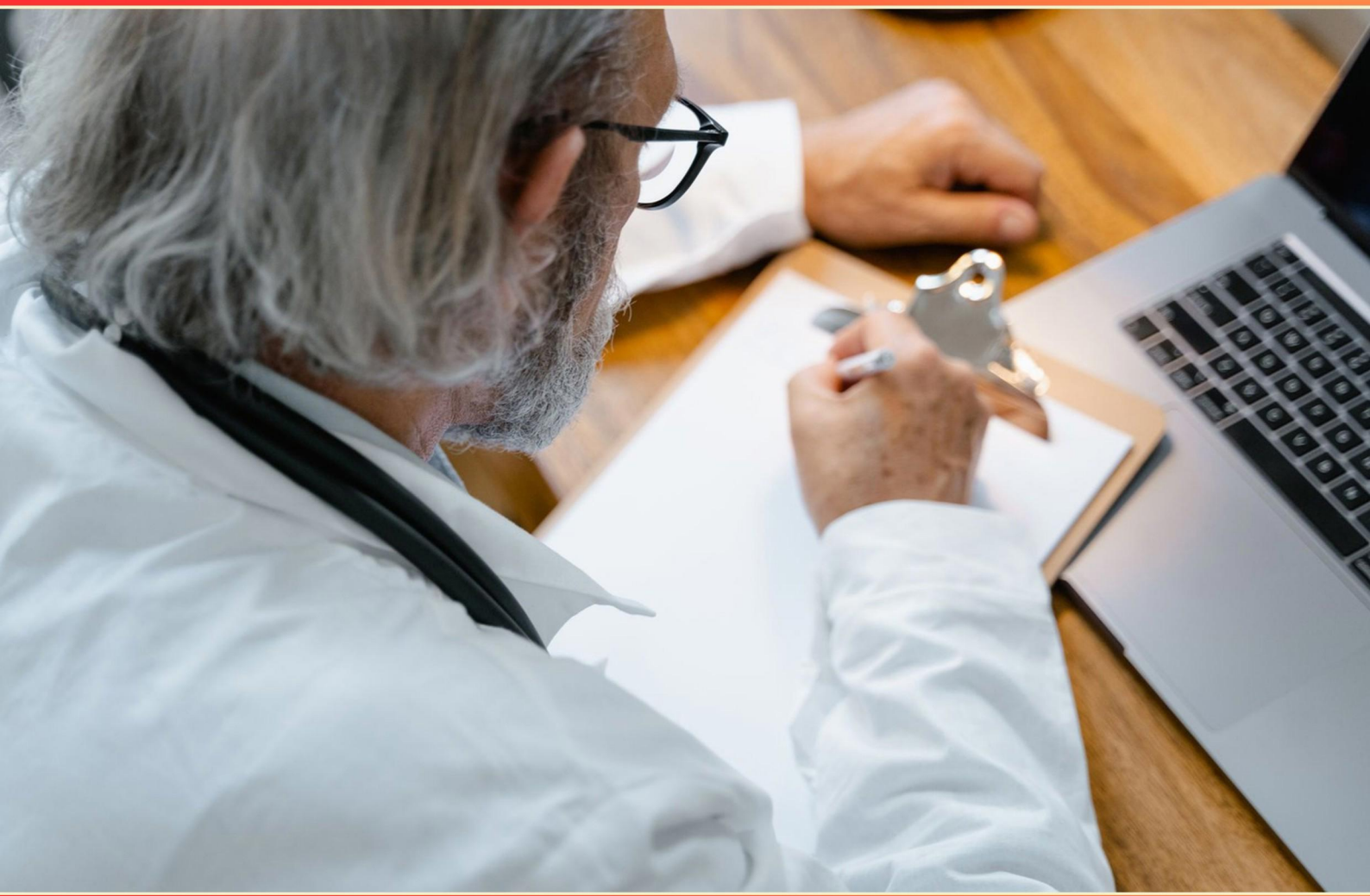
RHIA REIMBURSEMENT PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR THE FULL VERSION STUDY GUIDE

https://rhiareimbursement.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.

SAMPLE

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!

SAMPLE

Questions

SAMPLE

1. What does DNFB stand for in the context of hospital billing?

A. Descriptive Non-Final Billing

B. Discharged, No Final Bill

C. Disallowed, No Final Benefit

D. Deficient, Not Finalized Billing

2. How is a contractual allowance defined in healthcare reimbursement?

A. The total fees billed for service

B. The write-off amount accepted by the provider

C. The reimbursement amount from Medicare

D. The administrative costs incurred

3. A Medicare Summary Notice (MSN) is sent to whom as their explanation of benefits (EOB)?

A. Physicians

B. Patients (beneficiaries)

C. Hospitals

D. Skilled nursing facilities

4. What are errors in medical care that are clearly identifiable, preventable, and serious in consequences called?

A. Misadventures

B. Adverse preventable events

C. Never events or Sentinel events

D. Potential compensable events

5. What is the purpose of the HIPPS code used by home health agencies?

A. Identify surgical procedures

B. Classify patient diagnoses

C. Determine payment rates

D. Monitor patient outcomes

SAMPLE

6. What type of notice is sent to clarify reimbursement details to patients?

A. Advance Beneficiary Notice

B. Explanation of Benefits

C. Patient Financial Summary

D. Medicare Summary Notice

7. What practice involves knowingly making false statements to obtain a benefit for which no entitlement exists?

A. Fraud

B. Whistle-blowing

C. Abuse

D. Assault

8. Accounts Receivable (A/R) refers to what?

A. cases that have not yet been paid.

B. the amount the hospital was paid.

C. cases that have been paid.

D. denials that have been returned to the hospital.

9. What is applied to all procedures in ASC PPS after the highest level procedure is reimbursed at 100%?

A. 50%

B. 75%

C. 100%

D. 90%

10. If a patient has paid his deductible under Medicare Part B, what percentage of coinsurance is the patient liable for during an office visit?

A. 80%

B. 100%

C. 20%

D. 15%

SAMPLE

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. What does DNFB stand for in the context of hospital billing?

A. Descriptive Non-Final Billing

B. Discharged, No Final Bill

C. Disallowed, No Final Benefit

D. Deficient, Not Finalized Billing

DNFB stands for "Discharged, No Final Bill," which refers to a category in hospital billing that tracks patients who have been discharged from the hospital but for whom the billing process has not yet been completed. This situation often indicates that there may be outstanding charges that need to be finalized before the claim can be submitted to insurance or billed to the patient. Understanding the DNFB is crucial for healthcare facilities as it helps in monitoring and managing claims that are pending. A high DNFB can signify inefficiencies in the billing process, potentially leading to delayed revenue capture and cash flow issues. Hospitals aim to minimize the DNFB numbers to ensure timely billing and receipt of payment for services rendered. The other options, while they contain relevant terminology, do not accurately represent the common usage of DNFB in the healthcare billing context. They mix concepts or terms that do not align with the specific definition used in the industry, which is solely focused on the discharge status and the absence of a finalized bill.

2. How is a contractual allowance defined in healthcare reimbursement?

A. The total fees billed for service

B. The write-off amount accepted by the provider

C. The reimbursement amount from Medicare

D. The administrative costs incurred

A contractual allowance is defined as the write-off amount that a healthcare provider agrees to accept on a claim due to the terms of a contract with a payer. This typically happens when there is a discrepancy between the total fees billed for a service and the amount that the healthcare provider is allowed to collect from the insurance company or government program. When providers enter into contracts with health insurance companies or government payers like Medicare, they agree to accept certain payment rates for services rendered. The difference between what is billed (the full fee) and what the insurer pays is known as the contractual allowance. This write-off reflects the amount that providers won't collect from the patient or the insurance to settle the charges and is considered a reduction in revenue for the provider. This concept is crucial for understanding how reimbursement works in healthcare, as it helps professionals manage their accounting records and assess the financial effectiveness of negotiated contracts with insurers.

SAMPLE

3. A Medicare Summary Notice (MSN) is sent to whom as their explanation of benefits (EOB)?

A. Physicians

B. Patients (beneficiaries)

C. Hospitals

D. Skilled nursing facilities

The Medicare Summary Notice (MSN) serves as a key communication tool that provides beneficiaries (patients) with important information regarding the services they have received under Medicare. It outlines the services that were billed, the amount Medicare has paid, and any amounts that the beneficiary may still owe. This notice helps patients understand their healthcare costs and the benefits they've received, reflecting their rights to appeal any decisions if they disagree with what is billed or the payments made by Medicare. It is specifically designed for the beneficiaries themselves, making it an essential part of the healthcare billing process for those enrolled in Medicare. The other options, while involved in the healthcare service provision, are not the recipients of the MSN. Physicians, hospitals, and skilled nursing facilities are involved in the billing and claims process but don't receive the MSN as it is intended specifically for the individuals receiving the care, i.e., the patients. Thus, the correct response emphasizes the role of the MSN as a communication tool directed towards Medicare beneficiaries.

4. What are errors in medical care that are clearly identifiable, preventable, and serious in consequences called?

A. Misadventures

B. Adverse preventable events

C. Never events or Sentinel events

D. Potential compensable events

The term that best fits the description of errors in medical care that are clearly identifiable, preventable, and serious in consequences is "Never events or Sentinel events." This terminology is specifically used in healthcare settings to label severe errors that should never occur and typically indicate a major breach in quality of care. These events are critical because they represent fundamental failures in safety protocols that can lead to significant harm to patients, such as performing surgery on the wrong body part or leaving surgical instruments inside a patient after a procedure. The identification of such events helps healthcare organizations focus on enhancing their safety measures and preventing future occurrences, thereby improving overall patient safety. In contrast, misadventures refer to complications that occur during a procedure but do not necessarily fall under the category of errors. Adverse preventable events are similar but may not cover the full scope of serious consequences defined by never events. Potential compensable events may refer to incidents that could lead to legal liability or compensation claims but do not specifically address the severity and nature of preventable errors as defined by the term "Never events."

SAMPLE

5. What is the purpose of the HIPPS code used by home health agencies?

A. Identify surgical procedures

B. Classify patient diagnoses

C. Determine payment rates

D. Monitor patient outcomes

The HIPPS (Health Insurance Prospective Payment System) code is specifically designed to determine payment rates for home health services. Each HIPPS code consists of various components that capture patient characteristics and service needs, impacting the reimbursement that home health agencies receive for providing care. By using HIPPS codes, payers can assign appropriate payment levels based on the expected resource utilization for each patient's care, ensuring that funding aligns with the level of care provided. In the context of home health services, the correct use of HIPPS codes enables agencies to receive accurate reimbursements that reflect the complexity and requirements of the services delivered. This system plays a critical role in the overall revenue cycle for home health agencies, influencing their financial stability and the ability to deliver quality patient care.

6. What type of notice is sent to clarify reimbursement details to patients?

A. Advance Beneficiary Notice

B. Explanation of Benefits

C. Patient Financial Summary

D. Medicare Summary Notice

The Medicare Summary Notice (MSN) is a document sent to beneficiaries of Medicare that provides detailed information about the health care services they have received, which includes how much Medicare paid and what the patient may need to pay out-of-pocket. The MSN is essential for clarifying reimbursement details, as it contains a summary of the services covered, the date they were provided, the amounts billed by the provider, and any adjustments that were made to those amounts. This type of notice helps patients understand their financial responsibilities related to the services billed and provides transparency regarding what Medicare has covered. It's important because it allows beneficiaries to review their claims and address any discrepancies, ensuring they know how their coverage works. Understanding this context is critical for patients to navigate their healthcare expenses effectively and for healthcare providers to assist patients with questions related to billing and reimbursement.

SAMPLE

7. What practice involves knowingly making false statements to obtain a benefit for which no entitlement exists?

A. Fraud

B. Whistle-blowing

C. Abuse

D. Assault

Fraud is the practice of knowingly making false statements or deceiving someone to obtain a benefit that an individual is not entitled to. It involves intentional wrongdoing and is typically associated with various forms of dishonesty, such as falsifying documents or manipulating information for financial gain or to secure advantages in situations like insurance claims, medical billing, or loans. In the context of healthcare reimbursement, fraud can manifest when providers or patients submit false claims to insurance companies for procedures that were never performed or for services that were unnecessary. This not only harms the financial standing of healthcare systems but also compromises the integrity of healthcare practices, diverting resources away from legitimate cases. This understanding differentiates fraud from other options provided. Whistle-blowing refers to reporting unethical or illegal activities within an organization without the intent of benefiting oneself, while abuse typically involves overuse or misuse of healthcare services without necessarily being fraudulent. Assault, on the other hand, pertains to physical harm and does not fit within the scope of financial deception or healthcare practices.

8. Accounts Receivable (A/R) refers to what?

A. cases that have not yet been paid.

B. the amount the hospital was paid.

C. cases that have been paid.

D. denials that have been returned to the hospital.

Accounts Receivable (A/R) refers to the money that a healthcare provider is owed for services rendered but has not yet been collected. This includes all outstanding bills for care provided to patients where payment has not yet been received. It essentially represents pending payments for services delivered and is part of the financial tracking of a healthcare organization. When an A/R is mentioned, it highlights the financial aspect of the healthcare provider's operations, as they manage and track how much they are owed and follow up on those amounts for billing purposes. Monitoring A/R is critical for maintaining healthy cash flow and ensuring that the organization can continue to function effectively. The other options do not accurately define A/R: the amount the hospital was paid represents cash flow rather than the receivables, cases that have been paid are no longer part of A/R, and denials, while they do affect revenue, do not represent outstanding payments but rather claims that have been rejected. Thus, the concept of A/R specifically ties to cases that remain unpaid, distinguishing it from other financial categories.

SAMPLE

9. What is applied to all procedures in ASC PPS after the highest level procedure is reimbursed at 100%?

A. 50%

B. 75%

C. 100%

D. 90%

In the context of the Ambulatory Surgical Center (ASC) Prospective Payment System (PPS), after the highest level procedure is reimbursed at 100%, a specific percentage is applied to all subsequent lower-level procedures. The correct response indicates that 75% of the payment rate is applied to these additional procedures. This structure is designed to ensure that the ASC receives a fair level of reimbursement for all services that patients receive during a single surgical session. The system incentivizes efficiency while still allowing for adequate compensation for services rendered. By paying 75% for procedures that are performed in conjunction with the highest level procedure, the ASC is assured that they can still be compensated adequately for the complexities and resources required for multiple procedures within the same visit. The other percentage choices do not reflect the established practice under the ASC PPS. For instance, applying 50%, 100%, or 90% would not align with the regulation intended to balance the cost of care and the efficiency of surgical services within an outpatient setting. Therefore, 75% serves as the standardized reimbursement rate for additional procedures following the highest-level procedure.

10. If a patient has paid his deductible under Medicare Part B, what percentage of coinsurance is the patient liable for during an office visit?

A. 80%

B. 100%

C. 20%

D. 15%

In Medicare Part B, after a patient has met their deductible, they are responsible for a percentage of the covered services, known as coinsurance. The standard coinsurance amount for Medicare Part B is 20%. This means that once the deductible is satisfied, the patient would pay 20% of the Medicare-approved amount for the office visit, while Medicare would cover the remaining 80%. This structure helps ensure that patients share some of the costs associated with their healthcare, while also providing substantial coverage through Medicare. The percentages stated in the other options do not correctly reflect the coinsurance responsibilities under Part B; specifically, 80% is the amount covered by Medicare, and the other amounts (100% and 15%) do not align with the established coinsurance structure of Medicare. Thus, the correct response regarding the patient's liability for coinsurance after the deductible is indeed 20%.

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://rhiareimbursement.examzify.com

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

SAMPLE