helps streamline the reconciliation process and simplifies cash management. When multiple checks are combined, it allows for better tracking and reporting, making financial management more efficient. Combining checks into a single cash control group can be beneficial for operational purposes, as it reduces the number of transactions that need to be individually processed and recorded. This can enhance accuracy in financial reporting and facilitate easier audits. The assertion that checks must come from the same payer or different payers to be combined adds unnecessary complexity to the process. In practice, grouping checks together is typically a matter of operational convenience rather than requiring differentiation by payer, which is why the correct choice supports the flexibility of cash control group management.

9. What role does the Billing Compliance Committee play?

A. To oversee and enforce billing compliance policies and protocols

B. To manage patient care services at the practice

C. To train staff on customer service practices

D. To drive marketing strategies for practice growth

The Billing Compliance Committee is primarily responsible for overseeing and enforcing billing compliance policies and protocols. This role is crucial within healthcare organizations to ensure that billing practices adhere to legal and ethical standards, thereby reducing the risk of fraud, abuse, and error. The committee typically monitors billing procedures, conducts audits, and provides guidance on regulatory requirements, ensuring that all billing activities are compliant with the relevant laws and regulations. By focusing on compliance, the committee plays a vital part in protecting the organization from potential penalties and enhancing the integrity of the billing process. This ensures that healthcare providers can effectively manage revenue cycles while maintaining trust with patients and regulators. Other options describe roles that are important but do not pertain to billing compliance specifically. For instance, managing patient care services relates more to clinical operations, training staff on customer service practices focuses on the patient experience, and driving marketing strategies pertains to business growth, none of which fall under the purview of compliance in billing practices.

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10. What benefit does automated messaging provide in billing practices?

A. Improves patient communication and reduces delays in payment

B. Decreases the workload of the billing department

C. Enhances the accuracy of billing codes

D. Increases the number of services billed monthly

Automated messaging significantly improves patient communication, which in turn can lead to reduced delays in payment. This communication can take various forms, such as reminders, notifications about upcoming payments, or updates regarding billing status. By keeping patients informed, they are more likely to understand their financial responsibilities and are encouraged to make timely payments. This proactive approach helps to reduce confusion and builds a stronger relationship between the provider and the patient, ultimately leading to improved cash flow and efficiency in the billing process. While it is true that automated messaging can also have secondary benefits, such as reducing the workload of the billing department, enhancing the accuracy of billing codes, or even increasing the number of services billed, the primary and most direct benefit is its effect on patient communication and payment timing.

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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://epicresolutepbfundamentals.examzify.com

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

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