

Registered Health Information Technician (RHIT) Practice Exam (Sample)

Study Guide



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SAMPLE

Questions

- 1. How should the HIM director address the admissions director's concerns regarding notices of privacy practices?**
 - A. Require notices on every service provided**
 - B. Explain that they are only needed on the first admission**
 - C. Provide additional training for admissions staff**
 - D. Ignore the concerns as notices are not mandatory**
- 2. What is the first step in an inpatient record review?**
 - A. Verify correct assignment of the principal diagnosis**
 - B. Review the treatment plan**
 - C. Assess patient outcomes**
 - D. Validate discharge summaries**
- 3. Which of these is an example of a breach of confidentiality?**
 - A. An incorrect billing statement being sent to the wrong patient**
 - B. Advising patients of their appointment time**
 - C. Sharing patient information with family members without consent**
 - D. An employee discussing patient data in a break room**
- 4. If the HIM department's accuracy rate is too low, what should be done?**
 - A. Notify patients of the error rate**
 - B. Take corrective action to meet department standards**
 - C. Conduct an audit without changes**
 - D. Ignore the rate and continue with practices**
- 5. In a healthcare context, what does HIM stand for?**
 - A. Healthcare Information Management**
 - B. Hospital Internal Management**
 - C. Health Integrated Model**
 - D. Human Information Mechanism**

- 6. What role does the Health Information Management (HIM) professional play regarding patient records?**
- A. They solely manage billing processes**
 - B. They ensure proper documentation and regulation compliance**
 - C. They conduct patient assessments**
 - D. They are responsible for patient care plans**
- 7. What does a HIM professional do after completing a gap analysis?**
- A. Develop a plan for improvement**
 - B. Create a compliance report**
 - C. Initiate disciplinary actions**
 - D. Conduct further training**
- 8. If a patient's diagnosis is "Rule out GERD," what is the appropriate ICD-10-CM code?**
- A. R07.9, Chest pain, unspecified**
 - B. K21.9, Gastroesophageal reflux disease, unspecified**
 - C. R10.9, Abdominal pain, unspecified**
 - D. I20.9, Angina pectoris, unspecified**
- 9. What does the process of analyzing variations between current and proposed diagnosis codes create for an organization?**
- A. A data map**
 - B. A research report**
 - C. A budget analysis**
 - D. A patient care protocol**
- 10. Medical necessity is primarily based on what factor?**
- A. The cost of the service**
 - B. The physician's preference**
 - C. The beneficial effects of a service for the patient's needs**
 - D. The frequency of the service provided**

Answers

SAMPLE

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

SAMPLE

Explanations

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1. How should the HIM director address the admissions director's concerns regarding notices of privacy practices?

A. Require notices on every service provided

B. Explain that they are only needed on the first admission

C. Provide additional training for admissions staff

D. Ignore the concerns as notices are not mandatory

The best approach for the HIM director in addressing the admissions director's concerns regarding notices of privacy practices is to explain that these notices are typically only required at the time of the first admission. This aligns with the Health Insurance Portability and Accountability Act (HIPAA) regulations, which state that healthcare providers must provide patients with a notice of privacy practices upon their first visit or admission. Once the patient has received the notice, it does not need to be redistributed for every subsequent service, as long as the practices outlined in the notice remain consistent. This foundational understanding of when the notices are required helps clarify the admissions director's concerns by demonstrating compliance with regulations while also streamlining the admission process. Providing this clear and concise explanation can alleviate unnecessary anxiety regarding potential oversights in procedure. Offering additional training for admissions staff might be beneficial in ensuring that everyone understands the protocol, but it's ultimately the clarification of the requirements that addresses the core concern. Conversely, requiring notices on every service offered would likely create an unnecessary burden on staff and patients alike, while ignoring the concerns does not foster a collaborative environment for solving potential issues.

2. What is the first step in an inpatient record review?

A. Verify correct assignment of the principal diagnosis

B. Review the treatment plan

C. Assess patient outcomes

D. Validate discharge summaries

Verifying the correct assignment of the principal diagnosis serves as a foundational step in an inpatient record review. The principal diagnosis is the condition established after study to be chiefly responsible for the patient's admission to the hospital. Correctly identifying and assigning this diagnosis is critical as it influences a multitude of factors, including treatment decisions, billing, and statistical data related to patient health outcomes. Ensuring that the principal diagnosis is accurate sets the stage for subsequent steps in the review process. If the principal diagnosis is misidentified, all follow-up evaluations, including treatment plans and assessments of patient outcomes, could lead to inaccurate conclusions and potentially poor patient care. This initial verification is essential for maintaining the integrity of the patient's medical record and ensuring compliance with healthcare standards and regulations. After confirming the principal diagnosis is appropriate, the reviewer can effectively move on to other components of the record, but without this initial verification, the entire review process may be compromised.

3. Which of these is an example of a breach of confidentiality?

- A. An incorrect billing statement being sent to the wrong patient**
- B. Advising patients of their appointment time**
- C. Sharing patient information with family members without consent**
- D. An employee discussing patient data in a break room**

The example of sharing patient information with family members without consent is a clear instance of a breach of confidentiality. Confidentiality in healthcare is a fundamental principle that protects patient privacy and ensures that personal health information is only shared with authorized individuals. When healthcare providers disclose patient information to family members without obtaining the patient's explicit consent, it violates this principle. This breach not only undermines patient trust but can also lead to legal repercussions under laws such as HIPAA (Health Insurance Portability and Accountability Act), which mandates strict guidelines on who can access and share patient information. In contrast, the other scenarios do not constitute breaches in the same way. For instance, sending an incorrect billing statement might lead to confusion or inconvenience but is not a direct violation of confidentiality like unauthorized sharing is. Advising patients of their appointment time is a standard practice and does not infringe on confidentiality, as it pertains directly to the patient's care. Similarly, discussing patient data in a break room could compromise confidentiality, but if the discussion is within a controlled, healthcare-related context and among authorized personnel, it may not be a breach in itself. However, such discussions should be approached cautiously to avoid any potential risks.

4. If the HIM department's accuracy rate is too low, what should be done?

- A. Notify patients of the error rate**
- B. Take corrective action to meet department standards**
- C. Conduct an audit without changes**
- D. Ignore the rate and continue with practices**

The recommendation to take corrective action to meet department standards is crucial when the HIM department's accuracy rate is found to be too low. Maintaining high accuracy in health information management is vital for ensuring patient safety, adhering to regulations, and supporting quality care. Corrective actions could include additional staff training, revising processes, implementing new technology, or conducting thorough root cause analyses to identify and address the underlying issues affecting accuracy. In contrast, simply notifying patients of the error rate does not actively resolve the issue and may harm trust without providing solutions. Conducting an audit without making changes would likely result in a repetitive cycle of errors without improvement, offering no benefit. Ignoring the low accuracy rate compromises the integrity of health information and can have widespread impacts on patient care and the organization's reputation. Therefore, corrective action is essential to enhance accuracy and uphold the standards expected within health information management.

5. In a healthcare context, what does HIM stand for?

- A. Healthcare Information Management**
- B. Hospital Internal Management**
- C. Health Integrated Model**
- D. Human Information Mechanism**

In a healthcare context, HIM stands for Healthcare Information Management. This term encompasses the practices and systems used to manage patient data and health records within healthcare settings. It focuses on the collection, storage, analysis, and protection of health information, ensuring that it is accessible to authorized personnel while maintaining its integrity and confidentiality. Healthcare Information Management plays a critical role in supporting patient care, regulatory compliance, and the efficient operation of healthcare facilities. Professionals in this field work with various types of data, including clinical records, billing records, and health information exchange systems, ensuring that the information is accurate and that it complies with standards and regulations such as HIPAA. The other choices do not accurately represent the established terminology within the healthcare sector. While "Hospital Internal Management" might pertain to operations within a hospital, it does not relate directly to the management of health information. "Health Integrated Model" does not specifically recognize the focus on information management that HIM embodies. "Human Information Mechanism" is not a recognized term in healthcare or health information management. Therefore, the accurate understanding of HIM as Healthcare Information Management is essential for effective data governance and quality patient care in healthcare organizations.

6. What role does the Health Information Management (HIM) professional play regarding patient records?

- A. They solely manage billing processes**
- B. They ensure proper documentation and regulation compliance**
- C. They conduct patient assessments**
- D. They are responsible for patient care plans**

The Health Information Management (HIM) professional plays a critical role in the healthcare system by ensuring proper documentation and regulation compliance. This involves overseeing the management of patient records to ensure that they are accurate, up-to-date, and maintained according to legal and regulatory standards. HIM professionals are responsible for implementing and maintaining policies related to the privacy and security of health information, which is essential for protecting patient confidentiality and meeting the requirements of various health information laws, such as HIPAA. This role includes facilitating the accurate capture of health data and working with healthcare providers to improve documentation practices. By doing so, HIM professionals help ensure that patient records reflect the quality of care provided and support clinical decision-making. This is vital not only for individual patient outcomes but also for the overall quality and efficiency of healthcare services. The other options do not encompass the full scope of responsibilities held by HIM professionals. While billing processes, patient assessments, and care plans are important components of healthcare, they do not capture the primary focus of HIM professionals, which centers on the management and governance of health information.

7. What does a HIM professional do after completing a gap analysis?

A. Develop a plan for improvement

B. Create a compliance report

C. Initiate disciplinary actions

D. Conduct further training

After completing a gap analysis, a Health Information Management (HIM) professional typically develops a plan for improvement. This process involves identifying areas where the current health information practices do not meet desired standards or regulations and then outlining specific strategies and actions to bridge those gaps. The plan for improvement often includes setting measurable goals, allocating resources, assigning responsibilities, and establishing timelines to ensure that the necessary changes are implemented effectively. This approach is essential for enhancing the quality of health information management practices and ensuring compliance with relevant health regulations. Creating a compliance report, initiating disciplinary actions, or conducting further training may be part of the overall strategy but come afterward or as a result of the assessment and planning process initiated by the gap analysis. Thus, the focus post-gap analysis is to develop a structured and actionable improvement plan.

8. If a patient's diagnosis is "Rule out GERD," what is the appropriate ICD-10-CM code?

A. R07.9, Chest pain, unspecified

B. K21.9, Gastroesophageal reflux disease, unspecified

C. R10.9, Abdominal pain, unspecified

D. I20.9, Angina pectoris, unspecified

The appropriate ICD-10-CM code for "Rule out GERD" is K21.9, which signifies gastroesophageal reflux disease as unspecified. This is due to the fact that when a diagnosis is listed as "rule out," it is typically a clinical determination where the healthcare provider suspects a condition but has not definitively confirmed it. In such cases, the specific condition that is suspected—in this case, GERD—should be coded, even if it is not confirmed at the time of coding. The choice of R07.9, which denotes chest pain unspecified, does not accurately represent the suspected condition of GERD. Similarly, R10.9 refers to unspecified abdominal pain, and I20.9 pertains to unspecified angina pectoris—neither of which directly relates to the suspicion of gastroesophageal reflux disease and would be inappropriate for this specific scenario. The key takeaway is that the most accurate coding reflects the condition that is primarily being evaluated, which would be GERD in this context.

9. What does the process of analyzing variations between current and proposed diagnosis codes create for an organization?

- A. A data map**
B. A research report
C. A budget analysis
D. A patient care protocol

The process of analyzing variations between current and proposed diagnosis codes creates a data map for an organization. A data map serves as a visual representation or a detailed outline that illustrates the relationship between the current coding practices and the proposed changes. This tool helps organizations to identify discrepancies, understand the implications of new coding requirements, and ensure that the transition to new codes is seamless and accurate. A data map is instrumental in providing clarity on how data elements are connected and how they will be affected by introducing new codes. This enables health information managers and coding professionals to prepare for implementation, assess potential impacts on reporting and compliance, and train staff accordingly. In contrast, a research report is typically more focused on specific studies or findings rather than the mapping of data elements. A budget analysis deals with the financial implications and planning rather than the technical aspects of coding. Lastly, a patient care protocol pertains to the guidelines and standards for patient treatment and is not directly related to coding variations. Thus, the creation of a data map is essential for organizations to navigate changes in diagnosis coding effectively.

10. Medical necessity is primarily based on what factor?

- A. The cost of the service**
- B. The physician's preference**
- C. The beneficial effects of a service for the patient's needs**
- D. The frequency of the service provided**

Medical necessity is fundamentally determined by the beneficial effects of a service in addressing the specific needs of a patient. This concept revolves around the idea that any medical service or procedure must be clinically appropriate, reasonable, and necessary in relation to the patient's diagnosis, treatment goals, and overall health status. Ensuring that a service is medically necessary serves to validate that the care provided is in alignment with standards of practice and patient welfare. In determining medical necessity, healthcare providers and insurers evaluate whether the service will positively impact the patient's health outcomes. Factors such as the effectiveness of the intervention, its relevance to the patient's condition, and whether it contributes to their recovery or pain management play a critical role. Other factors, such as the cost of the service or the physician's preference, do not inherently dictate medical necessity. While these may influence the decision-making process or the availability of services, they cannot solely establish whether care is necessary for the patient's health. The frequency of a service provided also does not define its necessity, as the proper evaluation revolves around the specific context of the patient's situation and health needs.