

REVENUE CYCLE AND BILLING 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. What document must be provided to patients to inform them that Medicare may not cover certain services?**
 - A. Informational pamphlet
 - B. Cost estimate
 - C. Advance beneficiary notice (ABN)
 - D. Claim denial letter
- 2. In the context of healthcare billing, what typically refers to the agreed-upon payment amount for a service before it is rendered?**
 - A. Benefit schedule
 - B. Fee schedule
 - C. Charge sheet
 - D. Cost report
- 3. What does DNFB stand for in the context of health care billing?**
 - A. Daily Notification of Final Bill
 - B. Discharged Not Final Billed
 - C. Deferred Not Final Billing
 - D. Delinquent Not Final Billing
- 4. What does the term 'POA Indicators' refer to in a coding context?**
 - A. Procedures authorized post-admission
 - B. Patient outcome assessment indicators
 - C. Indications of diagnosis prior to admission
 - D. Provider outcome analytics
- 5. What is the correct sequence of activities within the revenue cycle?**
 - A. Billing, treatment, discharge, coding, registration
 - B. Registration, treatment, discharge, coding, billing
 - C. Coding, billing, treatment, registration, discharge
 - D. Discharge, registration, billing, treatment, coding

- 6. What is the name of the federally funded program designed to assist low-income individuals?**
- A. Medicare
 - B. Medicaid
 - C. CHIP
 - D. Social Security
- 7. Withdrawal of claims payment may occur due to audits. What is the defined period of time for Recovery Audit Contractors (RACs) to initiate a "look back" at a claim?**
- A. One year
 - B. Three years
 - C. Five years
 - D. Two years
- 8. Which of the following is not typically a part of the billing cycle?**
- A. Charge capture.
 - B. Patient scheduling.
 - C. Claim submission.
 - D. Payment posting.
- 9. In what way do industry regulations impact billing practices?**
- A. They specifically encourage higher billing amounts.
 - B. They set parameters for compliance and operational standards.
 - C. They eliminate the need for audits.
 - D. They are irrelevant to billing processes.
- 10. Which program is designed to ensure accuracy and timeliness in clinical documentation?**
- A. Clinical documentation improvement (CDI)
 - B. Quality Assurance Program
 - C. Medical Records Verification
 - D. Documentation Accuracy Initiative

Answers

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

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Explanations

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1. What document must be provided to patients to inform them that Medicare may not cover certain services?

- A. Informational pamphlet
- B. Cost estimate
- C. Advance beneficiary notice (ABN)**
- D. Claim denial letter

The correct document to inform patients that Medicare may not cover certain services is the Advance Beneficiary Notice (ABN). The ABN is a crucial tool used by providers to communicate with patients about their potential financial responsibility when a service may not be covered by Medicare. It ensures that patients are aware before receiving care that Medicare might not pay for certain services and gives them the option to either proceed with the service, accept financial responsibility, or choose not to have the service performed. The purpose of the ABN is to protect both patients and providers by clearly outlining the patient's rights and the possible financial implications of their care, ultimately allowing patients to make informed decisions about their health care. This ensures transparency in the billing process and helps prevent unexpected charges after treatment. Other documents, such as informational pamphlets, cost estimates, and claim denial letters, serve different purposes. Informational pamphlets might provide general information about services but do not specifically pertain to Medicare coverage. Cost estimates provide expected charges but do not address coverage issues. Claim denial letters are sent post-service to inform patients that a claim has been denied after the service has already been rendered, rather than proactively notifying them before the service.

2. In the context of healthcare billing, what typically refers to the agreed-upon payment amount for a service before it is rendered?

- A. Benefit schedule
- B. Fee schedule**
- C. Charge sheet
- D. Cost report

In healthcare billing, the term that typically refers to the agreed-upon payment amount for a service before it is rendered is the fee schedule. A fee schedule outlines the specific amounts that a provider will charge for various services and procedures, which are predetermined and negotiated with insurers or payers. This schedule is crucial as it provides a clear understanding for both the healthcare provider and the patient about what will be charged for specific services. The fee schedule serves as a tool for reimbursement and ensures that both parties have predefined expectations regarding the cost of care. It helps in streamlining the billing process, ensuring compliance with payer requirements, and facilitating accurate claims submission. Understanding the fee schedule is vital for both revenue cycle management and financial planning within healthcare practices.

3. What does DNFB stand for in the context of health care billing?

- A. Daily Notification of Final Bill
- B. Discharged Not Final Billed**
- C. Deferred Not Final Billing
- D. Delinquent Not Final Billing

DNFB stands for "Discharged Not Final Billed," which refers to patients who have been officially discharged from a healthcare facility but for whom the billing process has not yet been completed. This term is critical in revenue cycle management as it identifies revenue that is pending due to outstanding billing tasks that have not been processed. Monitoring DNFB is essential for healthcare facilities as it impacts cash flow and overall financial health. A lower DNFB figure indicates that billing processes are efficient and timely, while a higher figure may signal issues in billing, coding, or claims processing. Understanding this concept helps healthcare administrators and billing specialists prioritize their workflow to ensure timely revenue collection.

4. What does the term 'POA Indicators' refer to in a coding context?

- A. Procedures authorized post-admission
- B. Patient outcome assessment indicators
- C. Indications of diagnosis prior to admission**
- D. Provider outcome analytics

The term 'POA Indicators' refers to 'Present on Admission' indicators, which are essential in the coding and billing process within healthcare. These indicators determine whether a diagnosis was present when the patient was admitted to a healthcare facility. Understanding the presence of certain conditions at the time of admission has significant implications for hospital reimbursement and quality reporting. When coded correctly, POA indicators help distinguish between conditions that developed during the patient's stay and those that were present upon arrival. This is critical for determining the reimbursement rates under Medicare and Medicaid programs, as certain conditions may affect payment. Accurate POA indicator assignment also plays a role in hospital quality measures, as it influences various performance metrics. The other options do not accurately represent the meaning of POA Indicators. For instance, 'Procedures authorized post-admission' does not pertain to the diagnosis status upon admission but rather to actions taken after the fact. Similarly, 'Patient outcome assessment indicators' and 'Provider outcome analytics' focus on different aspects of healthcare assessment and performance, neither of which captures the specific criteria of whether a condition existed before the patient's admission.

5. What is the correct sequence of activities within the revenue cycle?

- A. Billing, treatment, discharge, coding, registration
- B. Registration, treatment, discharge, coding, billing**
- C. Coding, billing, treatment, registration, discharge
- D. Discharge, registration, billing, treatment, coding

The sequence of activities within the revenue cycle follows a logical progression that reflects the patient's journey through a healthcare encounter while ensuring that financial processes are efficiently managed. Starting with registration, this first step involves gathering necessary patient information before any services are provided. Next comes treatment, where healthcare services are delivered to the patient. After treatment, the patient is discharged, marking the conclusion of the care provided during that visit. Following discharge, coding takes place. Here, medical coders translate the services provided during treatment into standardized codes for billing and insurance purposes. Finally, billing occurs, where charges are submitted to insurance companies or billed directly to patients based on the coded services. This sequence is key to effectively managing the revenue cycle and ensuring proper reimbursement. The other options present a sequence that misplaces these key activities, which would disrupt the flow of revenue cycle management and potentially lead to billing delays or issues with insurance claims.

6. What is the name of the federally funded program designed to assist low-income individuals?

- A. Medicare
- B. Medicaid**
- C. CHIP
- D. Social Security

Medicaid is the federally funded program designed to assist low-income individuals by providing health coverage. Established in 1965, Medicaid is a state-managed program that works in partnership with the federal government to help cover medical expenses for eligible individuals, including families, pregnant women, children, the elderly, and people with disabilities. Each state has its own criteria for eligibility and benefits, but the primary goal remains the same: to ensure that low-income individuals receive necessary medical care without the burden of exorbitant costs. This program plays a crucial role in the U.S. healthcare system, as it allows individuals who might otherwise be unable to afford healthcare access to services such as hospital stays, routine check-ups, preventive care, and long-term care. By covering a range of healthcare services, Medicaid helps improve health outcomes for vulnerable populations and reduces the financial strain associated with medical expenses. In contrast, the other programs mentioned either focus on different demographics or do not specifically target low-income individuals in the same way that Medicaid does.

7. Withdrawal of claims payment may occur due to audits. What is the defined period of time for Recovery Audit Contractors (RACs) to initiate a "look back" at a claim?

- A. One year
- B. Three years**
- C. Five years
- D. Two years

The correct answer reflects the established guidelines governing the operations of Recovery Audit Contractors (RACs). According to the Centers for Medicare & Medicaid Services (CMS), RACs are authorized to review claims and initiate audits for up to three years from the date of service. This "look back" period allows RACs to ensure the accuracy of claims submitted and to identify potential overpayments or underpayments for services provided. This three-year timeframe is in line with statutory requirements, which promote a thorough review process to facilitate accountability in the billing practices of healthcare providers. This period can encompass various types of claims, including hospital inpatient and outpatient services. Understanding the implications of the look back period is essential for healthcare providers to maintain compliance and ensure appropriate revenue recovery practices. Adjusting to the regulatory framework regarding audits is critical for effective revenue cycle management.

8. Which of the following is not typically a part of the billing cycle?

- A. Charge capture.
- B. Patient scheduling.**
- C. Claim submission.
- D. Payment posting.

Patient scheduling is typically not considered a part of the billing cycle. The billing cycle primarily focuses on the processes that follow patient care, which includes charge capture, claim submission, and payment posting. Charge capture involves collecting information on the services provided to patients, which is essential for generating accurate billing. Claim submission refers to the process of sending the billed charges to insurers for reimbursement. Payment posting is the final step in the billing process, where payments received are recorded into the system, allowing for a complete view of revenue and outstanding balances. While patient scheduling is crucial for operational efficiency and patient flow management, it mainly relates to the front-end processes of healthcare service delivery, distinct from the specific activities involved in billing and revenue cycle management.

9. In what way do industry regulations impact billing practices?

- A. They specifically encourage higher billing amounts.
- B. They set parameters for compliance and operational standards.**
- C. They eliminate the need for audits.
- D. They are irrelevant to billing processes.

The answer is rooted in the understanding that industry regulations serve as a framework to ensure compliance and operational standards within healthcare billing practices. These regulations dictate specific guidelines that must be followed regarding what can be billed, how services are documented, and the methods of payment processing. By establishing these standards, regulations help maintain consistency, reduce fraud, and ensure that patients are billed correctly for the services they receive. For example, regulations such as HIPAA and the Affordable Care Act set forth requirements on patient privacy and coverage, which must directly inform how billing is conducted. Compliance with these frameworks not only protects the healthcare organizations but also safeguards patient interests. The emphasis on compliance is crucial because it affects billing accuracy, reduces the likelihood of claim denials or rejections, and directly impacts the overall revenue cycle efficiency. Organizations that adhere to these regulations are better positioned to avoid penalties and ensure their billing practices align with current laws and standards, ultimately leading to improved revenue management.

10. Which program is designed to ensure accuracy and timeliness in clinical documentation?

- A. Clinical documentation improvement (CDI)**
- B. Quality Assurance Program
- C. Medical Records Verification
- D. Documentation Accuracy Initiative

The program designed to ensure accuracy and timeliness in clinical documentation is Clinical Documentation Improvement (CDI). CDI initiatives focus on improving the quality of clinical documentation by promoting best practices, ensuring that medical records are complete and accurately reflect the patient's condition, and facilitating appropriate billing and coding processes. This is vital for healthcare providers as accurate documentation leads to better patient care, enhances communication among healthcare professionals, and improves the overall revenue cycle by reducing claims denials and ensuring proper reimbursement. Other potential choices, while related to healthcare and documentation, do not specifically target the improvement of clinical documentation in the same direct manner as CDI. For instance, a Quality Assurance Program often has a broader focus on overall healthcare quality and patient safety, rather than solely addressing documentation accuracy. Medical Records Verification typically ensures that records are maintained properly and comply with regulations but does not actively seek to improve the documentation quality itself. The Documentation Accuracy Initiative may exist, but it is not as widely recognized as CDI, which specifically focuses on enhancing the quality and effectiveness of clinical documentation practices across healthcare settings.

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://revenuecyclebilling.examzify.com>

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

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