

HFMA EXECUTIVE OF HEALTHCARE REVENUE CYCLE (EHRC) 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.

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

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- 1. Define 'underpayment' in the context of healthcare revenue cycle.**
 - A. Receiving more reimbursement than expected
 - B. Receiving less reimbursement than expected for services
 - C. Not receiving any payment at all
 - D. Overcharging patients for services
- 2. What are the structured progress notes that physicians use to document patient encounters in an EHR called?**
 - A. Clinical notes
 - B. Clinical templates
 - C. Patient logs
 - D. Medical summaries
- 3. Which of the following is true regarding adjustments made by insurance companies?**
 - A. Adjustments are always paid by the patient
 - B. Adjustments can reduce the total bill amount acknowledged by the insurer
 - C. All adjustments are permanent
 - D. Adjustments are only applicable to out-of-network providers
- 4. In the context of patient assessments, what do orders usually refer to?**
 - A. Follow-up consultations
 - B. Medications and treatments
 - C. Emergency procedures
 - D. Insurance inquiries
- 5. What is the main difference between prospective and retrospective payment models?**
 - A. Prospective pays before services, retrospective pays after
 - B. Both models pay in advance but differ in reimbursement rates
 - C. Retrospective models are obsolete
 - D. Only prospective models account for patient demographics

- 6. Which of the following is an example of unstructured data?**
- A. EHR Database
 - B. Dictated Report
 - C. Structured Questionnaire
 - D. Statistical Analysis
- 7. According to the birthday rule, how is a child's primary insurance determined when both parents cover dependents?**
- A. The parent who pays the higher premium is primary
 - B. The parent whose birthday is earlier in the calendar year is primary
 - C. The parent with the most healthcare coverage is primary
 - D. The parent employed by the larger organization is primary
- 8. What is the role of the chief financial officer (CFO) concerning the revenue cycle?**
- A. Oversees clinical operations and service delivery
 - B. Manages financial management and strategic planning
 - C. Executes marketing and community relations
 - D. Handles patient access and billing operational tasks
- 9. Which of the following is a requirement for services to be billed to insurance?**
- A. Necessary
 - B. Voluntary
 - C. Optional
 - D. Desirable
- 10. What impact does timely claim processing have on the revenue cycle?**
- A. Leads to higher operational costs
 - B. Increases the speed of revenue collection
 - C. Reduces patient satisfaction
 - D. Decreases transparency in billing

Answers

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

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Explanations

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1. Define 'underpayment' in the context of healthcare revenue cycle.

- A. Receiving more reimbursement than expected
- B. Receiving less reimbursement than expected for services**
- C. Not receiving any payment at all
- D. Overcharging patients for services

In the context of healthcare revenue cycle, 'underpayment' specifically refers to receiving less reimbursement than expected for the services rendered. This situation arises when the amount paid by a payer (such as an insurance company or government entity) is less than what the healthcare provider anticipated based on the contracted rates, especially when the provider has followed all guidelines and submitted accurate claims. Understanding underpayment is crucial for healthcare organizations as it directly affects their revenue and financial sustainability. Managing and mitigating underpayments involves meticulous billing practices, contract negotiations, and appeals to ensure that providers are compensated fairly for the care provided. Addressing underpayments effectively contributes to the overall efficiency of the revenue cycle, ensuring that resources are available for patient care and operational needs.

2. What are the structured progress notes that physicians use to document patient encounters in an EHR called?

- A. Clinical notes
- B. Clinical templates**
- C. Patient logs
- D. Medical summaries

The structured progress notes that physicians use to document patient encounters in an Electronic Health Record (EHR) are referred to as clinical templates. These templates provide a standardized format that helps ensure consistency and completeness in patient documentation. They often include predefined fields for entering patient information, assessments, and treatment plans, making it easier for healthcare providers to record and retrieve pertinent information during follow-up visits or consultations. Clinical templates assist in streamlining the documentation process, thereby enhancing efficiency and reducing the likelihood of errors. The standardized nature of these templates supports better communication among healthcare professionals, which is crucial for delivering high-quality patient care. Other options such as clinical notes, patient logs, and medical summaries do not specifically denote the structured format that clinical templates embody, which is essential for consistency across different clinicians and settings.

3. Which of the following is true regarding adjustments made by insurance companies?

- A. Adjustments are always paid by the patient
- B. Adjustments can reduce the total bill amount acknowledged by the insurer**
- C. All adjustments are permanent
- D. Adjustments are only applicable to out-of-network providers

The statement that adjustments can reduce the total bill amount acknowledged by the insurer is accurate. In healthcare billing, when an insurance company processes a claim, they may determine that certain services were not covered or were only partially covered. As a result, they make adjustments to the billed amount, which could reflect contractual obligations, fee schedule limitations, or disallowed services. These adjustments effectively lower the total amount that the insurer recognizes as being owed for a service, thus impacting what the healthcare provider can collect from the patient and the insurer. Adjustments play a critical role in billing as they help align the provider's charges with the insurer's payment policies. Therefore, it is important for providers to understand how adjustments work and how they can affect revenue cycle management. Regarding the other options, adjustments are not always the responsibility of the patient; they are often absorbed by the healthcare provider depending on the terms of their agreement with the insurance company. Not all adjustments are permanent, as they can sometimes be appealed or revised if new information comes to light. Lastly, adjustments are not limited to out-of-network providers; they apply to both in-network and out-of-network services, depending on the specifics of the insurance contract and the nature of the services provided.

4. In the context of patient assessments, what do orders usually refer to?

- A. Follow-up consultations
- B. Medications and treatments**
- C. Emergency procedures
- D. Insurance inquiries

In the context of patient assessments, orders typically refer to medications and treatments prescribed by healthcare providers. These orders are critical as they outline the specific actions or interventions that need to be taken to address a patient's medical condition. Medications might involve prescribing pharmaceuticals to manage symptoms or treat illnesses, while treatments could include procedures, therapy, or other interventions aimed at improving the patient's health. Understanding that "orders" specifically encompass the instructions given by physicians or clinicians allows for clarity in healthcare operations. This ensures that all involved in a patient's care, including nurses, pharmacists, and other medical staff, are aligned and informed about how to proceed with treatment based on the established care plan.

5. What is the main difference between prospective and retrospective payment models?

- A. Prospective pays before services, retrospective pays after**
- B. Both models pay in advance but differ in reimbursement rates
- C. Retrospective models are obsolete
- D. Only prospective models account for patient demographics

The main difference between prospective and retrospective payment models lies in the timing of the payment in relation to the delivery of services. In prospective payment models, providers receive payments before the services are rendered, which means they are paid based on a predetermined amount established by factors such as diagnosis or procedure type. This approach encourages efficiency and cost management, as providers are incentivized to keep costs down to maximize their reimbursement. Conversely, retrospective payment models involve payment after services have been delivered. In this system, providers are reimbursed based on actual costs incurred or on a fee-for-service basis, which can lead to higher expenditures as providers may not have the same incentives to control costs. Understanding this fundamental distinction is key for healthcare finance professionals as it influences budgeting, revenue forecasting, and overall strategy for financial management within healthcare organizations.

6. Which of the following is an example of unstructured data?

- A. EHR Database
- B. Dictated Report**
- C. Structured Questionnaire
- D. Statistical Analysis

Unstructured data refers to information that does not have a predefined data model or is not organized in a predefined manner. It often comes in formats that are not easily searchable or analyzable using traditional data-processing methods. A dictated report is a clear example of unstructured data because it typically includes freeform text, narratives, and potentially varying formats that are dependent on the individual who dictated the report. This form of data comprises rich, qualitative information but lacks the standardized structure that would allow for easy extraction and analysis. In contrast, an EHR database, while it may contain various types of data, typically organizes patient information in a structured format, making it easier to query and analyze. A structured questionnaire collects responses in a predefined format, which means the data collected is organized and easily quantifiable. Statistical analysis relies on structured data to derive insights, meaning it similarly functions within a defined structure. Therefore, the dictated report stands out as the correct example of unstructured data.

7. According to the birthday rule, how is a child's primary insurance determined when both parents cover dependents?

- A. The parent who pays the higher premium is primary
- B. The parent whose birthday is earlier in the calendar year is primary**
- C. The parent with the most healthcare coverage is primary
- D. The parent employed by the larger organization is primary

The birthday rule is a widely accepted guideline used to determine the primary insurance for a dependent child when both parents have insurance coverage. According to this rule, the parent whose birthday falls earlier in the calendar year is designated as the primary insurer for the child. This approach simplifies the process of determining which parent's insurance will be billed first, thereby avoiding potential complications that could arise from other criteria, such as who pays the premiums or whose plan offers the most comprehensive coverage. The birthday rule ensures consistency and eases the administrative burden on families when navigating healthcare costs and coverage for dependents. This rule focuses solely on the birth dates of the parents rather than factors such as the organization size or premium amounts, making it straightforward and easy to apply in practical scenarios.

8. What is the role of the chief financial officer (CFO) concerning the revenue cycle?

- A. Oversees clinical operations and service delivery
- B. Manages financial management and strategic planning**
- C. Executes marketing and community relations
- D. Handles patient access and billing operational tasks

The chief financial officer (CFO) plays a crucial role in managing the financial health and strategic direction of an organization, particularly in relation to the revenue cycle. This role encompasses overseeing financial management, which includes budgeting, forecasting, and financial reporting. In addition to managing the finances, the CFO is involved in strategic planning that aligns financial objectives with overall organizational goals. This is particularly important in the revenue cycle because effective financial management is essential for optimizing revenue generation and ensuring operational efficiency across clinical services and billing processes. In this context, while other areas mentioned in the options are important for a healthcare organization, they do not fall under the primary responsibilities of the CFO. The CFO does not typically oversee clinical operations or service delivery directly, nor do they execute marketing and community relations, which are usually handled by other leadership roles within the organization. Similarly, while patient access and billing operational tasks are integral to the revenue cycle, these functions are typically managed by operational teams rather than the CFO, who focuses on the overarching financial strategy.

9. Which of the following is a requirement for services to be billed to insurance?

- A. Necessary**
- B. Voluntary
- C. Optional
- D. Desirable

The requirement for services to be billed to insurance is that they must be necessary. In the context of healthcare, necessary services are those that are deemed essential for the diagnosis or treatment of a medical condition. Insurance companies typically require that a service is medically necessary to consider it for coverage and payment. This means that the service should be appropriate in scope, duration, and intensity, adhering to established guidelines for medical care. When services are characterized as necessary, they are more likely to meet the standards set forth by health plans, which helps ensure that patients receive appropriate treatment while minimizing unnecessary costs. If a service is not categorized as necessary, an insurance provider may deny coverage, leading to potential out-of-pocket expenses for the patient. The other options—voluntary, optional, and desirable—do not reflect the strict criteria that insurers use for billing purposes. Voluntary services might not be covered if they are not essential for patient care, while optional and desirable services would typically fall outside the realm of what is considered necessary for treatment or recovery, therefore lacking the justification for insurance reimbursement.

10. What impact does timely claim processing have on the revenue cycle?

- A. Leads to higher operational costs
- B. Increases the speed of revenue collection**
- C. Reduces patient satisfaction
- D. Decreases transparency in billing

Timely claim processing plays a crucial role in enhancing the efficiency of the revenue cycle, leading directly to an increase in the speed of revenue collection. When claims are processed promptly, the healthcare organization can submit bills to payers without delays, which accelerates payment timelines. This not only improves cash flow but also minimizes the days in accounts receivable, allowing the organization to maintain a healthier financial status. In the context of the revenue cycle, faster claim processing means that healthcare providers can quickly receive reimbursements for the services rendered. This is critical for maintaining operational sustainability, managing expenses, and ensuring resources are allocated effectively with respect to cash flow management. Moreover, timeliness in claim submissions can also reduce the likelihood of denials or rejections from insurers, which often occur when claims are submitted after the allowed timeframe. This further contributes to a more streamlined revenue cycle process, ultimately benefiting the organization's financial health.

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:

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

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