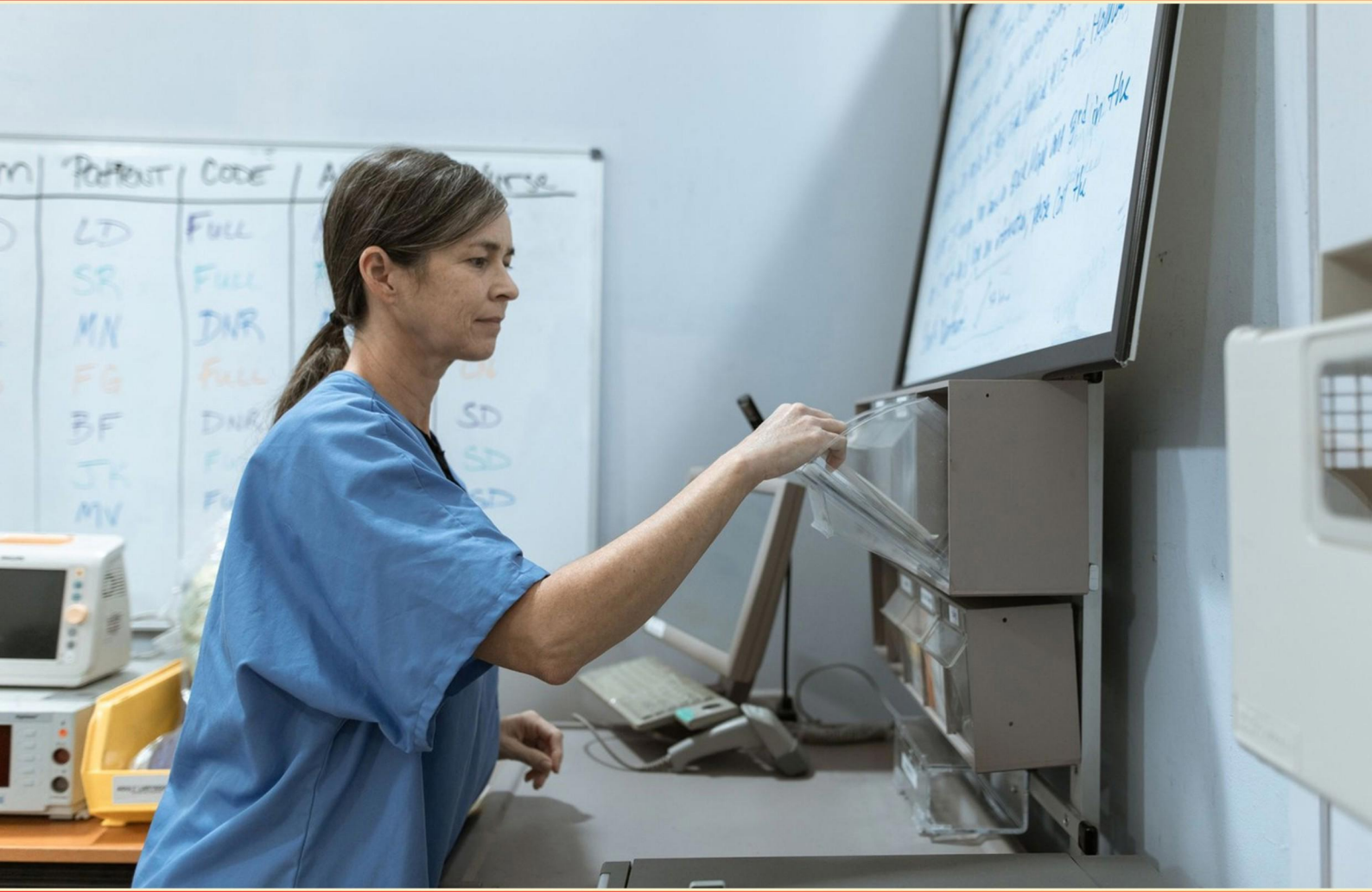
AAHAM CERTIFIED REVENUE CYCLE EXECUTIVE (CRCE) PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR THE FULL VERSION STUDY GUIDE

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Table of Contents

Copyright 1
Table of Contents 2
Introduction 3
How to Use This Guide 4
Questions 5
Answers 8
Explanations 10
Next Steps 16

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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.

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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!

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Questions

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1. Charity care is specifically designed to assist which group of patients?

A. Patients with private insurance

B. Patients unable to pay for healthcare services

C. Patients with government insurance

D. Patients seeking elective procedures

2. What characterizes Chapter 11 Bankruptcy?

A. Liquidation of all assets

B. Reorganization with a repayment plan while continuing operations

C. Personal debt repayment without loss of property

D. Specific to family farmers and fishermen

3. What does the Medicare Beneficiary Identifier (MBI) replace?

A. The social security number on the Medicare card

B. The enrollment date on the Medicare card

C. The plan type indicated on the card

D. The expiration date of coverage

4. What is a characteristic of the Ambulatory Payment Classification (APC) system?

A. Payments are made on a per-service basis

B. It combines payments for related services

C. It is only applicable to inpatient services

D. It does not consider the cost of services

5. What is one consequence of failing to recognize abuse in healthcare practices?

A. Increased trust from patients towards their providers

B. Potential legal issues and financial repercussions

C. Enhanced operational efficiency within healthcare facilities

D. Higher patient satisfaction ratings

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6. Which of the following factors are considered in MUE?

A. Only treatment costs

B. Nature of service, procedure, and coding instructions

C. Health insurance rates

D. Demographics of the healthcare provider

7. What is the main focus of the 837 transaction?

A. To streamline Medicaid billing only

B. To standardize claims for outpatient services

C. To facilitate hospital claims for inpatient services

D. To create a unified billing and caring process

8. What is the primary purpose of Medicare as it relates to the elderly?

A. Provide financial support for long-term care

B. Offer coverage for individuals aged 65 or older or those with permanent disabilities

C. Fund preventative health services exclusively

D. Replace private health insurance plans fully

9. Which legislation prohibits offering free or discounted services to referring physicians?

A. Patient Protection and Affordable Care Act

B. False Claims Act

C. Anti-Kickback Statute

D. Medicare Modernization Act

10. What type of claim denial occurs when the claim is suspended for medical review within the Medicare system?

A. Claim Rejection

B. Claim Suspension

C. Compliance Violation

D. Charity Care

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Answers

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

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Explanations

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1. Charity care is specifically designed to assist which group of patients?

A. Patients with private insurance

B. Patients unable to pay for healthcare services

C. Patients with government insurance

D. Patients seeking elective procedures

Charity care is specifically designated to assist patients who are unable to pay for healthcare services. This program serves as a financial safety net for individuals or families who lack insurance coverage or resources necessary to cover medical expenses. Charity care aims to ensure that access to necessary healthcare is not restricted due to financial limitations, thereby promoting health equity and ensuring that all patients receive essential medical attention regardless of their financial situation. This focus supports the core mission of many healthcare providers to care for the community and provide necessary services to those in need. Through charity care programs, hospitals and healthcare facilities can offer services such as emergency treatments, routine check-ups, and necessary procedures to low-income individuals, emphasizing patient-centered care over financial considerations.

2. What characterizes Chapter 11 Bankruptcy?

A. Liquidation of all assets

B. Reorganization with a repayment plan while continuing operations

C. Personal debt repayment without loss of property

D. Specific to family farmers and fishermen

Chapter 11 Bankruptcy is primarily characterized by reorganization, allowing a business or individual to restructure their debts while continuing their operations. This process enables the entity to create a repayment plan that is approved by the court, aimed at settling outstanding obligations without the immediate need to liquidate assets. The reorganization under Chapter 11 is particularly beneficial for businesses that have ongoing operations and believe they can return to profitability. This pathway not only helps in stabilizing the business and preserving jobs but also offers creditors an opportunity to receive repayment over time, rather than facing a total loss if the business were to shut down. In contrast, other forms of bankruptcy, such as Chapter 7, deal with liquidation of assets, while others focus on specific debtor types or have different repayment mechanisms. Thus, Chapter 11 is distinct in its focus on maintaining operations through reorganization and negotiation of debts.

3. What does the Medicare Beneficiary Identifier (MBI) replace?

A. The social security number on the Medicare card

B. The enrollment date on the Medicare card

C. The plan type indicated on the card

D. The expiration date of coverage

The Medicare Beneficiary Identifier (MBI) was introduced to improve the security and privacy of Medicare beneficiaries. The primary purpose of the MBI is to replace the Social Security number that was previously used on Medicare cards. This switch helps protect against identity theft and ensures that beneficiaries' personal information is kept confidential. The MBI is a unique, 11-character identifier that does not contain any personal identifiable information, like Social Security numbers, which were previously used. This change reflects a broader effort to enhance data security and to modernize how Medicare interacts with beneficiaries while maintaining streamlined access to their healthcare services. The other options pertain to different elements of the Medicare card that have not been replaced by the MBI. The enrollment date, plan type, and expiration date of coverage continue to provide necessary information regarding a beneficiary's Medicare plan and its terms, but the MBI specifically focuses on replacing the Social Security number as a means of identifying beneficiaries.

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4. What is a characteristic of the Ambulatory Payment Classification (APC) system?

A. Payments are made on a per-service basis

B. It combines payments for related services

C. It is only applicable to inpatient services

D. It does not consider the cost of services

The characteristic that payments are combined for related services is a core element of the Ambulatory Payment Classification (APC) system. This system is designed to group multiple outpatient services that are typically performed together into a single payment. It streamlines reimbursement by bundling these services, which can lead to increased efficiency in the billing process and a better understanding of costs for both providers and patients. By focusing on related services, the APC system addresses the complexities of various outpatient procedures, ensuring that healthcare providers are compensated for the comprehensive care they provide rather than just individual services in isolation. This bundling approach also encourages hospitals and outpatient facilities to deliver care more effectively, as they can optimize their resources across related services instead of managing payments for each service separately. This has implications for how healthcare organizations analyze cost and resource allocation, as efficiently managing the care continuum becomes a priority. Concerning the other options, payments made on a per-service basis does not apply because the APC system rather emphasizes the importance of bundled payments. The assertion that it only applies to inpatient services is incorrect; APC is specifically designed for outpatient services. Lastly, the statement about not considering the cost of services misrepresents the goal of the APC system. The system takes into account the cost associated with delivering bundled

5. What is one consequence of failing to recognize abuse in healthcare practices?

A. Increased trust from patients towards their providers

B. Potential legal issues and financial repercussions

C. Enhanced operational efficiency within healthcare facilities

D. Higher patient satisfaction ratings

Failing to recognize abuse in healthcare practices can lead to potential legal issues and financial repercussions. When abuse occurs—whether it's fraudulent billing, patient mistreatment, or failure to provide necessary care—it can violate laws and regulations meant to protect both patients and the integrity of the healthcare system. As a result, healthcare organizations can face lawsuits, penalties, and fines, leading to significant financial strain. Additionally, regulatory bodies may impose sanctions or revocations of licenses, further exacerbating operational challenges. Understanding this consequence underscores the importance of vigilance and continued training in recognizing and addressing abuse within healthcare settings. It emphasizes the need for robust compliance programs and policies aimed at safeguarding the organization against unchecked practices that could result in serious ramifications.

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6. Which of the following factors are considered in MUE?

A. Only treatment costs

B. Nature of service, procedure, and coding instructions

C. Health insurance rates

D. Demographics of the healthcare provider

The correct answer is based on the factors involved in Medical Utilization Edit (MUE) processes. MUE primarily focuses on ensuring that medical billing claims are appropriate and accurate, which directly influences payment and compliance. The nature of the service, procedure, and coding instructions play a pivotal role in the MUE process. This includes examining the specific details of the medical procedures, the context in which they are performed, and the appropriate codes that correspond to those services. By considering these factors, healthcare organizations can better manage billing practices, reduce claim denials, and ensure that services rendered are appropriately documented and billed to payers. In contrast, treatment costs, while important to the overall financial health of a healthcare organization, are not directly factored into MUE processes. Similarly, health insurance rates and demographics of the healthcare provider could influence broader billing strategies but do not directly relate to the specific edits applied through MUE. Therefore, the focus on the specific service characteristics and coding instructions is what makes the second choice the most accurate in the context of MUE.

7. What is the main focus of the 837 transaction?

A. To streamline Medicaid billing only

B. To standardize claims for outpatient services

C. To facilitate hospital claims for inpatient services

D. To create a unified billing and caring process

The main focus of the 837 transaction is to standardize claims submissions across all healthcare services, including inpatient claims for hospitals, outpatient services, and other healthcare-related transactions. The 837 transaction is part of the Health Insurance Portability and Accountability Act (HIPAA) and aims to facilitate the efficient exchange of healthcare claims information in a uniform format, thereby ensuring that claims can be processed swiftly and accurately. While the answer provided emphasizes hospital claims for inpatient services, the broader scope of the 837 transaction encompasses all types of claims submissions, which includes outpatient services and other healthcare transactions. This standardization helps reduce errors, decreases processing time, and aligns with the overall goal of improving efficiency in the healthcare revenue cycle. The other choices, while mentioning specific aspects of billing or services, do not capture the comprehensive purpose of the 837 transaction, which is to streamline the entire process of claim submissions across the healthcare spectrum. This unified approach helps ensure consistency, accuracy, and clarity in billing and reimbursement processes for providers and payers alike.

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8. What is the primary purpose of Medicare as it relates to the elderly?

A. Provide financial support for long-term care

B. Offer coverage for individuals aged 65 or older or those with permanent disabilities

C. Fund preventative health services exclusively

D. Replace private health insurance plans fully

The primary purpose of Medicare is to offer coverage for individuals aged 65 or older or those with permanent disabilities. This program was established to ensure that older adults, who may be less likely to have access to affordable health care due to age-related factors, have access to necessary medical services. Medicare is designed to provide health insurance and reduce the financial burden of medical expenses for both the elderly and people with certain disabilities. While one might consider financial support for long-term care, it is important to note that Medicare primarily covers hospital stays, outpatient services, and some aspects of skilled nursing care, but does not provide comprehensive coverage for long-term custodial care, which is typically not included. The funding of preventative health services is part of Medicare's benefits, allowing for screenings and wellness visits, but it is not the exclusive focus of the program. Additionally, Medicare is not designed to fully replace private health insurance plans; rather, it often works alongside them, offering essential coverage while individuals may still carry private insurance for additional benefits. The key aspect of Medicare is its role as a fundamental source of health insurance for the elderly and disabled, aligning with its mission to enhance health care access for these populations.

9. Which legislation prohibits offering free or discounted services to referring physicians?

A. Patient Protection and Affordable Care Act

B. False Claims Act

C. Anti-Kickback Statute

D. Medicare Modernization Act

The Anti-Kickback Statute is the legislation that specifically addresses the prohibition of offering free or discounted services to referring physicians. This statute aims to prevent healthcare providers from engaging in fraudulent practices that could lead to unnecessary services being rendered or increased costs to federal healthcare programs, like Medicare and Medicaid. Offering free or discounted services to physicians who refer patients can create a conflict of interest, potentially encouraging overutilization of healthcare services, which the statute intends to curtail. While the False Claims Act does deal with fraud in healthcare, it primarily focuses on the submission of false claims to government programs and does not specifically address the issue of financial relationships with referring physicians. The Patient Protection and Affordable Care Act and the Medicare Modernization Act have different scopes and purposes and also do not directly prohibit such practices. Therefore, the correct legislation in this context is the Anti-Kickback Statute, highlighting its critical role in maintaining ethical standards in medical referrals and services.

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10. What type of claim denial occurs when the claim is suspended for medical review within the Medicare system?

A. Claim Rejection

B. Claim Suspension

C. Compliance Violation

D. Charity Care

The answer is B, as claim suspension refers specifically to a situation where the claim is held for further review by Medicare, often to verify the medical necessity or appropriateness of the services provided. This process allows Medicare to evaluate the submitted documentation and ensure that the services billed meet the clinical criteria established in their guidelines. During this suspension, the claim is not processed for payment, and instead, it is pending review until a determination is made. In contrast, claim rejection typically occurs when a claim is found to be invalid before it even enters the processing system, often due to submission errors or inaccuracies in the information provided. Compliance violations relate to breaches of regulations or rules within the healthcare system but do not specifically denote claims under review. Charity care, meanwhile, refers to services provided for free or at a reduced cost to patients who cannot pay, which is unrelated to the processing of claims in the Medicare system. Therefore, claim suspension encompasses the specific scenario of a claim being held for medical review, making it the appropriate choice.

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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://aahamcrce.examzify.com

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

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