

**HFMA Certification Program  
Sample Exam Questions– 2009-2010**

## **Core Exam Sample Questions**

*This 20-question test is designed to provide a sample of the type of questions on the 166 question, four-hour Core certification examination. To best replicate the testing experience, allow about 30 minutes to complete these questions. None of these questions will appear on the actual certification exam.*

### **Healthcare Industry Overview**

1. In America, approximately what percentage of Americans is covered by some form of health insurance?
  - A. 55 %
  - B. 70 %
  - C. 85 %
  - D. 100 %

### **Cost Analysis and Management**

2. Four kinds of cost behaviors in cost accounting are:
  - A. Incremental, fixed, variable, and semi-variable.
  - B. Discretionary, fixed, variable, and semi-variable.
  - C. Direct, indirect, fixed, and variable.
  - D. Fixed, variable, semi-variable, and semi-fixed.

### **Auditing and Internal Control**

3. Internal control comprises the plan of organization and all the coordinate methods and measures adopted within a business to safeguard its assets, check the accuracy and reliability of its accounting data, promote operational efficiency, and encourage adherence to prescribed managerial policies. The phrase "encourage adherence to prescribed managerial policies" means:
  - A. The timely and accurate preparation of financial statements is a major goal of internal controls.
  - B. There is a criterion for the realistic evaluation of the specific internal control: it must promote operational efficiency.
  - C. Internal controls are general techniques to accomplish the broad stated objectives.
  - D. Internal controls should move the organization forward in accordance with management's general or specific authorization.

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Sample Exam Questions - Core**

**Accounting Concepts and Principles**

4. Amounts realizable from third-party payers for healthcare services are usually less than the provider's full established rates for those services. Which of the following is NOT used in determining the net realizable amount?
  - A. Contractual agreements.
  - B. Legislation or regulations.
  - C. Provider policy or practice.
  - D. Full cash advance refundings.
  
5. The purposes of the AICPA Audit and Accounting Guide for Health Care Organization can best be described as:
  - A. Required standards that all organizations must follow.
  - B. Generally Accepted Accounting Principles (GAAP).
  - C. An interpretation of GAAP as applied to healthcare organizations.
  - D. The healthcare accounting standards further interpreted GAAP.

**Capital Planning and Financing**

6. Of all the means of equity financing, the least expensive is usually:
  - A. Long-term.
  - B. Internal.
  - C. External.
  - D. Restrictive.

**Budgeting**

7. Responsibility reports require those responsible for budget entities to provide:
  - A. Capital budgeting responsibilities.
  - B. Lists of budget responsibilities.
  - C. Explanations for their budget variances.
  - D. Justifications for operating expenses.

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**Strategic Planning**

8. Participants in the strategic planning process include:
  - A. The Board of Directors.
  - B. Chief Executive Officer.
  - C. Chief Financial Officer.
  - D. All of the above
9. External environmental analysis typically includes:
  - A. Operating margins and debt capacity.
  - B. Demographic and socioeconomic characteristics of the service area.
  - C. Efficiency and staffing ratios.
  - D. Quality indicators.

**Investments and Cash Management**

10. The most common definition of a short-term cash budget is one which covers a period of less than:
  - A. One year.
  - B. Two years.
  - C. Three years.
  - D. Five years.

**Information Systems**

11. Orders for medication and treatments are a function of the:
  - A. Result reporting module.
  - B. Scheduling module.
  - C. Admission-discharge-transfer (ADT) module.
  - D. Order entry module.

**Patient Financial Services/Revenue Cycle**

12. Obtaining the patient's personal, demographic, insurance, and financial information should occur during:
  - A Account follow up.
  - B. Discharge.
  - C. Preadmission.
  - D. Admission.

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**Managed Care and Consumer-Driven Healthcare**

13. When any form of health care is provided to a member in exchange for a scheduled payment in advance of service rendered, this is known as:
- A. Pre-admission care.
  - B. Capitated care.
  - C. Managed care.
  - D. Up-front care.

**Regulatory Environment**

14. The federally funded and administered health insurance plan for all people over 65 years of age is:
- A. Medicare.
  - B. Blue Cross and Blue Shield.
  - C. Indemnity insurance.
  - D. Medicaid.

**Financial Analysis Techniques**

15. The current ratio is an example of a:
- A. Capital structure ratio.
  - B. Profitability ratio.
  - C. Activity ratio.
  - D. Liquidity ratio.

**Quality and Patient Safety**

16. The Institute of Medicine believes which of these will improve the quality of care?
- A. The growing complexity of technology.
  - B. The increase in chronic conditions.
  - C. The use of evidence-based medicine.
  - D. A poorly organized delivery system.

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**Management Skills**

17. Which of the following are managers who assume that the average employee enjoys work, seeks out responsibility, and is self-directed?
- A. Autocratic managers.
  - B. Theory Z managers.
  - C. Theory Y managers.
  - D. Theory X managers.

**Human Resources Management**

18. Which of the following acts forbids discrimination in hiring and employment based on race, religion, sex, and national origin?
- A. Americans with Disabilities Act.
  - B. Family and Medical Leave Act.
  - C. Federal Civil Rights Act.
  - D. Reemployment of Veterans Act.

**Legal Aspects**

19. When one of the parties to a contract does something that he or she was not already bound to do, this can be an example of:
- A. Legality.
  - B. Contractual capacity.
  - C. Mutual assent.
  - D. Consideration.

**Healthcare Financial Management Association Overview**

20. Which of the following is NOT one of HFMA's forums?
- A. CFO.
  - B. Managed Care.
  - C. Patient Friendly Billing.
  - D. Patient Financial Services.

**HFMA Certification Program  
Sample Exam Questions - Core**

**Answers**

**Healthcare Industry Overview**

1. C. 85 %.

**Cost Analysis and Management**

2. D. Fixed, variable, semi-variable, and semi-fixed.

**Auditing and Internal Control**

3. D. Internal controls should move the organization forward in accordance with management's general or specific authorization.

**Accounting Concepts and Principles**

4. D. Full cash advance refundings.
5. C. An interpretation of GAAP as applied to healthcare organizations.

**Capital Planning and Financing**

6. B. Internal.

**Budgeting**

7. C. Explanations for their budget variances.

**Strategic Planning**

8. D. All of the above.
9. B. Demographic and socioeconomic characteristics of the service area.

**Investments and Cash Management**

10. A. One year.

**Information Systems**

11. D. Order entry module.

**Patient Financial Services / Revenue Cycle**

12. C. Preadmission.

**Managed Care and Consumer-Driven Healthcare**

13. B. Capitated Care.

**Regulatory Environment**

14. A. Medicare.

**HFMA Certification Program  
Sample Exam Questions - Core**

**Financial Analysis Techniques**

15. D. Liquidity Ratio

**Quality and Patient Safety**

16. C. The use of evidence-based medicine.

**Management Skills**

17. C. Theory Y Managers.

**Human Resources Management**

18. C. Federal Civil Rights Act.

**Legal Aspects**

19. D. Consideration.

**Healthcare Financial Management Association Overview**

20. C. Patient Friendly Billing

**HFMA Certification Program**  
**Sample Exam Questions – Accounting and Finance**

*This 10-question test is designed to provide a sample of the type of questions on the 83 question, two-hour Accounting and Finance certification examination. To best replicate the testing experience, allow yourself about 15 minutes to complete these questions.*

**Capital Planning and Financing**

1. A factor critical to the capital decision-making process is:
  - A. Credit worthiness for an organization.
  - B. Medical staff requests.
  - C. Strategic planning activities.
  - D. Tax considerations.

**Cost Analysis and Management**

2. An effective strategy by which hospital management identifies departments with marginal profitability is to:
  - A. Evaluate departmental profitability against a historical standard.
  - B. Consider departmental costs on a full-absorption basis.
  - C. Use differential costing to evaluate incremental expenses of the least profitable product lines.
  - D. Evaluate standard operating costs against a synthetic standard.

**Financial Planning and Budgeting**

3. The statistical budget is a forecast of:
  - A. Patient volume and expenditures.
  - B. The activity level of clinical departments, excluding ancillary/support.
  - C. Procedure volume and patient revenues.
  - D. The activity level for each department.

**Investments and Cash Management**

4. Healthcare organizations should consider what factors in evaluating investment alternatives?
  - A. Obtaining the highest investment returns.
  - B. Ensuring no loss of investment principal ever occurs.
  - C. Controlling investment risk while maximizing investment returns.
  - D. What other healthcare organizations are doing.

**HFMA Certification Program**  
**Sample Exam Questions – Accounting and Finance**

**Employee Benefits, Insurance, and Risk Management**

5. One method used to transfer risk from one party to another is:
- A. Risk retention.
  - B. Self-insurance.
  - C. Copayment.
  - D. Commercial insurance.

**Internal Control**

6. A specific type of internal control which ensures that high-level decisions are free from unfavorable bias would be a(n):
- A. Adherence to generally accepted accounting principles (GAAP).
  - B. Asset accountability.
  - C. Authorization controls.
  - D. Conflict of interest statements.

**Financial Reporting, Accounting Principles & Auditing**

7. For external financial statement purposes, refunds due to and deposits from patients should be:
- A. Classified as contra-receivable.
  - B. Classified as a bad debt.
  - C. Disclosed in a footnote.
  - D. Classified as a liability.
8. What is the accounting implication of reporting an equity transfer?
- A. Reported as a change in net assets.
  - B. Include in operating income.
  - C. Results in a step-up in the basis of the underlying assets transferred.
  - D. Results in a change of ownership (of an immediate economic value) which must be accounted for as an investment as delineated in Accounting Principles Board (APB) Opinion number 18 and Financial Accounting Standards Board (FASB) Statement number 94.

**HFMA Certification Program**  
**Sample Exam Questions – Accounting and Finance**

**Regulatory Environment and Corporate Compliance**

9. A basic function of the Centers for Medicare and Medicaid Services (CMS) is to:
- A. Examine mergers of hospitals and other healthcare institutions.
  - B. Monitor the performance of contractors and states in administering CMS programs.
  - C. Conduct a voluntary survey program for hospitals and other healthcare organizations.
  - D. Granting tax-exempt status.
10. In which order is cost apportionment conducted as part of the process of determining Medicare cost reimbursement?
- A. Subsequent to determining settlement.
  - B. Subsequent to participation in cost finding.
  - C. Prior to determining allowable costs.
  - D. Prior to participating in cost finding

**HFMA Certification Program**  
**Sample Exam Questions – Accounting and Finance**

**Answers**

**Capital Planning and Financing**

1. A. Credit worthiness for an organization.

**Cost Analysis and Management**

2. B. Consider departmental costs on a full-absorption basis.

**Financial Planning and Budgeting**

3. D. The activity level for each department.

**Investments and Cash Management**

4. C. Controlling investment risk while maximizing investment returns.

**Employee Benefits, Insurance, and Risk Management**

5. D. Commercial insurance.

**Internal Control**

6. D. Conflict of interest statements.

**Financial Reporting, Accounting Principles & Auditing**

7. D. Classified as a liability.
8. A. Reported as a change in net assets.

**Regulatory Environment and Corporate Compliance**

9. B. Monitor the performance of contractors and states in administering CMS programs.
10. B. Subsequent to participating in cost finding

**HFMA Certification Program**  
**Sample Exam Questions – Physician Practice Management**

*This 10-question test is designed to provide a sample of the type of questions on the 83 question, two-hour Physician Practices Management certification examination. To best replicate the testing experience, allow about 15 minutes to complete these questions.*

**Budgeting and Benchmarking**

1. Revenue projections are subject to a wide range of possible errors due to which one of the following?
  - A. Variability of patient/consumer decision-making.
  - B. Flexibility required for physician income expectations.
  - C. Major assumptions built into the revenue projections.
  - D. Uncertainty about marketing efforts by competing groups.

**Accounts Receivable: Collections, Policy and Evaluation**

2. Which of the following is a key control point for internal control of accounts receivable?
  - A. Write-offs should require two signatures or written authorization.
  - B. Mail receipt of insurance correspondence should be coordinated with rebilling requests.
  - C. Charges should be posted for every patient within 60 days following rendering of services.
  - D. Insurance company requests for medical records should be logged.

**Information Systems**

3. Situations that give information value and mandate security include which of the following?
  - A. A need to generate fee schedules.
  - B. Natural disasters where information is destroyed.
  - C. Data that is provided to a public database.
  - D. Non specified data on patient treatment.

**Encounter Processing**

4. Potential fraud within encounter processing requires the use of internal control procedures such as:
  - a. Routine reconciliation of daily charges against postings.
  - b. Routine reconciliation of charges, fee schedules and payments.
  - c. Multiple levels of authorizations for refund checks, write-offs and disbursements.
  - d. Monthly reconciliation of accounts receivable.

**HFMA Certification Program**  
**Sample Exam Questions – Physician Practice Management**

**Contracting, Negotiating and Reimbursement Methodologies**

5. Physicians who organize into an independent practice association (IPA) to provide patient services:
- A. Increase profitability as IPA contracts will increase patient volumes.
  - B. Retain their independent practices and will treat patients outside of the health maintenance organization (HMO) beneficiary list.
  - C. Retain their independent medical practices but lose financial control to health maintenance organization (HMO) fiscal services.
  - D. Lose their independent practice autonomy and may treat only IPA patients.

**Cost Analysis and Management**

6. A major use of breakeven analysis is to identify the level of operations at which revenues equal:
- a. Step-incremental costs.
  - b. Total costs.
  - c. Variable costs.
  - d. Fixed costs.

**Insurance and Risk Management**

7. Malpractice insurance is sold in two basic forms related to when the insurer is responsible for coverage, these are:
- A. First year and fifth year.
  - B. Occurrence and claims made.
  - C. Time benefit and insuring event.
  - D. Expected litigated and projected litigated.

**Legal and Regulatory**

8. Stark I and Stark II laws prohibit which of the following types of physician activity?
- A. Receiving gifts and cash and other perks from patients who want preferential treatment.
  - B. Referring patients to the physician's colleagues and friends who own ancillary services.
  - C. Referring patients to external ancillary providers in whom the physician has a financial interest.
  - D. Referring patients to external ancillary service providers who also refer patients to the physician.

**HFMA Certification Program**  
**Sample Exam Questions – Physician Practice Management**

**Physician Compensation and Leadership**

9. Which of the following should be considered when developing a physician compensation plan?
- A. A plan that favors one physician in the group.
  - B. A plan that does not consider changes in reimbursement.
  - C. The culture of the physician group.
  - D. Input from the support staff.

**Physician Coding and Payment Systems**

10. What are some applications of International Classification of Diseases (ICD) code information?
- A. Used to document procedures done by physicians to request payment.
  - B. Provides supporting documentation to the service or procedure performed by non-physicians.
  - C. Supports correct coding initiatives, supports data requirements for residency program accreditation, and can provide a means of identifying cases that fit the criteria for research protocols.
  - D. Provides data to support credentialing agencies, Health Plan Employer Data and Information Set (HEDIS) reporting, and state licensure requirements.

**HFMA Certification Program**  
**Sample Exam Questions – Physician Practice Management**

**Answers**

**Budgeting and Benchmarking**

1. C. Major assumptions built into the revenue projections.

**Accounts Receivable, Collections, Policy & Evaluation**

2. A. Write-offs should require two signatures or written authorization.

**Information Systems**

3. B. Natural disasters where information is destroyed.

**Encounter Processing**

4. C. Multiple levels of authorizations for refund checks, write-offs and disbursements.

**Contracting, Negotiating & Reimbursement Methodologies**

5. B. Retain their independent practices and will treat patients outside of the health maintenance organization (HMO) beneficiary list.

**Cost Analysis and Management**

6. B. Total costs.

**Insurance and Risk Management**

7. B. Occurrence and claims made.

**Legal and Regulatory**

8. C. Referring patients to external ancillary providers in whom the physician has a financial interest.

**Physician Compensation and Leadership**

9. C. The culture of the physician group.

**Physician Coding and Payment Systems**

10. C. Supports correct coding initiatives, supports data requirements for residency program accreditation, and can provide a means of identifying cases that fit the criteria for research protocols.

**HFMA Certification Program**  
**Sample Exam Questions – Managed Care**

*This 10-question test is designed to provide a sample of the type of questions on the 83 question, two-hour Managed Care certification examination. To best replicate the testing experience, allow yourself about 15 minutes to complete these questions*

**Overview of Managed Care**

1. The effect of temporarily decreasing the medical loss ratio by spending promotional funds to advertise in more expensive media markets and increase the premium constitutes a:
  - A. Numerator increase.
  - B. Denominator increase.
  - C. Denominator reduction.
  - D. Numerator reduction.

**The Healthcare Delivery System**

2. Which of the following is NOT a characteristic of per diem pricing methodologies?
  - A. A pre-negotiated price paid per day to cover all products and services.
  - B. Additional payments may be made if a patient exceeds the expected length of stay.
  - C. Patients do not incur any cost by way of deductibles and coinsurance.
  - D. Different per diems may be paid for different services.
3. Well-managed third-party administrators (TPAs) provide or contract to provide:
  - A. Workers' compensation programs.
  - B. Healthcare services by their own staff physicians.
  - C. Insurance products.
  - D. Utilization review.

**Medical Management**

4. The utilization management (UM) technique that involves evaluation during the patient's hospitalization, covering appropriateness of admission, timeliness of care, and need for continued stay is:
  - A. Discharge planning.
  - B. Case management.
  - C. Second opinion.
  - D. Concurrent length of stay.

**HFMA Certification Program  
Sample Exam Questions – Managed Care**

**Forces Driving State & Federal Health Policy**

5. In which area of National Commission on Quality Assurance (NCQA) review do reviewers assess the preventive services, diagnosis, and appropriateness and continuity of care provided to patients?
- A. Utilization management.
  - B. Quality assurance.
  - C. Medical records.
  - D. Member rights and responsibilities.

**Medicare & Medicaid**

6. Which of the following groups are NOT covered under the Medicare program?
- A. All persons 65 years of age or older.
  - B. All spouses of persons 65 years or older.
  - C. Individual with permanent renal of age failure.
  - D. Individuals with certain disabilities.

**Financial Management**

7. Cost calculations often involve translating utilization data, expressed in utilization per 1,000 members per year, into per member per month (PMPM) numbers by:
- A. Dividing by 12.
  - B. Multiplying by 12.
  - C. Dividing by 1,000.
  - D. Dividing by 12,000.

**Managed Care Operations**

8. Provider authorization serves several purposes, EXCEPT which one of the following?
- A. Enables the organization's medical management staff to review a case for medical necessity
  - B. Channels care to the most expensive setting or provider
  - C. Provides timely information to the care management system and the concurrent review utilization management system
  - D. Enables the finance department to estimate the monthly accruals for medical expenses

**HFMA Certification Program**  
**Sample Exam Questions – Managed Care**

***Contracting and Negotiating***

9. A carve out refers to:
- A. Per diem rates
  - B. Non-covered healthcare expenses or charges subject to deductibles.
  - C. Stop loss payments.
  - D. Special services that have reimbursement rates.

***Regulation and Accreditation***

10. The accreditation organization for Medicare+Choice organization is the :
- A. Health Insurance Association of America (HIAA).
  - B. National Committee on Quality Assurance (NCQA).
  - C. Centers for Medicare and Medicaid Service (CMS).
  - D. American Accreditation Program, Inc. (AAPI).

**HFMA Certification Program  
Sample Exam Questions – Managed Care**

Answers

**Overview of Managed Care**

1. B. Denominator increase.

**The Healthcare Delivery System**

2. C. Patients do not incur any cost by way of deductibles and coinsurance.
3. D. Utilization review

**Medical Management**

4. D. Concurrent length of stay.

**Forces Driving State & Federal Health Policy**

5. C. Medical records.

**Medicare and Medicaid**

6. B. All spouses of persons 65 years of age or older.

**Financial Management**

7. A. Dividing by 12.

**Managed Care Operations**

8. B. Channels care to the most expensive setting or provider

**Contacting and Negotiating**

9. D. Special services that have reimbursement rates

**Regulation and Accreditation**

10. C. Centers for Medicare and Medicaid Services (CMS).

**HFMA Certification Program**  
**Sample Exam Questions – Patient Financial Services**

*This 10 question test is designed to provide a sample of the type of questions on the 83 question, two-hour Patient Financial Services certification examination. To best replicate the testing experience, allow yourself about 15 minutes to complete these questions.*

**Organizational Forecasting**

1. Plans which complement the strategic plan and are typically set for time periods ranging from one week to a month to several years are:
  - A. Budgets.
  - B. Operational plans.
  - C. Program plans.
  - D. Decision packages.

**Accounts Receivable Management**

2. When a creditor is unable to collect a debt using reasonable collection techniques, the creditor may resort to a:
  - A. Statutory lien.
  - B. Judicial lien.
  - C. Consensual lien.
  - D. Tax lien.

**Information Technology**

3. Level 3 automation of the X12 835 is used primarily to:
  - A. Standardize remittance information.
  - B. Provide automated clearing house (ACH) payments.
  - C. Receive remittance data electronically and post payments and adjustments to the individual patient account.
  - D. Eliminate all human intervention except in extreme cases of major variances.

**Policy, Planning, and Evaluation**

4. In developing a business plan, the staffing analysis phase should include a review of which of the following?
  - A. Overall and individual skill levels in the department.
  - B. Electronic claims compatibilities.
  - C. Identification of types of software required.
  - D. Accounts receivable trends and aging categories.

**HFMA Certification Program**  
**Sample Exam Questions – Patient Financial Services**

**Access Management**

5. Performing a financial assessment to determine the patient's ability to pay for an actual or anticipated obligation is a critical task involved in:
- A. Encounter registration processing.
  - B. Zero-based budgeting.
  - C. Financial counseling.
  - D. Patient accounting customer service.

**Claims Processing**

6. Quality Improvement Organizations (QIO) review to determine the medical necessity of Medicare inpatients and the appropriateness of Medicare service delivery is a(n):
- A. Admission review.
  - B. Diagnosis-related group (DRG) validation.
  - C. Procedure review.
  - D. Medicare audit.

**Managed Care**

7. Which of the following is not a staffing concern when entering into a managed care contract?
- A. Simplified billing.
  - B. Precertification requirements.
  - C. Longer registration time
  - D. Comparison of actual versus expected reimbursement.

**Legal Aspects**

8. The agreement by the contracting parties which usually is manifested by an offer and acceptance is called:
- A. Recognized promise.
  - B. Legality.
  - C. Mutual assent.
  - D. Consideration.

**HFMA Certification Program**  
**Sample Exam Questions – Patient Financial Services**

**Physician Entities**

9. The formula for accounts receivable turnover is:

A. Annualized Billings per Period

Average Accounts Receivable

365

B. Annualized Billings per Period

Average Accounts Receivable

C. Average Accounts Receivable

Annualized Billings per Period

D. Annualized Billings per Period x Average Accounts Receivable

365

**Other Related Entities**

10. An individual is considered to be terminally ill, according to Medicare hospice guidelines, if their life expectancy is:

A. Three months or less.

B. Six months or less.

C. One year or less.

D. Two years or less.

**HFMA Certification Program**  
**Sample Exam Questions – Patient Financial Services**

**Organizational Forecasting**

1. B. Operational plans.

**Accounts Receivable Management**

2. B. Judicial lien.

**Information Technology**

3. C. Receive remittance data electronically and post payments and adjustments to the individual patient account.

**Policy, Planning, and Evaluation**

4. A. Overall and individual skill levels in the department.

**Access Management**

5. C. Financial counseling.

**Claims Processing**

6. A. Admission review.

**Managed Care**

7. A. Simplified billing.

**Legal Aspects**

8. C. Mutual assent.

**Physician Entities**

9. B. Annualized Billings per Period / Average Accounts Receivable

**Other Related Entities**

10. B. Six months or less.