

EPIC RESOLUTE PROFESSIONAL BILLING (PB) FUNDAMENTALS PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

**VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE**

<https://epicresolutepbfundamentals.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	15

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.

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

SAMPLE

- 1. What is the significance of maintaining up-to-date fee schedules in Epic PB?**
 - A. It reduces the need for software updates
 - B. It ensures billing is accurate and reflects current market rates
 - C. It simplifies the claims submission process
 - D. It allows for more flexibility in payment plans
- 2. Which of the following statements is correct about a patient refund module?**
 - A. It can only process check refunds
 - B. It allows for partial refunds
 - C. It is limited to cash payments
 - D. It requires patient consent
- 3. What does the term 'charge review' refer to in the context of professional billing?**
 - A. A verification process to ensure accurate coding.
 - B. A strategy to minimize billing errors.
 - C. A method to evaluate outstanding charges.
 - D. A review of payment adjustments.
- 4. 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
- 5. What does 'Procedure count' refer to?**
 - A. Number of procedures submitted for approval
 - B. Number of procedures to be entered
 - C. Total revenue from procedures
 - D. Average time taken for procedures

- 6. What action is typically performed first in the billing process?**
- A. Submitting claims
 - B. Entering charge details
 - C. Generating invoices
 - D. Counting cash
- 7. What does the term 'patient responsibility' refer to in billing?**
- A. The total amount billed before insurance applies
 - B. The portion of the bill that the patient is obligated to pay after insurance reimbursement
 - C. The initial amount charged to the patient
 - D. The amount deducted for services not covered by insurance
- 8. What is the use of revenue codes in Epic PB?**
- A. To categorize services for internal reporting
 - B. To classify billing services for correct reimbursement purposes
 - C. To track inventory of medical supplies
 - D. To manage patient appointments
- 9. Which type of workqueues are claim denials that need review caught by the system?**
- A. Follow-up workqueues
 - B. Credit workqueues
 - C. Payer workqueues
 - D. Charge Review requeues
- 10. What does HAR stand for in the context of hospital accounts?**
- A. Hospital Accommodations Record
 - B. Health Account Record
 - C. Hospital Account Record
 - D. Health Admissions Record

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. What is the significance of maintaining up-to-date fee schedules in Epic PB?

- A. It reduces the need for software updates
- B. It ensures billing is accurate and reflects current market rates**
- C. It simplifies the claims submission process
- D. It allows for more flexibility in payment plans

Maintaining up-to-date fee schedules in Epic Professional Billing is crucial because it ensures that billing is accurate and reflects current market rates. Accurate fee schedules are essential for healthcare organizations to bill patients and insurance companies correctly. If the fee schedules are outdated, there is a risk that services may be billed at incorrect rates, leading to potential revenue loss or compliance issues. By keeping fee schedules current, organizations can ensure they are charging appropriate amounts for services rendered, which helps in maximizing revenue and minimizing disputes with payers. This practice also enhances the overall efficiency of the revenue cycle by ensuring that all parties are on the same page regarding the cost of services provided.

2. Which of the following statements is correct about a patient refund module?

- A. It can only process check refunds
- B. It allows for partial refunds**
- C. It is limited to cash payments
- D. It requires patient consent

The statement that "it allows for partial refunds" is accurate concerning the patient refund module. This reflects the flexibility within the system to accommodate various billing situations where only a portion of the payment made by the patient needs to be returned. Such scenarios may arise in cases of overpayment, adjustments due to billing errors, or when services that were billed were not provided or were canceled. This feature is crucial for maintaining patient satisfaction as it ensures that patients are reimbursed accurately based on the specifics of their situation rather than requiring a full refund when only a part of the original payment needs to be returned. It allows healthcare providers to appropriately manage finances while also fostering trust and transparency with patients.

3. What does the term 'charge review' refer to in the context of professional billing?

- A. A verification process to ensure accurate coding.**
- B. A strategy to minimize billing errors.
- C. A method to evaluate outstanding charges.
- D. A review of payment adjustments.

The term 'charge review' in the context of professional billing refers to a verification process that ensures accurate coding. This is a crucial aspect of billing procedures because accurate coding directly affects the reimbursement process. Incorrect codes can lead to denied claims, delayed payments, or even legal implications. In this process, the charges for services rendered are examined to confirm that the codes used match the documentation of the services provided. This includes not only verifying that the correct procedure codes are applied but also ensuring compliance with guidelines for modifiers and revenue codes. An effective charge review helps maintain the integrity of the billing cycle and ensures that healthcare providers are reimbursed correctly for their services.

4. 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.

5. What does 'Procedure count' refer to?

- A. Number of procedures submitted for approval
- B. Number of procedures to be entered**
- C. Total revenue from procedures
- D. Average time taken for procedures

'Procedure count' refers specifically to the total number of procedures that are documented or recorded for a patient or for billing purposes. This metric is commonly used in professional billing systems to track the quantity of services provided. By focusing on the number of procedures to be entered, it represents a crucial aspect of managing patient data and ensuring that all services are accounted for in billing. The importance of procedure count lies in its application for ensuring accurate billing and reimbursement. Each procedure typically correlates with a specific billing code, making it essential for the billing department to have a precise count to avoid discrepancies and ensure that all rendered services are billed correctly. Understanding procedure count as the number of procedures to be entered assists professionals in maintaining accurate records and preparing for the billing process effectively, ensuring that healthcare providers are compensated for all services rendered.

6. What action is typically performed first in the billing process?

- A. Submitting claims
- B. Entering charge details**
- C. Generating invoices
- D. Counting cash

The first action typically performed in the billing process is entering charge details. This is a fundamental step that involves accurately recording the services or procedures that have been provided to the patient. Charge entry serves as the foundation for the entire billing cycle and is essential for ensuring that all subsequent actions, such as claim submission and invoice generation, have accurate and complete data. When charge details are entered correctly, it facilitates the creation of claims that reflect the services rendered, which is critical for obtaining payment from insurers or patients. Errors or omissions at this stage can lead to delays in the billing process, denied claims, and ultimately, challenges in cash flow for the practice or provider. Therefore, charge entry is prioritized in the billing sequence to ensure a smooth and efficient revenue cycle management process.

7. What does the term 'patient responsibility' refer to in billing?

- A. The total amount billed before insurance applies
- B. The portion of the bill that the patient is obligated to pay after insurance reimbursement**
- C. The initial amount charged to the patient
- D. The amount deducted for services not covered by insurance

The term 'patient responsibility' in billing specifically refers to the portion of the bill that the patient is obligated to pay after insurance reimbursement is accounted for. This amount typically includes deductibles, copayments, and any other expenses that the insurance plan does not cover. It's crucial to distinguish this from the total amount billed or the initial charges, as patient responsibility reflects the financial obligation remaining after the insurance company has processed the claim and made their payments. Understanding this term is essential in both patient billing practices and healthcare administration because it highlights the patient's share of healthcare costs. When patients receive statements or bills, knowing what constitutes their responsibility helps them understand their financial obligations and aids in more accurate financial planning. The other options pertain to different aspects of the billing process, yet they do not capture the definition of patient responsibility as accurately as the correct choice does.

8. What is the use of revenue codes in Epic PB?

- A. To categorize services for internal reporting
- B. To classify billing services for correct reimbursement purposes**
- C. To track inventory of medical supplies
- D. To manage patient appointments

Revenue codes play a crucial role in the billing process within Epic Professional Billing by classifying billing services that are essential for ensuring correct reimbursement from payers. These codes provide a standardized method for identifying specific services rendered to patients, which is important for several reasons. First, accurate classification of services through revenue codes directly impacts the reimbursement process. Different services may have varying reimbursement rates based on codes assigned, so it is essential to apply the correct revenue code to avoid claim denials or underpayment. This coding helps payers understand what services were provided and invoice accordingly. Additionally, revenue codes are used to comply with regulations and payer requirements, ensuring that the billing information aligns with the services provided in the medical records. Properly utilizing these codes can significantly enhance revenue cycle management by minimizing billing discrepancies and optimizing payment collection. The other options do not align with the primary purpose of revenue codes. While internal reporting, inventory management, and patient appointment management are important functions within a healthcare system, they do not directly relate to the classification of services for billing and reimbursement, which is the main focus of revenue codes.

9. Which type of workqueues are claim denials that need review caught by the system?

A. Follow-up workqueues

B. Credit workqueues

C. Payer workqueues

D. Charge Review queues

The correct choice highlights that claim denials requiring review are effectively managed through follow-up workqueues. Follow-up workqueues are specifically designed to track and address outstanding issues related to claims, including those that have been denied by payers. When a claim is denied, it typically indicates that additional information or clarification is needed, prompting the need for subsequent action. These workqueues facilitate the systematic review of denied claims, ensuring that appropriate steps are taken to resolve the issues and submit corrected claims or appeals as necessary. The emphasis in follow-up workqueues is on addressing the status of claims post-submission, making them ideally suited for handling denials. Employees responsible for billing can prioritize these cases to improve the likelihood of successful resolution and revenue recovery, making them an integral part of the claims management process in revenue cycle operations. Other types of workqueues, such as credit workqueues, focus more on managing financial transactions related to overpayments or adjustments. Payer workqueues may deal with issues linked to specific insurance payers but do not specialize in the resolution of denials. Charge Review queues are usually concerned with pre-submission checks on charges rather than post-denial reviews. Hence, follow-up workqueues stand out as the necessary tools for effectively managing denials that

10. What does HAR stand for in the context of hospital accounts?

A. Hospital Accommodations Record

B. Health Account Record

C. Hospital Account Record

D. Health Admissions Record

The term HAR stands for Hospital Account Record. This is an essential component in hospital billing processes, as it serves as a comprehensive record for a patient's account within a hospital setting. The HAR is used to track all financial transactions related to a patient's visit, including charges for services, payments, and billing adjustments. It plays a critical role in ensuring accurate billing and helps healthcare organizations maintain financial accountability. Each of the other choices represents names that can sound plausible but do not specifically pertain to the standard terminology used in the healthcare billing context. Hospital Accommodations Record, Health Account Record, and Health Admissions Record, while they might describe aspects of patient care or admission processes, do not accurately reflect the established terminology used for tracking financial accounts within the hospital billing framework. The clarity and specificity of the term "Hospital Account Record" make it the correct choice for understanding the processes of hospital accounting.

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!

SAMPLE