EPIC RESOLUTE HOSPITAL BILLING FUNDAMENTALS PRACTICE TEST (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 term describes an outstanding claim with no response, where payment and reason codes have been recorded?

A. No Response (Outstanding Claim)

B. Correct Payment (Outstanding Claim)

C. Denial (Outstanding Claim)

D. Variance (Outstanding Claim)

2. What is a revenue center, and how does it affect charging in Resolute?

A. A revenue center is a patient demographic field used for eligibility

B. A revenue center is the department/service category used to group charges and drive reporting

C. A revenue center is used to allocate staff schedules

D. A revenue center is the means of classifying claim submission order

3. Which term is the amount passed on to the patient. NRP to self-pay (or secondary coverage)?

A. Patient Responsibility (Posting Term)

B. Not Allowed Amount (Posting Term)

C. Follow-Up Record

D. Allowed Amount (Contract term)

4. Balance has been communicated and the claim or statement has been sent

A. Created

B. Outstanding

C. Closed

D. HAR

5. What is DSO, and how is it calculated in hospital billing?

A. Days Sales Outstanding measures average days to collect payment; calculated as ending AR balance divided by average daily charges or payments.

B. DSO is the total number of days in a billing cycle.

C. DSO equals the total revenue divided by total charges.

D. DSO is the number of days to deny a claim.

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6. Which option writes off the late charges and creates no new claim?

A. Late Charge Write-Off

B. Late Charge Addition

C. No Response (Outstanding Claim)

D. Cash Management

7. Which action is typically taken when a denial is due to a duplicate claim?

A. Remove the duplicate and resubmit a single corrected claim

B. Ignore and wait for payer to correct itself

C. Verify patient eligibility again

D. Cancel the claim and terminate service

8. In Resolute, what is the Remittance Advice file and how is it used?

A. Demographics file used for scheduling

B. Remittance Advice file containing payer payments and adjustments; used to post payments/adjustments to accounts

C. Claim error log used for auditing denials

D. Payer contract file used to determine allowed amounts

9. Which statement best describes why hospital accounts are important?

A. They hold the HB HAR in three stages of the revenue cycle: Initiate Billing, Claims Processing, and Statement Processing.

B. They store HB HAR in three stages of the revenue cycle, not including billing and statements.

C. They track patient appointments.

D. They store only charges, not payments.

10. Assign and track financial liability for an HB HAR throughout the revenue cycle

A. Created

B. Outstanding

C. Min Days

D. Liability Buckets

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Answers

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

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Explanations

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1. Which term describes an outstanding claim with no response, where payment and reason codes have been recorded?

A. No Response (Outstanding Claim)

B. Correct Payment (Outstanding Claim)

C. Denial (Outstanding Claim)

D. Variance (Outstanding Claim)

The key idea is tracking claims that have been filed but haven't received a decision from the payer yet. When a claim is outstanding because there has been no response from the payer, the label No Response (Outstanding Claim) is used. It signals that the claim is still in limbo and needs adjudication, not that a payment has been posted or that a denial has been issued. This distinguishes it from other states: a payment status would indicate money has been received, a denial means the payer issued an adverse decision, and a variance points to a mismatch between billed and allowed amounts. Even if payment and reason codes appear in the claim's history, the defining factor here is the absence of a payer response, which is why this option best fits.

2. What is a revenue center, and how does it affect charging in Resolute?

A. A revenue center is a patient demographic field used for eligibility

B. A revenue center is the department/service category used to group charges and drive reporting

C. A revenue center is used to allocate staff schedules

D. A revenue center is the means of classifying claim submission order

A revenue center is the department or service category a charge belongs to, and in Resolute it's used to group charges and drive reporting. By tagging each charge with a revenue center, the system can aggregate revenue by department, apply department-specific pricing or rules, and feed the correct data into financial and utilization reports. This tagging also supports accurate charge capture and the revenue cycle, because the department view determines how charges are posted, tracked, and reported for performance and budgeting. It isn't a patient demographic field for eligibility, it isn't used to schedule staff, and it isn't the mechanism for the order of claim submission.

3. Which term is the amount passed on to the patient. NRP to self-pay (or secondary coverage)?

A. Patient Responsibility (Posting Term)

B. Not Allowed Amount (Posting Term)

C. Follow-Up Record

D. Allowed Amount (Contract term)

The key idea here is understanding what gets charged to the patient after an insurance claim is processed. Once the payer adjudicates a claim, the amount the patient ultimately owes is the remaining balance after the insurer pays its part. In Resolute posting terms, that remaining balance is called the Patient Responsibility. This includes things like deductibles, coinsurance, copays, and any portions not covered by the plan. When the account shifts to self-pay or to secondary coverage, the amount that must be collected from the patient is precisely this patient responsibility. Not Allowed Amount refers to funds the payer will not cover due to contract limits, which isn't the amount the patient pays in most standard scenarios. The Allowed Amount is the maximum the payer will reimburse under the contract, not the amount the patient owes. A Follow-Up Record is a tracking entry, not a money amount. So, the amount passed on to the patient under self-pay or secondary coverage is the Patient Responsibility.

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4. Balance has been communicated and the claim or statement has been sent

A. Created

B. Outstanding

C. Closed

D. HAR

In accounts receivable, a balance that has been communicated and the claim or statement sent is still awaiting payment. This state is described as outstanding, signaling that money is due and follow-up is needed with the payer or patient. It isn't just created (that would be the initial generation before any notification), nor is it closed (that would mean the balance is resolved or paid). HAR isn't a standard status for this scenario. So the best fit is outstanding.

5. What is DSO, and how is it calculated in hospital billing?

A. Days Sales Outstanding measures average days to collect payment; calculated as ending AR balance divided by average daily charges or payments.

B. DSO is the total number of days in a billing cycle.

C. DSO equals the total revenue divided by total charges.

D. DSO is the number of days to deny a claim.

DSO measures how long, on average, it takes to convert a service into cash in the hospital setting. It's calculated by taking the ending accounts receivable balance and dividing it by the average daily net revenue (or average daily charges/payments) for the period. In practice, this shows how many days' worth of revenue is tied up in receivables. A lower DSO means faster collections and better cash flow, while a higher DSO indicates slower payment collection and potential cash flow concerns. The other descriptions don't fit because they describe cycle length, a revenue-to-charge ratio, or denial timing, none of which reflect the speed of collecting payments.

6. Which option writes off the late charges and creates no new claim?

A. Late Charge Write-Off

B. Late Charge Addition

C. No Response (Outstanding Claim)

D. Cash Management

When you need to remove a late charge without billing the patient again, the action to choose is the one that performs a write-off. A Late Charge Write-Off clears the late charge from the account and does not generate a new claim for that amount, keeping the patient balance accurate without extra billing steps. This is used when the late charge should not be billed or is no longer valid, so no new claim is created. The other options would not meet this goal. Adding a late charge would re-bill the amount and likely create a new claim. An Outstanding Claim status indicates an unresolved claim that's still in process, not a write-off. Cash Management deals with handling payments and cash flow, not waiving or removing charges.

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7. Which action is typically taken when a denial is due to a duplicate claim?

A. Remove the duplicate and resubmit a single corrected claim

B. Ignore and wait for payer to correct itself

C. Verify patient eligibility again

D. Cancel the claim and terminate service

When a denial is caused by a duplicate claim, the goal is to have only one valid submission for that service. The typical action is to remove the duplicate entry from the system (void or delete the extra claim) and resubmit a single corrected claim with the same patient, date of service, and service details. This prevents duplicate payment and aligns with payer expectations that only one claim for a given service is processed. Ignoring the denial, rechecking eligibility, or canceling the claim and terminating service wouldn't resolve the duplicate and could create additional problems.

8. In Resolute, what is the Remittance Advice file and how is it used?

A. Demographics file used for scheduling

B. Remittance Advice file containing payer payments and adjustments; used to post payments/adjustments to accounts

C. Claim error log used for auditing denials

D. Payer contract file used to determine allowed amounts

Remittance Advice in Resolute refers to the data feed that carries the payer's adjudication results for processed claims, including the actual payments and any adjustments. This file (often in an 835-like format) is used to post those payments and adjustments to the corresponding patient accounts in the accounts receivable ledger. By applying the posted amounts to the correct claims, Resolute reconciles what was billed, what the payer paid, and what remains due, and it updates balances and payment histories accordingly. The other options don't fit this function. A demographics file is about patient information used for scheduling and records, not for posting payments. A claim error log tracks denials and processing errors for auditing, not for posting payments. A payer contract file stores terms and allowed amounts to help adjudicate claims, rather than posting actual payments to accounts.

9. Which statement best describes why hospital accounts are important?

A. They hold the HB HAR in three stages of the revenue cycle: Initiate Billing, Claims Processing, and Statement Processing.

B. They store HB HAR in three stages of the revenue cycle, not including billing and statements.

C. They track patient appointments.

D. They store only charges, not payments.

Hospital accounts serve as the financial hub for a patient encounter, capturing the HB HAR data through three key stages of the revenue cycle before billing and statements are generated. This organization ensures that charges, payer information, and encounter details stay linked to the same account as the claim moves toward submission and payment processing, supporting accurate revenue recognition and reconciliation. The other options either shift focus to scheduling (appointments) or oversimplify the scope by only mentioning charges, whereas accounts also reflect payments and adjustments and are not limited to billing and statements.

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10. Assign and track financial liability for an HB HAR throughout the revenue cycle

A. Created

B. Outstanding

C. Min Days

D. Liability Buckets

Tracking financial liability across the revenue cycle is best done by placing each HAR liability into categorized groups called liability buckets. This approach gives a clear, ongoing view of where every liability stands—from creation through billing, submission, adjudication, denial management, and payment. By assigning a liability to a specific bucket, you can monitor its aging, identify gaps, trigger appropriate actions, and generate accurate reports. It's the bucket system that provides the structure needed to see progress, prioritize tasks, and reconcile amounts as they move toward resolution. Other options describe state or metric ideas (a liability being created, outstanding status, or a minimum time metric) but they don't provide a structured mechanism to continuously classify and track liabilities through the entire revenue cycle. Liability buckets, in contrast, are specifically about organizing and monitoring liabilities over time.

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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://epicresolutehospbillingfund.examzify.com

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

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