

# Epic Resolute Professional Billing (PB) Fundamentals Practice Exam (Sample)

## Study Guide



**Everything you need from our exam experts!**

**This is a sample study guide. To access the full version with hundreds of 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. Don't worry about getting everything right, 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, and take breaks to retain information better.**

## 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.**

## 7. Use Other Tools

**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. Should creating claims be mostly an automated process?**
  - A. Yes**
  - B. No**
  - C. Only for specific types of claims**
  - D. It depends on the system configuration**
- 2. What influence does the clinical application have on charge updates?**
  - A. It determines reimbursement amounts.**
  - B. It drives patient engagement strategies.**
  - C. It ensures accuracy in clinical documentation.**
  - D. It controls the flow of charge updates.**
- 3. Why might you need to use the Force Resubmit option?**
  - A. To finalize the charges for the fiscal year.**
  - B. For timely filing and if build requires fixing.**
  - C. To cancel the charges.**
  - D. To adjust patient account numbers.**
- 4. What is the primary purpose of Epic Resolute Professional Billing?**
  - A. To facilitate the billing process for professional services rendered in healthcare**
  - B. To manage patient scheduling and appointments**
  - C. To oversee pharmacy operations and inventory**
  - D. To handle medical record documentation and coding**
- 5. What does NAA (WO) stand for and what does it do?**
  - A. No Allowed Adjustment; tracks uncollected fees**
  - B. Not Allowed Adjustment; writes off the amount over the allowed amount**
  - C. New Accounts Adjustment; creates new patient accounts**
  - D. Non-Applicable Adjustment; applies to service errors**

**6. Where in Account Maintenance can you view information about self-pay and insurance balances, as well as any payments or adjustments made for all HARs belonging to the same guarantor?**

- A. Account Summary**
- B. Account Contact**
- C. Liability Buckets**
- D. Guarantor Summary**

**7. What does a facility record represent?**

- A. Individual patient information**
- B. Your entire healthcare organization**
- C. Specific departments within the hospital**
- D. Accounts receivable for services rendered**

**8. Which process ensures that the amount collected matches the amounts posted in the system?**

- A. Financial auditing**
- B. Cash reconciliation**
- C. Patient invoicing**
- D. Claims submission**

**9. How often should billing staff review accounts for potential denials?**

- A. Annually, as per operational guidelines**
- B. Regularly, typically on a daily or weekly basis**
- C. Quarterly, to meet audit requirements**
- D. Monthly, for financial reconciliations**

**10. True or False: Confirming a cash control group posts the payments into Epic.**

- A. True**
- B. False**
- C. It depends on the system settings**
- D. Only if manual adjustments are made**

## **Answers**

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

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## **Explanations**

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## 1. Should creating claims be mostly an automated process?

- A. Yes**
- B. No**
- C. Only for specific types of claims**
- D. It depends on the system configuration**

Creating claims should be mostly an automated process to enhance efficiency, reduce human error, and streamline the revenue cycle in healthcare billing. Automation allows for swift processing of a large volume of claims, which can lead to faster reimbursements and improved cash flow for healthcare providers. By leveraging technology to handle repetitive and rule-based tasks, staff can focus on more complex issues that require human intervention, such as resolving discrepancies or addressing denied claims. Automated claim creation typically utilizes pre-defined rules and data inputs to generate claims accurately. This approach ensures consistency and compliance with payer requirements, which is crucial in the ever-evolving landscape of healthcare billing regulations. Moreover, automation can significantly decrease the administrative burden on billing staff, allowing for a strategic allocation of resources within the revenue cycle team. While other choices may imply a specific approach or conditionality to the claim creation process, the prevailing trend in healthcare is towards automation to maintain efficiency and accuracy. Automated systems can adapt to various claim types, thus supporting the overall goal of optimizing billing operations.

## 2. What influence does the clinical application have on charge updates?

- A. It determines reimbursement amounts.**
- B. It drives patient engagement strategies.**
- C. It ensures accuracy in clinical documentation.**
- D. It controls the flow of charge updates.**

The influence of clinical application on charge updates is primarily reflected in ensuring accuracy in clinical documentation. Accurate clinical documentation is essential for reflecting the services provided to patients. This documentation serves as the basis for generating charges, as it describes the care delivered, the complexity of the patient's condition, and the procedures performed. When clinical applications effectively capture and manage this documentation, it leads to precise and timely charge updates, which are critical for proper billing processes. This focus on accuracy helps prevent billing discrepancies and supports compliance with regulatory standards, ultimately contributing to appropriate revenue cycle management. While the other options touch on significant aspects of healthcare operations, they do not directly address the relationship between clinical applications and the accuracy of charge updates in the same way.

### 3. Why might you need to use the Force Resubmit option?

- A. To finalize the charges for the fiscal year.
- B. For timely filing and if build requires fixing.**
- C. To cancel the charges.
- D. To adjust patient account numbers.

Using the Force Resubmit option is necessary when there is a need to ensure that billing claims are processed in a timely manner, especially if there are issues that require correcting within the claim builds. This option alleviates concerns related to timely filing, which is crucial for receiving reimbursement from payers. If there are errors or adjustments needed in the claim details—such as incorrect coding or missing information—utilizing the Force Resubmit option allows for the revised claims to be sent out again without the typical delays that could occur in standard resubmission processes. Timeliness in filing is critical, particularly given the regulations surrounding reimbursement timelines set by insurance companies, and Force Resubmit helps meet those deadlines effectively while ensuring that the necessary corrections are made.

### 4. What is the primary purpose of Epic Resolute Professional Billing?

- A. To facilitate the billing process for professional services rendered in healthcare**
- B. To manage patient scheduling and appointments
- C. To oversee pharmacy operations and inventory
- D. To handle medical record documentation and coding

The primary purpose of Epic Resolute Professional Billing is indeed to facilitate the billing process for professional services rendered in healthcare. This system is designed to streamline and manage the complex tasks associated with billing, ensuring that healthcare providers can efficiently track and process claims for services they have delivered to patients. Epic Resolute helps to automate billing workflows, ensuring that billing codes are applied accurately, claims are submitted promptly, and payments are processed effectively. By focusing on the revenue cycle management aspect, it allows healthcare organizations to improve their financial performance and enhance cash flow. In contrast, other options focus on different aspects of healthcare operations. Managing patient scheduling and appointments relates to patient flow and access to care, while overseeing pharmacy operations and inventory pertains to the management of medications and supplies. Handling medical record documentation and coding involves the clinical side of patient information management rather than billing. Thus, the focus of the Epic Resolute system on billing distinctly places it as a critical tool in the professional services billing landscape.

## 5. What does NAA (WO) stand for and what does it do?

- A. No Allowed Adjustment; tracks uncollected fees
- B. Not Allowed Adjustment; writes off the amount over the allowed amount**
- C. New Accounts Adjustment; creates new patient accounts
- D. Non-Applicable Adjustment; applies to service errors

The term NAA (WO) stands for "Not Allowed Adjustment." In the context of professional billing, this adjustment is specifically used to write off amounts that exceed the allowed amount established by the insurance payer. When a provider submits a claim, the payer sets a limit on what they are willing to reimburse for a certain service. If a provider bills more than this allowed amount, the excess is recorded as a Not Allowed Adjustment. This process is essential for accurate financial management, as it helps ensure that the billing reflects the amounts that will realistically be collected. By writing off these disallowed charges, the practice can maintain clean financial records and avoid confusion regarding patient balances. Understanding this classification allows billing professionals to accurately process claims and manage the financial interactions between patients, providers, and payers effectively. The other options do not accurately represent the function of the NAA (WO) within the billing system, as they refer to other contexts or processes that are not pertinent to the classification of adjustments based on payer allowances.

## 6. Where in Account Maintenance can you view information about self-pay and insurance balances, as well as any payments or adjustments made for all HARs belonging to the same guarantor?

- A. Account Summary
- B. Account Contact
- C. Liability Buckets
- D. Guarantor Summary**

The Guarantor Summary is the appropriate location to view comprehensive information regarding self-pay and insurance balances, along with details about any payments or adjustments associated with all Hospital Accounts Receivable (HARs) linked to the same guarantor. This section consolidates data relevant to the guarantor, providing a complete overview of their financial responsibilities and account statuses. In the Guarantor Summary, users can see not only current balances but also transaction histories that reflect all financial activities, including any payments received or adjustments made. This makes it a crucial tool for understanding the overall financial engagement of a guarantor with the accounts they are responsible for. While the Account Summary provides a snapshot of the account, including primary balances and some transaction history, it does not specifically consolidate information across multiple HARs for a single guarantor. The Account Contact focuses more on contact information and communication detail rather than financial standing. Liability Buckets display breakdowns of liabilities but do not summarize this information by guarantor across multiple accounts. Therefore, the Guarantor Summary most accurately provides the desired information.

## 7. What does a facility record represent?

- A. Individual patient information
- B. Your entire healthcare organization**
- C. Specific departments within the hospital
- D. Accounts receivable for services rendered

A facility record represents your entire healthcare organization. This means it encompasses all aspects and information regarding the organization, including the various departments, services provided, billing processes, and overall operational data. By capturing comprehensive information about the organization, the facility record serves as a crucial reference point for managing inter-departmental functions, patient care coordination, and financial processes. Understanding the facility record is essential as it plays a vital role in how the organization administers patient care and handles billing and reimbursement. It provides a unified structure that reflects the entirety of the healthcare operations, facilitating efficient communication and management across the different areas within the organization. This holistic view is critical for maintaining effective workflows, ensuring compliance, and optimizing revenue cycle processes.

## 8. Which process ensures that the amount collected matches the amounts posted in the system?

- A. Financial auditing
- B. Cash reconciliation**
- C. Patient invoicing
- D. Claims submission

Cash reconciliation is the process that ensures the amounts collected from patients or payers match the amounts posted in the billing system. This step is crucial because it helps to verify that all transactions recorded in the system, such as payments and adjustments, are accurate and reflect the actual cash received. During cash reconciliation, billing staff compare the payments entered into the system against bank statements, payment reports, and other financial records. This process helps identify discrepancies, whether due to clerical errors, unposted payments, or other billing inaccuracies. By ensuring that the collected amounts align with the amounts recorded in the system, organizations can maintain financial integrity and effectively manage their revenue cycle. In contrast, financial auditing focuses on the overall accuracy and compliance of financial statements rather than matching cash collections. Patient invoicing pertains to generating statements for patients, which is a different aspect of the billing process. Claims submission involves sending information to insurance payers to receive reimbursement for services rendered, which does not directly address the matching of collected amounts with posted amounts in the system.

## 9. How often should billing staff review accounts for potential denials?

- A. Annually, as per operational guidelines**
- B. Regularly, typically on a daily or weekly basis**
- C. Quarterly, to meet audit requirements**
- D. Monthly, for financial reconciliations**

Billing staff should review accounts for potential denials regularly, typically on a daily or weekly basis, to promptly identify and address issues that could lead to denied claims. Regular reviews help in monitoring the accuracy of submitted claims, ensuring that any discrepancies are caught early and can be resolved quickly. This proactive approach minimizes the delay in revenue cycle processes, allows for faster follow-up on outstanding claims, and ultimately aids in maintaining a healthy cash flow for the organization. The frequency of daily or weekly reviews is essential in adapting to the volume of claims processed and changes in billing regulations or payer requirements, enabling timely interventions to mitigate denial risks.

## 10. True or False: Confirming a cash control group posts the payments into Epic.

- A. True**
- B. False**
- C. It depends on the system settings**
- D. Only if manual adjustments are made**

The statement that confirming a cash control group posts the payments into Epic is false. Confirming a cash control group is primarily a process that involves verifying and finalizing the financial transactions that have been processed. This step ensures that cash receipts and payments are reconciled and accounted for, but it does not directly result in the posting of payments into the Epic system. In Epic, payments are typically posted through other activities, such as directly entering payments or through the processing of payment batches. The confirmation process serves as a record-keeping measure, ensuring that the cash controls align with the entries made in the accounting system rather than being the act that inflates payment records in the system. Understanding the functions of cash control groups is crucial in billing and payment management, particularly in a system like Epic, where proper tracking of cash flow is vital for maintaining financial accuracy and operational efficiency.

# 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](mailto: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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