EPIC CLAIMS AND REMIT PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED 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.

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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. When you accept a claims reconciliation run, which of the following can happen to claims or accounts?

A. The claim is accepted

B. The claim is sent to the error pool

C. The claim status code is recorded on the insurance bucket

D. All of the above

2. Which statement best describes CDF responsibilities?

A. It handles only error checking

B. It handles only claims formatting

C. It handles error checking, defines claims splitting, and determines claim form and claim medium use

D. It handles none of these

3. Which statement best distinguishes a crossover payer from an alternate payer?

A. The crossover payer is the same as the primary payer

B. An alternate payer handles charges for specific services while a crossover payer receives the claim from Medicare as the secondary payer

C. They are the same payer

D. Crossover payer is always the secondary payer

4. The claim edit workqueue companion is also known as?

A. Claims Processing Assistant

B. Rule Engine

C. Data Validator

D. Claim Edit Assistant

5. What is the primary purpose of the ACN in attachments?

A. It encrypts the attachment data

B. It links attachments to the correct claim

C. It encodes patient insurance type

D. It indicates attachment priority

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6. Which action describes the insurance bucket's use in the reconciliation workflow?

A. It stores the status code of claims.

B. It stores remittance documents.

C. It stores patient demographics.

D. It stores archived claims.

7. Which statement about a catch-all claim edit work queue is true?

A. It requires heavy manual processing

B. It is used to route specific subsets of claims

C. It organizes claims in priority order

D. It is generally used to monitor the volume and is not worked by users

8. Claims reconciliation must be run manually.

A. True

B. It can be run automatically only on weekends

C. False

D. Not applicable

9. What happens if there are no rules?

A. Every claim in the error pool qualifies for the workque

B. The workque becomes inactive

C. Only the first error is processed

D. No claims are added to any workque

10. What best describes the function of the Type of Bill Extension setting in the CDF?

A. It automatically closes the claim after processing

B. It determines the bill's payment method

C. It allows you to change the Bill Type of the claim to something different than the normal Bill Types

D. It fixes the bill to a single standard type

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Answers

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

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Explanations

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1. When you accept a claims reconciliation run, which of the following can happen to claims or accounts?

A. The claim is accepted

B. The claim is sent to the error pool

C. The claim status code is recorded on the insurance bucket

D. All of the above

A claims reconciliation run can produce several outcomes for each claim or account. Some items will be accepted when they match correctly and are ready to be posted. Others may be routed to the error pool when there are mismatches, missing data, or other issues that prevent automatic reconciliation. At the same time, the system records a status code on the insurance bucket to capture the processing result for each item, enabling traceability and reporting. Because a single reconciliation run can include many claims, you can see a mix of accepted items, items in the error pool, and status codes updated on the insurance bucket. That combination is why all of the above can occur.

2. Which statement best describes CDF responsibilities?

A. It handles only error checking

B. It handles only claims formatting

C. It handles error checking, defines claims splitting, and determines claim form and claim medium use

D. It handles none of these

The essential function here is that the CDF oversees the entire lifecycle of claim submission quality and routing. It performs error checking to catch missing or inconsistent data, codes that don't align, or other issues that would cause a claim to reject. It also defines how a single encounter might be split into multiple claims when needed—such as when different payers, benefit structures, or service lines require separate submissions. Finally, it determines the appropriate claim form and submission medium, ensuring the claim uses the correct format (for example, CMS-1500 or UB-04) and the proper electronic or paper transmission method to meet payer requirements. If it only did error checking, crucial steps like proper claim splitting and form/medium selection would be missed. If it only handled formatting, it wouldn't ensure data validity or proper splitting. And choosing none of these would ignore fundamental responsibilities involved in preparing and submitting claims.

3. Which statement best distinguishes a crossover payer from an alternate payer?

A. The crossover payer is the same as the primary payer

B. An alternate payer handles charges for specific services while a crossover payer receives the claim from Medicare as the secondary payer

C. They are the same payer

D. Crossover payer is always the secondary payer

Understanding payer roles in Medicare billing helps. A crossover payer is the insurer that Medicare forwards the claim to after Medicare processes the claim as the primary payer; essentially, Medicare passes the claim to a secondary payer to coordinate benefits or pay remaining charges. An alternate payer is a different payer designated to handle charges for specific services under the patient's plan, not necessarily tied to the Medicare cross over process. The statement that best distinguishes them is that an alternate payer handles charges for specific services, while a crossover payer receives the claim from Medicare as the secondary payer. This captures the functional difference: alternate payer coverage is service specific, whereas the crossover payer is involved in the Medicare secondary claim flow.

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4. The claim edit workqueue companion is also known as?

A. Claims Processing Assistant

B. Rule Engine

C. Data Validator

D. Claim Edit Assistant

The main idea here is identifying the supportive tool that works alongside the claim edit workqueue to help reviewers apply edits more efficiently. In Epic, the companion that accompanies the Claim Edit Workqueue and guides users through edits is called the Claim Edit Assistant. It's named to reflect its role as a tool that assists with edits rather than a separate rule logic or data-check component. The other options refer to different parts of the system—such as a rule engine that handles edit logic, a data validator that checks field correctness, or a more generic claims processing helper—not the specific companion term used for this workflow. So, the best answer is Claim Edit Assistant.

5. What is the primary purpose of the ACN in attachments?

A. It encrypts the attachment data

B. It links attachments to the correct claim

C. It encodes patient insurance type

D. It indicates attachment priority

The main task of the ACN in attachments is to link each attached document to the correct claim in the payer's system. Each attachment carries this Attachment Control Number, which references the claim's unique identifier (and often its line items), so the document is filed with the right claim during intake, adjudication, and archival. This ensures the right documents accompany the right claim, avoiding mix-ups when multiple claims or many attachments are involved. The ACN isn't used for encryption, it doesn't encode patient insurance type, and it isn't a signal of attachment priority; those functions are handled by other parts of the submission process. When the ACN is missing or doesn't match the claim, attachments can be misfiled or delayed, underscoring why this linkage is essential.

6. Which action describes the insurance bucket's use in the reconciliation workflow?

A. It stores the status code of claims.

B. It stores remittance documents.

C. It stores patient demographics.

D. It stores archived claims.

In reconciliation workflows, quickly knowing where each claim stands is essential. The insurance bucket is where the system records the claim's current status code, such as submitted, in review, paid, or denied. This status lets the workflow track progress, flag mismatches with remittance data, and determine the next required action (like resubmission or denial review) without digging through raw data. Remittance documents belong in the remittance area, patient demographics live in the patient records store, and archived claims are kept in an historical archive. So, storing the status code of claims in the insurance bucket is the most direct way to manage reconciliation efficiently.

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7. Which statement about a catch-all claim edit work queue is true?

A. It requires heavy manual processing

B. It is used to route specific subsets of claims

C. It organizes claims in priority order

D. It is generally used to monitor the volume and is not worked by users

The catch-all claim edit work queue is meant as a general gathering place for edits that don't have a specific routing path, serving primarily to monitor overall activity. Its main role is to observe volume, identify spikes or backlogs, and help with staffing and workload planning. Because of this monitoring orientation, it isn't typically a queue from which staff actively pull work for processing. If you needed to route particular kinds of edits to specialized teams or to enforce priority handling, there are other, more targeted queues designed for those purposes. So the statement that this queue is generally used to monitor volume and is not worked by users best captures its purpose.

8. Claims reconciliation must be run manually.

A. True

B. It can be run automatically only on weekends

C. False

D. Not applicable

Reconciliation of claims is typically automated in Epic's claims and remittance workflow. When a payer's remittance advice arrives, the system can automatically apply payments to the matching claims, update patient responsibility, and balance batches without requiring a user to run a process manually. Manual reconciliation is generally reserved for exceptions or situations where automation can't resolve a discrepancy. Because of that, the statement that reconciliation must be run manually isn't accurate in standard Epic configurations. The option indicating not applicable fits, since the usual approach is automated reconciliation with manual review only as an exception path, not a mandatory manual run for every case.

9. What happens if there are no rules?

A. Every claim in the error pool qualifies for the workque

B. The workque becomes inactive

C. Only the first error is processed

D. No claims are added to any workque

In this scenario, rules act as the filters that decide what items should enter the work queue. If there are no rules, there's nothing to filter out or restrict entry, so every claim in the error pool qualifies to be placed in the work queue. That means all errors ready for review would show up for processing, rather than just a subset or nothing at all. The other options imply some filtering, inactivity, or exclusion, which doesn't happen when there are no rules.

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10. What best describes the function of the Type of Bill Extension setting in the CDF?

A. It automatically closes the claim after processing

B. It determines the bill's payment method

C. It allows you to change the Bill Type of the claim to something different than the normal Bill Types

D. It fixes the bill to a single standard type

The key idea is that the Type of Bill Extension lets you override the standard Bill Type for a claim. It's used when you need to bill using a non standard type for a specific situation, instead of being bound to the normal set of Bill Types. Because of that, this setting enables you to change the Bill Type of the claim to something different than the normal Bill Types. It does not automatically close the claim, nor does it determine how payment is made, and it doesn't lock the bill to a single fixed type.

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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://epicclaimsremit.examzify.com

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

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