

RHIA Reimbursement Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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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. In cases where a physician does not accept assignment, how is the patient's financial liability calculated?**
 - A. Based on full charges only**
 - B. Only by the non-PAR Fee Schedule amount**
 - C. By balancing total charges and limitations**
 - D. Only depending on Medicare's payments**
- 2. When a participating physician accepts assignment, what is the patient's financial liability for a visit costing \$200.00 under the PAR Medicare Fee Schedule?**
 - A. \$200.00**
 - B. \$40.00**
 - C. \$160.00**
 - D. \$30.00**
- 3. Which software program is used to assign appropriate MS-DRGs based on the information provided for each episode of care?**
 - A. Encoder**
 - B. Case-mix analyzer**
 - C. Grouper**
 - D. Scrubber**
- 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. Who is responsible for negotiating settlements when providers are guilty under civil false claims?**
 - A. Hospital administration**
 - B. Office of Inspector General**
 - C. State health departments**
 - D. Medicare compliance offices**

6. What describes the difference between what is charged and what is actually paid?

- A. Costs**
- B. Customary pricing**
- C. Reimbursement**
- D. Contractual allowance**

7. What does DNFB stand for in the context of hospital billing?

- A. Descriptive Non-Final Billing**
- B. Discharged, No Final Bill**
- C. Disallowed, No Final Benefit**
- D. Deficient, Not Finalized Billing**

8. What is the primary objective of a reimbursement methodology?

- A. To ensure accurate payment for services rendered**
- B. To minimize the paperwork for providers**
- C. To simplify patient billing**
- D. To enhance clinical outcomes**

9. Which type of condition must hospitals report if it is present on admission?

- A. Only chronic conditions.**
- B. All conditions.**
- C. Only surgical complications.**
- D. All conditions related to the patient's primary diagnosis.**

10. Under the inpatient prospective payment system, what is required for preadmission services to be covered by the IPPS MS-DRG payment?

- A. Diagnostic services**
- B. Therapeutic services that match the inpatient principal diagnosis code**
- C. Therapeutic services that do not match the inpatient principal diagnosis code**
- D. Diagnostic and therapeutic services that match the inpatient principal diagnosis code**

Answers

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

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Explanations

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1. In cases where a physician does not accept assignment, how is the patient's financial liability calculated?

- A. Based on full charges only**
- B. Only by the non-PAR Fee Schedule amount**
- C. By balancing total charges and limitations**
- D. Only depending on Medicare's payments**

When a physician does not accept assignment, the patient's financial liability is calculated by balancing total charges and limitations. This approach takes into account the physician's full charges for the services rendered while also considering the maximum allowable amount that Medicare will reimburse for those services. In such cases, the physician may bill the patient for the difference between the total charge and what Medicare pays, subject to the limitations set by Medicare. Therefore, the financial responsibility for the patient often includes any excess charges that exceed the Medicare allowable amount, which leads to a clearer financial understanding of what the patient must pay out of pocket. This method provides a structured way to determine financial responsibility, ensuring that patients are aware of both the provider's charges and the amount covered by their insurance. Other methods mentioned would not accurately reflect the balance between the physician's charges and their acceptance of Medicare's payment limits; thus, they do not represent correct calculations of the patient's liability when assignment is not accepted.

2. When a participating physician accepts assignment, what is the patient's financial liability for a visit costing \$200.00 under the PAR Medicare Fee Schedule?

- A. \$200.00**
- B. \$40.00**
- C. \$160.00**
- D. \$30.00**

When a participating physician accepts assignment under the Medicare Fee Schedule, they agree to accept the Medicare-approved amount as full payment for their services. For the scenario provided, where the visit costs \$200.00, the physician must adhere to the fee schedule determined by Medicare. Under Medicare, patients are typically responsible for certain costs that may include deductibles, copayments, or coinsurance. Depending on the specifics of the insurance plan and the Medicare structure in place, this often results in a set percentage of the Medicare-approved amount that the patient must pay. In this case, the amount patients are liable for is calculated as a copayment. If the patient's financial liability is \$40.00, this suggests that the approved Medicare rate for the service results in that copayment amount, which is typical for many outpatient physician services. Thus, if a patient is responsible for \$40.00 after Medicare's adjustments and payments, this reflects the standard patient cost-sharing responsibilities for a participating physician when assignment is accepted, confirming that the patient's portion of the financial liability for a \$200.00 visit would indeed be \$40.00.

3. Which software program is used to assign appropriate MS-DRGs based on the information provided for each episode of care?

- A. Encoder**
- B. Case-mix analyzer**
- C. Grouper**
- D. Scrubber**

The correct choice is the grouper, as it is specifically designed to assign the appropriate Medicare Severity Diagnosis Related Groups (MS-DRGs) based on the clinical and billing information of an episode of care. When healthcare providers submit claims, the grouper software analyzes the data related to the patient's diagnoses, procedures, and other relevant factors to determine the correct DRG assignment. This is essential for proper reimbursement under the Medicare program, as the DRG assigned influences the amount hospitals will be reimbursed for the services rendered. Understanding the role of grouping software is crucial because accurate DRG assignment impacts revenue cycle management and compliance with payer policies. The grouper takes into consideration the complexity and resource intensity of the care provided, which is critical for healthcare facilities in ensuring they receive the reimbursement that aligns with the care they delivered. In contrast, other options serve different purposes. An encoder is primarily used for coding diagnoses and procedures into standardized formats, which can facilitate accurate billing but does not perform the grouping. A case-mix analyzer can assess patient populations and their resource consumption patterns but is not specifically meant to assign MS-DRGs. A scrubber, on the other hand, is focused on claim validation and ensuring that all aspects of a claim are compliant and complete prior

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. Who is responsible for negotiating settlements when providers are guilty under civil false claims?

- A. Hospital administration
- B. Office of Inspector General**
- C. State health departments
- D. Medicare compliance offices

The Office of Inspector General (OIG) is responsible for negotiating settlements when healthcare providers are found guilty under civil false claims. This is because the OIG is an agency of the U.S. Department of Health and Human Services that oversees and enforces compliance with federal healthcare laws, including the False Claims Act. They are tasked with investigating and penalizing fraud, waste, and abuse in Medicaid and Medicare programs. In the case of violations under the False Claims Act, the OIG not only investigates cases but also plays a crucial role in negotiating settlements, ensuring that providers are held accountable for fraudulent practices. This includes working with legal entities to resolve issues related to overbilling or submission of false claims, ultimately aiming to protect federal health programs and maintain the integrity of the healthcare system. The other choices, while they may play roles in overall healthcare compliance and administration, do not have the specific authority nor responsibility for negotiating settlements in these cases. Hospital administration typically manages the internal operations of a healthcare facility, state health departments oversee public health matters at the state level, and Medicare compliance offices may focus on adherence to specific program regulations but do not engage in settlement negotiations related to false claims. Thus, the OIG's role in this context is both critical and

6. What describes the difference between what is charged and what is actually paid?

- A. Costs
- B. Customary pricing
- C. Reimbursement
- D. Contractual allowance**

The difference between what is charged and what is actually paid is referred to as a contractual allowance. This term describes the reduction in the amount billed to a patient or insurance payer due to negotiated rates or agreements that healthcare providers have with insurers. Essentially, when a provider submits a bill, the total charge may be higher than what they ultimately receive as payment. The discrepancy between these two amounts often stems from contractual agreements that specify the prices that will be accepted for services, thereby leading to the allowance being deducted from the billed amount. This distinction is important in healthcare finance as it affects revenue reporting and overall financial performance of healthcare organizations. Understanding contractual allowances helps organizations manage their finances better and navigate payer contracts effectively, ensuring that they are aligning their billing practices with the realities of reimbursement. Other terms such as costs, customary pricing, and reimbursement do not specifically capture this nuanced relationship between charges and payments in the context of negotiated agreements with insurers. Each of these terms has its own implications in healthcare finance that differ from the concept of a contractual allowance.

7. What does DNFB stand for in the context of hospital billing?

- A. Descriptive Non-Final Billing**
- B. Discharged, No Final Bill**
- C. Disallowed, No Final Benefit**
- D. Deficient, Not Finalized Billing**

DNFB stands for "Discharged, No Final Bill," which refers to a category in hospital billing that tracks patients who have been discharged from the hospital but for whom the billing process has not yet been completed. This situation often indicates that there may be outstanding charges that need to be finalized before the claim can be submitted to insurance or billed to the patient. Understanding the DNFB is crucial for healthcare facilities as it helps in monitoring and managing claims that are pending. A high DNFB can signify inefficiencies in the billing process, potentially leading to delayed revenue capture and cash flow issues. Hospitals aim to minimize the DNFB numbers to ensure timely billing and receipt of payment for services rendered. The other options, while they contain relevant terminology, do not accurately represent the common usage of DNFB in the healthcare billing context. They mix concepts or terms that do not align with the specific definition used in the industry, which is solely focused on the discharge status and the absence of a finalized bill.

8. What is the primary objective of a reimbursement methodology?

- A. To ensure accurate payment for services rendered**
- B. To minimize the paperwork for providers**
- C. To simplify patient billing**
- D. To enhance clinical outcomes**

The primary objective of a reimbursement methodology is to ensure accurate payment for services rendered. This means that the system is designed to evaluate and compensate healthcare providers fairly based on the services they provide to patients. Accurate reimbursement is crucial because it reflects the actual cost of care, helps maintain the financial stability of healthcare institutions, and ensures that patients receive necessary services. When a reimbursement methodology is effective, it supports the overall financial functioning of the healthcare system by providing an incentive for providers to offer high-quality care. Additionally, accurate payment mechanisms help prevent underpayment or overpayment issues, which can strain provider resources and negatively impact patient care. In contrast, minimizing paperwork for providers, simplifying patient billing, and enhancing clinical outcomes are secondary effects or goals that may arise from a well-structured reimbursement system rather than primary objectives. These aspects can contribute to a better overall experience for both providers and patients, but they do not capture the main aim of establishing a reimbursement methodology.

9. Which type of condition must hospitals report if it is present on admission?

- A. Only chronic conditions.**
- B. All conditions.**
- C. Only surgical complications.**
- D. All conditions related to the patient's primary diagnosis.**

The focus of this question pertains to the standards for hospital reporting of conditions present on admission (POA) and the specific requirements set forth by regulatory bodies such as the Centers for Medicare & Medicaid Services (CMS). The correct answer involves the understanding that hospitals must report all conditions that are present at the time of a patient's admission to the facility. This is critical for accurate coding and reimbursement, as it impacts the severity of illness, resource utilization, and can influence reimbursement rates. Reporting all conditions ensures that a complete clinical picture is presented, allowing for the appropriate care and management of the patient, as well as proper coding for reimbursement purposes. Each condition, whether chronic or acute, must be documented if identified on admission. This comprehensive approach allows for better quality assessments, compliance with regulatory requirements, and ensures that hospitals receive appropriate payment based on the full scope of the patient's healthcare needs. Understanding this requirement is key for those involved in health information management and reimbursement practices, as it directly influences coding accuracy and financial outcomes for healthcare organizations.

10. Under the inpatient prospective payment system, what is required for preadmission services to be covered by the IPPS MS-DRG payment?

- A. Diagnostic services**
- B. Therapeutic services that match the inpatient principal diagnosis code**
- C. Therapeutic services that do not match the inpatient principal diagnosis code**
- D. Diagnostic and therapeutic services that match the inpatient principal diagnosis code**

The requirement for preadmission services to be covered by the inpatient prospective payment system (IPPS) MS-DRG payment is that these services must encompass both diagnostic and therapeutic services that correspond with the inpatient principal diagnosis code. This ensures that the services provided before admission are relevant to the primary reason for the hospitalization, thereby justifying the associated costs under the MS-DRG payment model. When preadmission services are aligned with the principal diagnosis, they contribute to the overall treatment plan and support the necessity of the inpatient stay. By including both diagnostic and therapeutic services, hospitals can adequately prepare for and address the patient's condition upon admission. This requirement is integral to ensuring that the IPPS system mitigates unnecessary costs while validating that all components of care lead toward the patient's treatment goals. Services that do not align with the principal diagnosis, whether they are strictly diagnostic or therapeutic, would typically not be covered under this payment system, as they do not demonstrate the same relevance or necessity in addressing the patient's immediate health needs during hospitalization.

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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