

AAHAM Certified Revenue Cycle Executive (CRCE) Practice Exam (Sample)

Study Guide



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Questions

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- 1. What methodology is used to establish payment for outpatient services by Medicare?**
 - A. Outpatient Prospective Payment System**
 - B. Fee Schedule**
 - C. Cost Reimbursement**
 - D. Diagnosis-Related Group**
- 2. What is a conditional payment in Medicare terms?**
 - A. A payment made when a claim is immediately settled**
 - B. A payment pending recovery from another payer**
 - C. A payment made only to providers**
 - D. A payment without any conditions attached**
- 3. What is the primary purpose of the 1-day payment window rule?**
 - A. To allow outpatient services to be billed separately from inpatient admissions**
 - B. To combine specific outpatient services with inpatient claims for reimbursement**
 - C. To ensure hospitals only bill for services provided within the hospital premises**
 - D. To increase Medicare reimbursements for outpatient services**
- 4. What is another term for Medicare Part C?**
 - A. Medicare Supplemental Insurance**
 - B. Medicare Advantage**
 - C. Medicare Plus**
 - D. Medicare Managed Care**
- 5. What term refers to the percentage of allowable charges that a patient must pay after meeting their deductible?**
 - A. Coinsurance**
 - B. Deductible Payment**
 - C. Copayment**
 - D. Out-of-Pocket Maximum**

- 6. What is a primary goal of the Americans with Disabilities Act?**
- A. Enhance healthcare access for all**
 - B. Support financial reimbursement for providers**
 - C. Protect individuals with disabilities against discrimination**
 - D. Promote health information technology**
- 7. What agency aims to improve the quality of healthcare through research?**
- A. Centers for Disease Control and Prevention**
 - B. Food and Drug Administration**
 - C. Agency for Healthcare Research and Quality**
 - D. National Institutes of Health**
- 8. What type of information is typically included in the MSP questionnaire?**
- A. Patient's medical history only**
 - B. Employment status and information regarding accidents**
 - C. Patient's preferred healthcare providers**
 - D. Demographics of the patient's family**
- 9. What is the role of the primary care physician (PCP) in patient care?**
- A. Provide specialist referrals**
 - B. Perform surgeries**
 - C. Coordinate patient care**
 - D. Manage emergency care**
- 10. What is capitation in healthcare payment models?**
- A. A fee-for-service payment model**
 - B. A method where providers receive a set amount per patient over a specific time**
 - C. A variable payment model based on services rendered**
 - D. A reimbursement for only emergency services**

Answers

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

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Explanations

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1. What methodology is used to establish payment for outpatient services by Medicare?

- A. Outpatient Prospective Payment System**
- B. Fee Schedule**
- C. Cost Reimbursement**
- D. Diagnosis-Related Group**

The methodology used to establish payment for outpatient services by Medicare is the Outpatient Prospective Payment System (OPPS). OPPS is a system that reimburses healthcare providers a predetermined rate for outpatient services based on the procedure performed, rather than the costs incurred. This structured payment approach allows for standardized reimbursements, which simplifies the billing process and ensures that providers receive consistent compensation for similar services across the board. In OPPS, payment rates are established through a combination of national and local policies, with adjustments made based on various factors, such as geographic location and the resources utilized. The fee schedule, while relevant in other contexts, does not directly apply to outpatient services under Medicare; rather, it is more associated with physician services in a separate context. Cost reimbursement, which bases payment on the actual cost incurred by the provider, is also not applicable here, as OPPS relies on pre-established rates. Finally, Diagnosis-Related Groups (DRGs) are relevant to inpatient services, not outpatient services under Medicare. Understanding OPPS is crucial for effective revenue cycle management and optimizing reimbursement processes for outpatient care.

2. What is a conditional payment in Medicare terms?

- A. A payment made when a claim is immediately settled**
- B. A payment pending recovery from another payer**
- C. A payment made only to providers**
- D. A payment without any conditions attached**

A conditional payment in Medicare terms refers specifically to a payment that is made pending recovery from another payer. This situation arises when Medicare pays for a service or treatment on the assumption that another insurance company may be responsible for the payment. The payment is categorized as "conditional" because it is granted on the premise that Medicare will recover that amount later from the third-party payer once responsibility is established. This mechanism is essential in ensuring that beneficiaries receive timely medical services while also allowing Medicare to attempt to recoup costs from the appropriate payer, which might include private insurance or workers' compensation. The structured process helps manage the coordination of benefits and ensures that Medicare does not bear financial responsibility when another party is liable for the costs of care.

3. What is the primary purpose of the 1-day payment window rule?

- A. To allow outpatient services to be billed separately from inpatient admissions**
- B. To combine specific outpatient services with inpatient claims for reimbursement**
- C. To ensure hospitals only bill for services provided within the hospital premises**
- D. To increase Medicare reimbursements for outpatient services**

The primary purpose of the 1-day payment window rule is to combine specific outpatient services with inpatient claims for reimbursement. This rule is applicable to services rendered within 1 day of an inpatient admission. It aims to streamline the billing process for certain outpatient services that are directly related to a patient's inpatient stay. By including these services on the inpatient claim, hospitals can receive a consolidated payment rather than billing for outpatient services separately. This approach not only simplifies the billing process but also ensures that the reimbursement reflects the comprehensive care provided during the inpatient admission. The other options do not accurately reflect the intent of the 1-day payment window rule. The aim is not to allow outpatient services to be billed separately, nor is it focused solely on ensuring that hospitals bill only for services performed on their premises or to increase overall reimbursements for outpatient services.

4. What is another term for Medicare Part C?

- A. Medicare Supplemental Insurance**
- B. Medicare Advantage**
- C. Medicare Plus**
- D. Medicare Managed Care**

Medicare Part C is commonly referred to as Medicare Advantage. This program allows beneficiaries to receive their Medicare benefits through private insurance companies that are approved by Medicare. These plans often include coverage beyond what is provided by Original Medicare, such as dental, vision, and wellness services. The hallmark of Medicare Advantage plans is that they can bundle health coverage and provide additional services, which is essential for many beneficiaries looking for more comprehensive healthcare options. While terms like "Medicare Supplemental Insurance" may refer to Medigap policies that cover the costs not paid by Original Medicare, they do not encompass the full range of Medicare Advantage services. Similarly, "Medicare Plus" and "Medicare Managed Care" may be used informally in some contexts but are not the official designation for Part C. Medicare Advantage is the clear and recognized term that reflects the nature of these plans as an alternative to traditional Medicare coverage.

5. What term refers to the percentage of allowable charges that a patient must pay after meeting their deductible?

- A. Coinsurance**
- B. Deductible Payment**
- C. Copayment**
- D. Out-of-Pocket Maximum**

The term that refers to the percentage of allowable charges that a patient must pay after meeting their deductible is known as coinsurance. Coinsurance is a cost-sharing mechanism where, after the deductible has been satisfied, the insured person is responsible for a specific percentage of the costs of covered healthcare expenses, while the insurance company pays the remaining percentage. This arrangement helps to share the financial burden between the patient and the insurer, promoting cost-conscious decision-making regarding healthcare services. For instance, if a patient's coinsurance rate is 20%, it means that after meeting the deductible, the patient will pay 20% of the costs for services, while the insurer pays the remaining 80%. Understanding coinsurance is essential for managing financial responsibilities in the revenue cycle, particularly in how patients plan for their healthcare expenses following that deductible phase.

6. What is a primary goal of the Americans with Disabilities Act?

- A. Enhance healthcare access for all**
- B. Support financial reimbursement for providers**
- C. Protect individuals with disabilities against discrimination**
- D. Promote health information technology**

The primary goal of the Americans with Disabilities Act (ADA) is to protect individuals with disabilities against discrimination. This landmark legislation, enacted in 1990, aims to ensure that people with disabilities have the same rights and opportunities as everyone else. This includes access to public services, transportation, employment, and accommodations in public spaces. By focusing on preventing discrimination, the ADA helps to foster an inclusive society where individuals with disabilities can participate fully and equitably without facing barriers. In the context of the other options, while enhancing healthcare access, supporting financial reimbursement, and promoting health information technology are important aspects of healthcare and overall societal improvement, they do not encapsulate the fundamental aim of the ADA, which is centered on safeguarding the rights of individuals with disabilities. Hence, the focus of the ADA is clearly on non-discrimination rather than directly addressing healthcare access, financial issues for providers, or technological advancements.

7. What agency aims to improve the quality of healthcare through research?

- A. Centers for Disease Control and Prevention**
- B. Food and Drug Administration**
- C. Agency for Healthcare Research and Quality**
- D. National Institutes of Health**

The Agency for Healthcare Research and Quality (AHRQ) is the correct choice because its primary mission is to improve the quality, safety, efficiency, and effectiveness of healthcare for all Americans. AHRQ conducts research that provides evidence-based information to help healthcare stakeholders, including providers and policymakers, make informed decisions that improve health care outcomes. Their focus is specifically on generating knowledge and insights that can be applied to raise the standards of care across various healthcare settings. Other agencies mentioned have different primary focuses. The Centers for Disease Control and Prevention (CDC) predominantly work on disease prevention and public health, while the Food and Drug Administration (FDA) is primarily concerned with the regulation of food, pharmaceuticals, and medical devices to ensure their safety and efficacy. The National Institutes of Health (NIH) focuses on biomedical and health-related research, but its mandate is broader and more focused on discovery and research rather than specifically improving the quality of healthcare directly. Thus, the AHRQ stands out as the agency dedicated explicitly to the quality of healthcare through systematic research and quality improvement initiatives.

8. What type of information is typically included in the MSP questionnaire?

- A. Patient's medical history only**
- B. Employment status and information regarding accidents**
- C. Patient's preferred healthcare providers**
- D. Demographics of the patient's family**

The correct choice focuses on the information relevant to coordinating benefits with other insurance sources, specifically concerning the patient's employment status and details about any accidents. The Medicare Secondary Payer (MSP) questionnaire is designed to gather information necessary to determine if Medicare is the primary or secondary payer for a patient's healthcare costs. This is crucial as it affects billing practices and overall reimbursement processes. Employment status is significant because some individuals may have additional coverage from their employer, which can influence how claims are processed. Information regarding accidents is equally vital; if a patient was injured in an accident, there might be other parties responsible for covering the medical expenses, thereby making Medicare the secondary payer. Understanding these elements helps healthcare providers ensure they are billing the correct party, maintaining compliance, and maximizing revenue flow.

9. What is the role of the primary care physician (PCP) in patient care?

- A. Provide specialist referrals**
- B. Perform surgeries**
- C. Coordinate patient care**
- D. Manage emergency care**

The primary care physician (PCP) plays a crucial role in coordinating patient care, which encompasses a broad range of responsibilities aimed at ensuring that patients receive appropriate and comprehensive health services. PCPs are often the first point of contact for patients within the healthcare system. They assess patients' health needs, provide preventive care, diagnose various conditions, and manage a range of chronic and acute health issues. By coordinating care, the PCP ensures that patients are directed to the right specialists when needed, facilitates communication among various providers, and helps manage the overall treatment plan. This coordination is vital for improving health outcomes, enhancing patient satisfaction, and reducing the costs associated with fragmented care. The PCP's ability to understand the whole patient—considering their medical history, lifestyle, and individual needs—enables them to provide holistic care and follow through with long-term health management strategies. While providing specialist referrals and managing emergency care are aspects of care typically associated with primary physicians, their primary responsibility is to ensure that all elements of a patient's health care are effectively managed and coordinated. This is what sets the role of the PCP apart in the landscape of healthcare providers.

10. What is capitation in healthcare payment models?

- A. A fee-for-service payment model**
- B. A method where providers receive a set amount per patient over a specific time**
- C. A variable payment model based on services rendered**
- D. A reimbursement for only emergency services**

Capitation is a payment model used in healthcare where providers are compensated with a predetermined amount for each patient over a specific time period, regardless of the number of services the patient may need during that time. This model encourages healthcare providers to manage patient care efficiently, as they are responsible for providing adequate care within the fixed payment they receive. By implementing capitation, healthcare systems aim to promote preventive care and overall health management, as providers are incentivized to keep their patient population healthy to avoid additional costs. This model can discourage overutilization of services since the provider's revenue is not directly tied to the number of services rendered. Understanding this payment structure is crucial for those involved in revenue cycle management, as it influences how financial resources are allocated and how patient care is approached within the healthcare setting. It also distinguishes capitation from models like fee-for-service, where providers are paid based on the volume of services provided, and from variable payment models that fluctuate based on specific services.