

RHIA Reimbursement Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

This is a sample study guide. To access the full version with hundreds of 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. Don't worry about getting everything right, 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, and take breaks to retain information better.

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.

7. Use Other Tools

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!

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Questions

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- 1. What does the charge/service code represent?**
 - A. A unique service identification number**
 - B. A general ledger section**
 - C. The total charge amount**
 - D. The patient's billing information**

- 2. What must a nonparticipating physician do to ensure they receive the correct reimbursement from Medicare?**
 - A. Charge the full standard fee**
 - B. Accept assignment on the claim**
 - C. Bill the patient the full amount**
 - D. Use the participating provider fee schedule**

- 3. ICD-10-PCS procedure codes are reported on which form to detail services provided to a patient?**
 - A. UB-04**
 - B. CMS-1500**
 - C. CMS-1491**
 - D. MDC 02**

- 4. This prospective payment system is designed specifically for which type of facility?**
 - A. Skilled nursing facilities**
 - B. Inpatient rehabilitation facilities**
 - C. Home health agencies**
 - D. Long-term acute care hospitals**

- 5. What is the total amount that a facility bills for the services it renders?**
 - A. Costs**
 - B. Charges**
 - C. Reimbursement**
 - D. Contractual allowance**

6. What report is frequently generated to monitor timely claims processing in a hospital?

- A. Patient treatment summary**
- B. Patient receivables summary**
- C. Patient satisfaction report**
- D. Patient discharge summary**

7. Which law prohibits a physician from referring Medicare patients to clinical laboratory services where they or a family member have a financial interest?

- A. A. the False Claims Act**
- B. B. the Civil Monetary Penalties Act**
- C. C. the Federal Antikickback Statute**
- D. D. the Stark Law**

8. Lifetime reserve days under Medicare are applicable for which type of stays?

- A. Outpatient stays**
- B. Emergency room visits**
- C. Hospital inpatient stays**
- D. Long-term care stays**

9. Who signs the Advance Beneficiary Notice (ABN) indicating their decision about Medicare services?

- A. Utilization review coordinator**
- B. Physician advisor**
- C. Patient**
- D. Provider**

10. What is the main role of the Medicare Summary Notice for beneficiaries?

- A. Provide billing details to hospitals**
- B. Communicate charges to physicians**
- C. Outline benefits paid by Medicare**
- D. Inform skilled nursing facilities of claims**

Answers

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

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Explanations

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1. What does the charge/service code represent?

- A. A unique service identification number**
- B. A general ledger section**
- C. The total charge amount**
- D. The patient's billing information**

The charge/service code represents a unique service identification number that specifically identifies the medical service or procedure provided to a patient. This code is essential in the healthcare billing process as it allows for the clear categorization and efficient processing of claims. By using standardized codes, such as those from the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS), healthcare providers can ensure that the services rendered are accurately transmitted to payers for reimbursement. This unique identification is crucial for tracking the various services rendered, facilitating communication among providers, payers, and patients, and ensuring that billing is consistent and transparent. Proper coding helps to minimize billing errors and streamline the claims submission process, ultimately impacting the revenue cycle management for healthcare organizations.

2. What must a nonparticipating physician do to ensure they receive the correct reimbursement from Medicare?

- A. Charge the full standard fee**
- B. Accept assignment on the claim**
- C. Bill the patient the full amount**
- D. Use the participating provider fee schedule**

To ensure the correct reimbursement from Medicare, a nonparticipating physician must accept assignment on the claim. Accepting assignment means that the physician agrees to accept the Medicare-approved amount for their services as full payment. By doing this, the physician can ensure that they will receive direct reimbursement from Medicare, rather than waiting for the patient to potentially pay the full charge and then seek reimbursement themselves. When a nonparticipating physician accepts assignment, they are also responsible for collecting the applicable coinsurance and deductibles from the patient, which encourages the patient to seek necessary care without financial barriers based on unexpected charges. Moreover, accepting assignment can help improve the physician's cash flow since Medicare reimburses them directly. The other options do not adequately ensure proper reimbursement from Medicare. Charging the full standard fee or billing the patient the full amount could lead to confusion regarding payment responsibilities and may not align with Medicare's guidelines. Using the participating provider fee schedule is relevant for participating physicians, but it does not apply in the same way for nonparticipating ones unless they accept assignment. Therefore, accepting assignment on the claim is the correct procedure for facilitating Medicare reimbursement effectively.

3. ICD-10-PCS procedure codes are reported on which form to detail services provided to a patient?

- A. UB-04**
- B. CMS-1500**
- C. CMS-1491**
- D. MDC 02**

ICD-10-PCS procedure codes are specifically used to report inpatient procedures and services provided to patients in a hospital setting. The UB-04 form is the standardized billing form used by institutional providers, such as hospitals, to bill for services rendered, including those procedures indicated by ICD-10-PCS codes. This form is designed to capture all necessary information about the patient's stay, including diagnoses, procedures, and the associated charges, making it the appropriate choice for reporting these detailed services. The use of ICD-10-PCS codes on the UB-04 ensures that the procedures are clearly documented for billing and reimbursement purposes. Other forms do not align with the reporting requirements for inpatient procedure coding. The CMS-1500 is primarily used for outpatient and professional service billing, the CMS-1491 is not a recognized billing form, and MDC 02 refers to a Medicare Diagnosis-Related Group rather than a billing form. Thus, the UB-04 is the correct answer for reporting ICD-10-PCS codes for inpatient services.

4. This prospective payment system is designed specifically for which type of facility?

- A. Skilled nursing facilities**
- B. Inpatient rehabilitation facilities**
- C. Home health agencies**
- D. Long-term acute care hospitals**

The prospective payment system designed specifically for inpatient rehabilitation facilities (IRFs) is the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). This payment system was established to provide a predetermined payment amount to IRFs based on the patient's diagnosis, the intensity of services required, and the settings in which care is provided. The IRF PPS includes a classification system called the Rehabilitation Impairment Categories (RICs) that helps determine the payment by grouping patients with similar clinical characteristics and need for rehabilitation services. The primary goal of this system is to streamline payments, ensuring that facilities are compensated fairly based on the resources utilized and the care provided. This focuses on achieving better patient outcomes and incentivizes facilities to deliver efficient and effective rehabilitation services. While other types of facilities have their own distinct payment systems—for example, skilled nursing facilities operate under a different model (SNF PPS), home health agencies receive payments through the Home Health Prospective Payment System (HH PPS), and long-term acute care hospitals utilize the LTCH PPS—the IRF PPS is specifically tailored to address the needs and functionalities of inpatient rehabilitation, thus validating that option B is the correct answer.

5. What is the total amount that a facility bills for the services it renders?

- A. Costs**
- B. Charges**
- C. Reimbursement**
- D. Contractual allowance**

The total amount that a facility bills for the services it renders is referred to as charges. Charges represent the list prices for the services provided, which include all treatment, care, and services a patient receives during their time in the facility. This figure does not necessarily reflect the actual money received by the facility after negotiations with payers (such as insurance companies) or any adjustments that might be applied. Charges serve as a starting point in the billing process and are used for various purposes, including billing to patients and determining the expected revenue for services rendered. It is important to distinguish charges from reimbursement, which is what the facility actually receives after claims processing, contractual allowances, and any reductions due to negotiated rates with insurance providers. Understanding charges is essential in revenue cycle management, as it allows facilities to track financial performance and ensure they are billing appropriately for the services provided.

6. What report is frequently generated to monitor timely claims processing in a hospital?

- A. Patient treatment summary**
- B. Patient receivables summary**
- C. Patient satisfaction report**
- D. Patient discharge summary**

The patient receivables summary is essential for monitoring timely claims processing in a hospital. This report provides a comprehensive overview of the amounts owed by patients and the status of those accounts. It allows healthcare administrators and financial managers to track whether claims have been filed, payments received, and outstanding balances. By analyzing the patient receivables summary, the hospital can identify delays in the billing process, assess cash flow, and ensure that claims are submitted promptly to payers for reimbursement. In contrast, the other reports serve different purposes. The patient treatment summary focuses on the clinical care provided to patients and does not provide financial data needed for monitoring claims. The patient satisfaction report evaluates patient experiences and satisfaction levels but is not directly related to claims processing. The patient discharge summary contains information about the patient's condition at discharge but does not track financial aspects of claims or payments. Thus, the patient receivables summary is specifically tailored to support the timely processing and collection of claims within the healthcare revenue cycle.

7. Which law prohibits a physician from referring Medicare patients to clinical laboratory services where they or a family member have a financial interest?

- A. A. the False Claims Act**
- B. B. the Civil Monetary Penalties Act**
- C. C. the Federal Antikickback Statute**
- D. D. the Stark Law**

The Stark Law specifically addresses the issue of physician self-referral, particularly in the context of Medicare patients. It prohibits physicians from referring patients to clinical laboratories or other designated health services in which they or their immediate family members have a financial interest. This law aims to prevent conflicts of interest and ensure that medical decisions are made based on patient care needs rather than financial incentives. By limiting these referrals, the Stark Law seeks to protect patients and maintain the integrity of the healthcare system. The other laws mentioned do tackle aspects of healthcare fraud and abuse but do not focus specifically on the issue of self-referral in the same manner as the Stark Law. The False Claims Act addresses false claims for payment submitted to government programs, while the Civil Monetary Penalties Act allows for penalties against individuals or entities for various forms of misconduct in healthcare. The Federal Antikickback Statute criminalizes the exchange of remuneration for referrals of services covered by government healthcare programs, but it is broader and does not specifically target the direct referral practices covered by the Stark Law.

8. Lifetime reserve days under Medicare are applicable for which type of stays?

- A. Outpatient stays**
- B. Emergency room visits**
- C. Hospital inpatient stays**
- D. Long-term care stays**

Lifetime reserve days under Medicare are specifically applicable to hospital inpatient stays. These reserve days are a provision within Medicare that allows beneficiaries to extend their coverage for inpatient hospital services beyond the standard benefit period, which typically covers up to 90 days of hospitalization. When patients have exhausted their regular coverage, they may use these additional reserve days, which can total up to 60 extra days over their lifetime. This is particularly important for beneficiaries who may require extended hospital stays due to serious health conditions. Outpatient stays, emergency room visits, and long-term care stays do not qualify for lifetime reserve days under Medicare. Outpatient services are compensated differently, focusing on specific service payments rather than per diem hospital costs. Emergency room visits are treated separately within Medicare's outpatient payment structure, and long-term care facilities have entirely different reimbursement methodologies that do not involve lifetime reserve days. Thus, the correct answer highlights the specific context of hospital inpatient care where these reserve days are relevant.

9. Who signs the Advance Beneficiary Notice (ABN) indicating their decision about Medicare services?

- A. Utilization review coordinator
- B. Physician advisor
- C. Patient**
- D. Provider

The Advance Beneficiary Notice (ABN) is a crucial document used in the Medicare system that informs patients of their financial responsibility for services that may not be covered by Medicare. The correct answer, indicating that the patient signs the ABN, is based on the fundamental role of the patient in expressing their understanding and acceptance of the potential costs of the services they are about to receive. By signing the ABN, the patient acknowledges that they have been informed about the possibility that their Medicare claim may not be paid, whether due to the nature of the service or their specific circumstances. This signature is a key element in ensuring that patients are not surprised by unexpected medical bills and it indicates their consent to proceed with the service despite the coverage uncertainty. Other individuals, such as a utilization review coordinator, physician advisor, or provider, play important roles within the healthcare system, but they do not have the authority or the responsibility to sign the ABN on behalf of the patient. The patient's signature is essential as it directly relates to their rights and responsibilities under Medicare guidelines.

10. What is the main role of the Medicare Summary Notice for beneficiaries?

- A. Provide billing details to hospitals
- B. Communicate charges to physicians
- C. Outline benefits paid by Medicare**
- D. Inform skilled nursing facilities of claims

The Medicare Summary Notice (MSN) plays a crucial role in providing beneficiaries with a clear and comprehensive summary of the services they have received and the corresponding payments made by Medicare. It is primarily designed to help beneficiaries understand their healthcare expenses by detailing what claims have been processed, the amounts billed by healthcare providers, the payments made by Medicare, and any remaining balances that the beneficiary may owe. This transparency is essential for beneficiaries to track their medical expenses and understand their financial responsibilities. While the other options relate to various aspects of healthcare billing and communication, they do not accurately capture the specific purpose of the MSN. For example, the notice is not intended to provide billing details to hospitals or communicate charges to physicians; rather, it's focused on enhancing the beneficiary's comprehension of their benefits and payments. Similarly, it does not serve to inform skilled nursing facilities about claims, as those communications are typically managed through other mechanisms within the Medicare system. The emphasis on outlining benefits paid by Medicare makes the Medicare Summary Notice a vital tool for beneficiaries in navigating their healthcare costs.

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://rhiareimbursement.examzify.com>

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

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