

RHIA Reimbursement Practice Exam (Sample)

Study Guide



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Questions

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- 1. How is the total financial liability calculated for a patient with Medicare who sees a nonparticipating physician?**
 - A. Based on patient's total income**
 - B. Using only the total charges**
 - C. By factoring limiting charges and coinsurance**
 - D. Only 20% of the PAR Fee Schedule**
- 2. What does the present on admission (POA) indicator indicate for conditions acquired during hospital stays?**
 - A. sentinel event**
 - B. payment status indicator**
 - C. hospital acquired condition**
 - D. present on admission**
- 3. A Medicare Summary Notice (MSN) is sent to whom as their explanation of benefits (EOB)?**
 - A. Physicians**
 - B. Patients (beneficiaries)**
 - C. Hospitals**
 - D. Skilled nursing facilities**
- 4. Which classification is primarily used to facilitate the reimbursement of outpatient services?**
 - A. APCs**
 - B. MS-DRGs**
 - C. DRGs**
 - D. ICD-10 codes**
- 5. For a nonparticipating physician who does not accept assignment, what is the maximum amount the physician can charge over the non-PAR Medicare Fee Schedule amount?**
 - A. \$250.00**
 - B. \$200.00**
 - C. \$218.50**
 - D. \$190.00**

- 6. If the Medicare non-PAR approved payment amount is \$128.00 for a proctoscopy, what is the total approved payment amount for a doctor who does not accept assignment?**
- A. \$140.80**
 - B. \$143.00**
 - C. \$192.00**
 - D. \$147.20**
- 7. Which term indicates that a service or procedure is necessary and reasonable for treatment according to accepted standards of care?**
- A. A. appropriateness**
 - B. B. evidence-based medicine**
 - C. C. benchmarking**
 - D. D. medical necessity**
- 8. If a patient has paid his deductible under Medicare Part B, what percentage of coinsurance is the patient liable for during an office visit?**
- A. 80%**
 - B. 100%**
 - C. 20%**
 - D. 15%**
- 9. Which prospective payment system reimburses providers according to predetermined rates for a 60-day episode of care?**
- A. Home health resource groups**
 - B. Inpatient rehabilitation facility**
 - C. Long-term care Medicare severity diagnosis-related groups**
 - D. The skilled nursing facility prospective payment system**

10. Which classification system groups inpatient hospital cases that are expected to require similar resources?

- A. IPPS**
- B. CMS**
- C. DRG**
- D. MAC**

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Answers

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

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Explanations

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1. How is the total financial liability calculated for a patient with Medicare who sees a nonparticipating physician?

A. Based on patient's total income

B. Using only the total charges

C. By factoring limiting charges and coinsurance

D. Only 20% of the PAR Fee Schedule

The total financial liability for a patient with Medicare who sees a nonparticipating physician is calculated by factoring in limiting charges and coinsurance.

Nonparticipating physicians are allowed to charge up to 115% of the Medicare fee schedule for their services, which is known as the limiting charge. However, Medicare only pays a portion of the allowable charges, and the patient is typically responsible for coinsurance (20% of the Medicare-approved amount) and any excess charges that go above the limiting amount. In this case, the patient's financial responsibility includes not just the coinsurance but also any additional charges that exceed the Medicare-approved amount. Since nonparticipating providers can charge more than the standard fee schedule, it's crucial to account for both the limiting charges that set the maximum fee they can bill and the coinsurance that applies to the payment made by Medicare. This comprehensive approach is necessary to arrive at an accurate figure of what the patient ultimately owes.

2. What does the present on admission (POA) indicator indicate for conditions acquired during hospital stays?

A. sentinel event

B. payment status indicator

C. hospital acquired condition

D. present on admission

The present on admission (POA) indicator plays a crucial role in healthcare documentation and billing by distinguishing between conditions that existed at the time of admission and those that developed during a hospital stay. When a condition is marked as "present on admission," it indicates that the patient had that condition prior to being admitted to the hospital. This can affect reimbursement rates, as certain conditions that are acquired during a hospital stay may lead to penalties, reduced payments, or other consequences under the Medicare program. In contrast, the other options relate to different concepts in healthcare management. A sentinel event refers to an unexpected occurrence involving death or serious physical or psychological injury. A payment status indicator relates to reimbursement classifications in billing, which delineates how services are reimbursed but does not specifically address the timing of condition onset. A hospital-acquired condition specifically describes conditions that patients develop while receiving care in a hospital, but this term does not capture the full meaning of the POA indicator, which succinctly indicates whether a condition was present before the patient's hospital admission. Thus, identifying a condition as present on admission ensures accurate reporting and appropriate reimbursement for healthcare services.

3. A Medicare Summary Notice (MSN) is sent to whom as their explanation of benefits (EOB)?

- A. Physicians**
- B. Patients (beneficiaries)**
- C. Hospitals**
- D. Skilled nursing facilities**

The Medicare Summary Notice (MSN) serves as a key communication tool that provides beneficiaries (patients) with important information regarding the services they have received under Medicare. It outlines the services that were billed, the amount Medicare has paid, and any amounts that the beneficiary may still owe. This notice helps patients understand their healthcare costs and the benefits they've received, reflecting their rights to appeal any decisions if they disagree with what is billed or the payments made by Medicare. It is specifically designed for the beneficiaries themselves, making it an essential part of the healthcare billing process for those enrolled in Medicare. The other options, while involved in the healthcare service provision, are not the recipients of the MSN. Physicians, hospitals, and skilled nursing facilities are involved in the billing and claims process but don't receive the MSN as it is intended specifically for the individuals receiving the care, i.e., the patients. Thus, the correct response emphasizes the role of the MSN as a communication tool directed towards Medicare beneficiaries.

4. Which classification is primarily used to facilitate the reimbursement of outpatient services?

- A. APCs**
- B. MS-DRGs**
- C. DRGs**
- D. ICD-10 codes**

The classification primarily used to facilitate the reimbursement of outpatient services is Ambulatory Payment Classifications (APCs). APCs are a system established by Medicare to determine the payment for outpatient services provided in hospitals. Each APC is assigned a fixed payment amount for a certain grouping of services, which streamlines the reimbursement process and allows for predictability in payment amounts based on patient diagnosis and procedure codes. APCs are particularly suited for outpatient services because they accommodate the vast array of services rendered in an outpatient setting, such as diagnostic tests and minor surgical procedures. This classification helps to reflect the complexity and resources used in outpatient care, ensuring that hospitals receive appropriate compensation for the services they provide. Other classifications, such as MS-DRGs (used for inpatient services), DRGs (Diagnostic Related Groups), and ICD-10 codes (International Classification of Diseases, used for diagnosis coding), are not designed specifically for outpatient reimbursement. MS-DRGs and DRGs focus on inpatient hospital stays, while ICD-10 codes serve primarily for diagnostic classification but do not determine payment amounts directly for outpatient services.

5. For a nonparticipating physician who does not accept assignment, what is the maximum amount the physician can charge over the non-PAR Medicare Fee Schedule amount?

- A. \$250.00
- B. \$200.00
- C. \$218.50**
- D. \$190.00

For a nonparticipating (non-PAR) physician who does not accept assignment, there are specific rules governing the maximum amount they can charge above the non-PAR Medicare Fee Schedule amount. The maximum charge that a non-PAR physician can bill is limited to 115% of the Medicare fee schedule amount for that service. To determine the maximum allowed amount that can be charged, you take the non-PAR fee schedule amount and multiply it by 1.15. If the calculated amount exceeds the limit for that specific service, the physician must adhere to the fee schedule limit imposed by Medicare. Therefore, in this scenario, the correct answer reflects the permissible billing practices for non-PAR physicians, providing a clear understanding of how fees are regulated and ensuring that billing remains compliant with Medicare guidelines. The other amounts listed in the choices, although they might seem plausible, do not align with the established billing percentages applicable to nonparticipating providers within the Medicare system.

6. If the Medicare non-PAR approved payment amount is \$128.00 for a proctoscopy, what is the total approved payment amount for a doctor who does not accept assignment?

- A. \$140.80
- B. \$143.00
- C. \$192.00
- D. \$147.20**

To determine the total approved payment amount for a doctor who does not accept Medicare assignment, one must understand how Medicare payment is structured in such scenarios. In instances where a provider is a non-participating (non-PAR) provider, Medicare pays 95% of the approved amount for that service. Given that the Medicare non-PAR approved payment for a proctoscopy is \$128.00, the first step is to calculate 95% of this amount. Calculating 95% of \$128.00 involves multiplying \$128.00 by 0.95, which yields \$121.60. This is the amount that Medicare will pay to the physician. However, when a non-PAR provider performs the service, they can also bill the patient for what is referred to as the "balance billing" amount. This is typically capped by CMS at an additional 15% beyond the Medicare approved amount. Therefore, the maximum that the physician can charge the patient is 115% of the approved Medicare payment amount. In this case, calculating 115% of \$128.00 gives \$147.20. Hence, the total approved payment amount when a non-PAR provider is involved is \$147.20, which confirms

7. Which term indicates that a service or procedure is necessary and reasonable for treatment according to accepted standards of care?

- A. A. appropriateness**
- B. B. evidence-based medicine**
- C. C. benchmarking**
- D. D. medical necessity**

The term that indicates a service or procedure is necessary and reasonable for treatment according to accepted standards of care is "medical necessity." This concept is fundamental in healthcare and reimbursement processes, as it establishes that a specific service or treatment meets the criteria for coverage by insurance providers. Medical necessity requires that the offering is appropriate for the patient's condition, aligns with established medical standards, and is deemed effective, thus ensuring that patients receive appropriate care based on clinical guidelines. In contrast, appropriateness refers more to the suitability of procedures or services for specific clinical situations but does not inherently imply the acceptance of necessary actions for reimbursement. Evidence-based medicine involves integrating clinical experience with the best available research evidence but does not alone define whether a service is medically necessary. Benchmarking is a process used to measure performance against established standards, often utilized for quality improvement but does not directly pertain to the necessity or reasonableness of medical services. Thus, medical necessity is the most precise term reflective of the criteria needed for treatment coverage and practices in healthcare reimbursement.

8. If a patient has paid his deductible under Medicare Part B, what percentage of coinsurance is the patient liable for during an office visit?

- A. 80%**
- B. 100%**
- C. 20%**
- D. 15%**

In Medicare Part B, after a patient has met their deductible, they are responsible for a percentage of the covered services, known as coinsurance. The standard coinsurance amount for Medicare Part B is 20%. This means that once the deductible is satisfied, the patient would pay 20% of the Medicare-approved amount for the office visit, while Medicare would cover the remaining 80%. This structure helps ensure that patients share some of the costs associated with their healthcare, while also providing substantial coverage through Medicare. The percentages stated in the other options do not correctly reflect the coinsurance responsibilities under Part B; specifically, 80% is the amount covered by Medicare, and the other amounts (100% and 15%) do not align with the established coinsurance structure of Medicare. Thus, the correct response regarding the patient's liability for coinsurance after the deductible is indeed 20%.

9. Which prospective payment system reimburses providers according to predetermined rates for a 60-day episode of care?

A. Home health resource groups

B. Inpatient rehabilitation facility

C. Long-term care Medicare severity diagnosis-related groups

D. The skilled nursing facility prospective payment system

The correct answer is that home health resource groups (HHRGs) reimburse providers according to predetermined rates for a 60-day episode of care. Under the Home Health Prospective Payment System (HH PPS), Medicare pays home health agencies a fixed amount for each 60-day episode of care based on the characteristics of the patient, including their clinical and functional status, rather than the specific services provided. This prospective payment system aims to encourage efficiency and improve care delivery by offering a set payment amount for comprehensive services over the episode period. Other options describe different payment systems that do not align with the 60-day episode of care model relevant to home health services. Inpatient rehabilitation facilities, for example, focus on acute rehabilitation services under a different payment structure. Similarly, long-term care and skilled nursing facilities utilize their distinct prospective payment systems linked to various criteria depending on the patient population and the services rendered, which do not conform to the 60-day episode framework used in home health care.

10. Which classification system groups inpatient hospital cases that are expected to require similar resources?

A. IPPS

B. CMS

C. DRG

D. MAC

The classification system that groups inpatient hospital cases expected to require similar resources is the Diagnosis-Related Group (DRG). DRGs are used to categorize hospital cases into groups that are clinically similar and that are expected to consume similar amounts of hospital resources. This classification facilitates the implementation of prospective payment systems, where hospitals receive a fixed payment based on the DRG associated with a patient's diagnosis. The purpose of DRGs is to streamline healthcare reimbursement and monitor the quality and efficiency of care. By grouping cases with similar characteristics, it helps insurers, including Medicare, to determine appropriate payment rates for various inpatient services. The system incentivizes hospitals to manage their resources effectively, as they receive a predetermined payment regardless of the actual costs incurred. In contrast, the other options represent different entities or systems that are not primarily focused on classifying inpatient cases by resource utilization. The Inpatient Prospective Payment System (IPPS) is the payment structure that utilizes DRGs, but it does not classify the cases itself. CMS (Centers for Medicare & Medicaid Services) is the federal agency overseeing these programs but does not classify cases. MAC (Medicare Administrative Contractors) are organizations that manage claims and payment processes but do not function as a classification system. Hence, DRG is the correct