

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

Study Guide



Everything you need from our exam experts!

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	16

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

- 1. If the facility's Medicare case-mix index has decreased, what type of review should be performed to check for coding errors?**
 - A. Comprehensive audit**
 - B. Focused audit**
 - C. Random audit**
 - D. Peer review**
- 2. What certification is essential for an EHR system to demonstrate compliance with national standards?**
 - A. HEAR**
 - B. CEHRT**
 - C. EMR**
 - D. ISO 9001**
- 3. What should a hospital do if a request for a patient's health records includes records from a previous treatment facility?**
 - A. Release only the current hospital's records**
 - B. Release records only with patient consent**
 - C. Exclude previous hospital records since they are not relevant**
 - D. Include previous hospital records as they are part of the designated record set**
- 4. What is a health record with deficiencies called if it is not completed within the specified timeframe?**
 - A. Inactive record**
 - B. Delinquent record**
 - C. Incomplete record**
 - D. Suspended record**
- 5. 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**

- 6. Based on a coding test score output table, what is the average coding test score for the beginner coding professional?**
- A. 73**
 - B. 89.5**
 - C. 84.75**
 - D. 93**
- 7. The RHIT supervisor at a clinic needs to schedule productive hours for scanning and quality control of records. Given the clinic's standards, how many productive hours are needed daily?**
- A. 15 hours per day**
 - B. 20 hours per day**
 - C. 22.5 hours per day**
 - D. 25 hours per day**
- 8. What coding model allows for records to be coded while the patient is still an inpatient?**
- A. Retrospective coding**
 - B. Concurrent coding**
 - C. Prospective coding**
 - D. Post-discharge coding**
- 9. In measuring coding productivity, which of the following factors is typically not included?**
- A. Types of records coded**
 - B. Health record ID**
 - C. Patient demographics**
 - D. Daily productive hours**
- 10. Which of the following best describes the role of a medical transcription company in relation to HIPAA?**
- A. Must ensure confidentiality of PHI**
 - B. Is exempt from HIPAA regulations**
 - C. Only responsible for providing accurate transcripts**
 - D. Required to submit audits to the government**

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. If the facility's Medicare case-mix index has decreased, what type of review should be performed to check for coding errors?

A. Comprehensive audit

B. Focused audit

C. Random audit

D. Peer review

When a facility's Medicare case-mix index has decreased, conducting a focused audit is essential to check for potential coding errors. A focused audit specifically targets areas of concern or topics that may have contributed to the decline in the case-mix index. This type of audit allows for a more in-depth examination of selected records, ensuring that the coding accurately reflects the services provided and the complexity of the patients treated. The focus is critical here because it helps in identifying discrepancies or errors that might have affected the case-mix index, which could result from misreported diagnoses or procedures. By isolating and evaluating these specific elements, coders and auditors can pinpoint errors that, once corrected, may help improve the facility's reimbursement and accurate representation of patient case complexity. In contrast, a comprehensive audit would evaluate all areas without a specific focus, potentially being less efficient in addressing the immediate issue of the decreased index. A random audit lacks direction and could miss the specific errors contributing to the decline, while a peer review is more qualitative and typically involves discussions around performance rather than a strict audit of coding accuracy. Thus, the focused audit is the most appropriate approach in this scenario.

2. What certification is essential for an EHR system to demonstrate compliance with national standards?

A. HEAR

B. CEHRT

C. EMR

D. ISO 9001

The correct choice is CEHRT, which stands for Certified Electronic Health Record Technology. This certification is essential for an Electronic Health Record (EHR) system to demonstrate compliance with national standards, particularly with those set forth by the Office of the National Coordinator for Health Information Technology (ONC). CEHRT ensures that an EHR system meets specific criteria for interoperability, security, and functionality, allowing for safe and efficient information exchange in the health care sector. Obtaining CEHRT is a key component in federal initiatives aimed at promoting the use of certified EHR technology, especially under the Medicare and Medicaid Electronic Health Record Incentive Programs. This certification helps health care providers qualify for these incentive payments, ensuring they are using systems that meet established criteria for quality and efficiency. In contrast, the other options do not confer the same level of relevance to EHR compliance with national standards. HEAR is not a recognized certification in the industry, EMR refers to electronic medical records but does not specifically denote compliance with national standards, while ISO 9001 is a quality management system certification that is unrelated to health care technology standards specifically for EHR systems.

3. What should a hospital do if a request for a patient's health records includes records from a previous treatment facility?
- A. Release only the current hospital's records
 - B. Release records only with patient consent
 - C. Exclude previous hospital records since they are not relevant
 - D. Include previous hospital records as they are part of the designated record set**

When a request for a patient's health records is made, it is essential to consider what constitutes the designated record set as defined by regulatory frameworks such as HIPAA. The designated record set includes the medical records and billing records about an individual maintained by or for a covered entity, as well as other records used in making decisions about the individual. Including previous hospital records in response to a request aligns with the idea that all relevant health information about the patient, regardless of where it was obtained, is part of their comprehensive medical history. It is crucial for continuity of care, as these records can provide valuable context for the patient's current treatment and assist healthcare providers in making informed decisions. Simply releasing only the current hospital's records would ignore part of the patient's medical history, potentially leading to gaps in understanding their health status. Releasing records only with patient consent could delay care and is not always required for records that are part of the designated record set. Excluding previous records on the basis of not being relevant does not consider the holistic view necessary for adequate patient care. Thus, including previous hospital records is not only about compliance with regulations but also serves the overarching goal of promoting quality patient care through comprehensive access to a patient's health information across different treatment settings.

4. What is a health record with deficiencies called if it is not completed within the specified timeframe?
- A. Inactive record
 - B. Delinquent record**
 - C. Incomplete record
 - D. Suspended record

A health record with deficiencies that are not addressed within the specified timeframe is referred to as a delinquent record. This term indicates that there are outstanding issues that prevent the health record from being considered complete and acceptable according to the standards set by healthcare organizations and regulatory bodies. In the context of health information management, a delinquent record typically signifies that the healthcare provider has not fulfilled the necessary requirements to finalize the documentation, such as improved note-taking or entering lab results. This status prompts staff to take corrective measures to resolve the deficiencies, ensuring that the records can be used effectively for patient care, billing purposes, and legal compliance. The concept of delinquency in this context emphasizes the importance of timely updates to health records to maintain their accuracy and integrity. While other terms like inactive or incomplete records describe different conditions, they do not capture the specific implications of a record that has not met completion deadlines. An inactive record refers to one that is no longer actively in use, while an incomplete record suggests that there are outstanding components, but it does not imply a failure to meet any specific timeframe. A suspended record is one that has been temporarily halted for various reasons, such as pending further information or review. Thus, the term delinquent record is the most appropriate designation for

5. 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.

6. Based on a coding test score output table, what is the average coding test score for the beginner coding professional?

A. 73

B. 89.5

C. 84.75

D. 93

To determine the average coding test score for a beginner coding professional, you would sum all the individual scores from the relevant data set and then divide that total by the number of scores recorded. The average, often referred to as the mean, provides a useful indicator of the overall performance of the beginner group. In this case, if option A, which is 73, represents the average calculated from the provided test scores, it suggests that when all the scores were tallied and divided by their quantity, the result was 73. This number reflects the central tendency of the scores in the beginner category, indicating that while there may be variability in individual performances, 73 is the typical score for this group. This average can be particularly useful for assessing training programs, determining areas that might need additional focus, or measuring overall progress within the beginner cohort. Understanding this contextual application of the average helps provide insights into the effectiveness of coding training and the overall competency of beginners in the field.

7. The RHIT supervisor at a clinic needs to schedule productive hours for scanning and quality control of records. Given the clinic's standards, how many productive hours are needed daily?

- A. 15 hours per day**
- B. 20 hours per day**
- C. 22.5 hours per day**
- D. 25 hours per day**

The need for 22.5 productive hours per day for scanning and quality control reflects an understanding of how many hours are realistically available for focused work within the clinic's operational framework. In healthcare settings, especially clinics dealing with records management, productivity metrics are often based on the amount of work that can be done in a standard workday considering full-time staffing and operational demands. This figure likely includes time allocated to both scanning physical records into electronic systems and ensuring that these records meet quality standards, which is a critical component to ensure compliance with regulations and to maintain data integrity. The specific choice of 22.5 hours indicates that it is a balanced estimate of the time that personnel can effectively contribute to these tasks given normal shift lengths, breaks, and other clinic duties. This number makes sense for a small to medium-sized clinic environment where multiple staff members contribute to these tasks, striving to optimize workflow while maintaining high levels of accuracy in data handling. In contrast, the other options might represent either an unrealistic workload, exceeding the available hours in a workday, or might fail to account for necessary breaks and operational efficiency, making them less feasible in the context of daily productivity requirements in a healthcare setting.

8. What coding model allows for records to be coded while the patient is still an inpatient?

- A. Retrospective coding**
- B. Concurrent coding**
- C. Prospective coding**
- D. Post-discharge coding**

The coding model that allows for records to be coded while the patient is still an inpatient is concurrent coding. This approach involves the healthcare coder reviewing and coding the medical records in real-time as the patient receives treatment. It facilitates immediate feedback to the clinical team regarding documentation and can impact the quality of care and billing processes, as any necessary documentation improvements can be addressed before the patient is discharged. In contrast, retrospective coding occurs after the patient has been discharged, which can delay coding and billing processes. Prospective coding involves coding before treatment is initiated based on expected services, which does not apply to inpatient records currently in progress. Post-discharge coding also pertains to coding after the patient has been discharged and finalizing the medical records later. Thus, concurrent coding is the only option that pertains to coding activities conducted during the actual inpatient stay.

9. In measuring coding productivity, which of the following factors is typically not included?

- A. Types of records coded**
- B. Health record ID**
- C. Patient demographics**
- D. Daily productive hours**

In measuring coding productivity, the focus is primarily on the efficiency and output of coding activities, which typically involves quantifying the number of records coded and the various influences that impact this activity. The correct choice indicates that patient demographics are not generally included in evaluating coding productivity. This is because patient demographics, while important for understanding the patient population and supporting quality care, do not directly contribute to measuring how effectively and efficiently coding personnel are performing their tasks. On the other hand, factors such as the types of records coded provide relevant context and specifics about the complexity and volume of coding tasks, health record ID is crucial for tracking individual records, and daily productive hours are essential for calculating actual output in a set timeframe. Thus, they all play a significant role in assessing productivity, while patient demographics serve a different purpose in the overall healthcare documentation process.

10. Which of the following best describes the role of a medical transcription company in relation to HIPAA?

- A. Must ensure confidentiality of PHI**
- B. Is exempt from HIPAA regulations**
- C. Only responsible for providing accurate transcripts**
- D. Required to submit audits to the government**

The role of a medical transcription company in relation to HIPAA (Health Insurance Portability and Accountability Act) is best described by the requirement to ensure confidentiality of protected health information (PHI). Medical transcription companies handle sensitive patient information as they convert verbal patient notes into written records. Under HIPAA regulations, any entity that deals with PHI—including medical transcription companies—must implement measures to protect the confidentiality and security of that information. This includes safeguarding against unauthorized access and ensuring that any electronic systems used for transcription comply with HIPAA security standards. Given this context, the other options do not accurately reflect the responsibilities of medical transcription companies. They are not exempt from HIPAA regulations; rather, they must adhere to these privacy and security requirements. While providing accurate transcripts is important, it is not the sole responsibility. The requirement to submit audits to the government is also not a standard expectation of transcription companies but rather applies broadly to covered entities and their business associates. Thus, the primary obligation remains the safeguarding of PHI.

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://registeredhealthinformationtechnician.examzify.com>

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