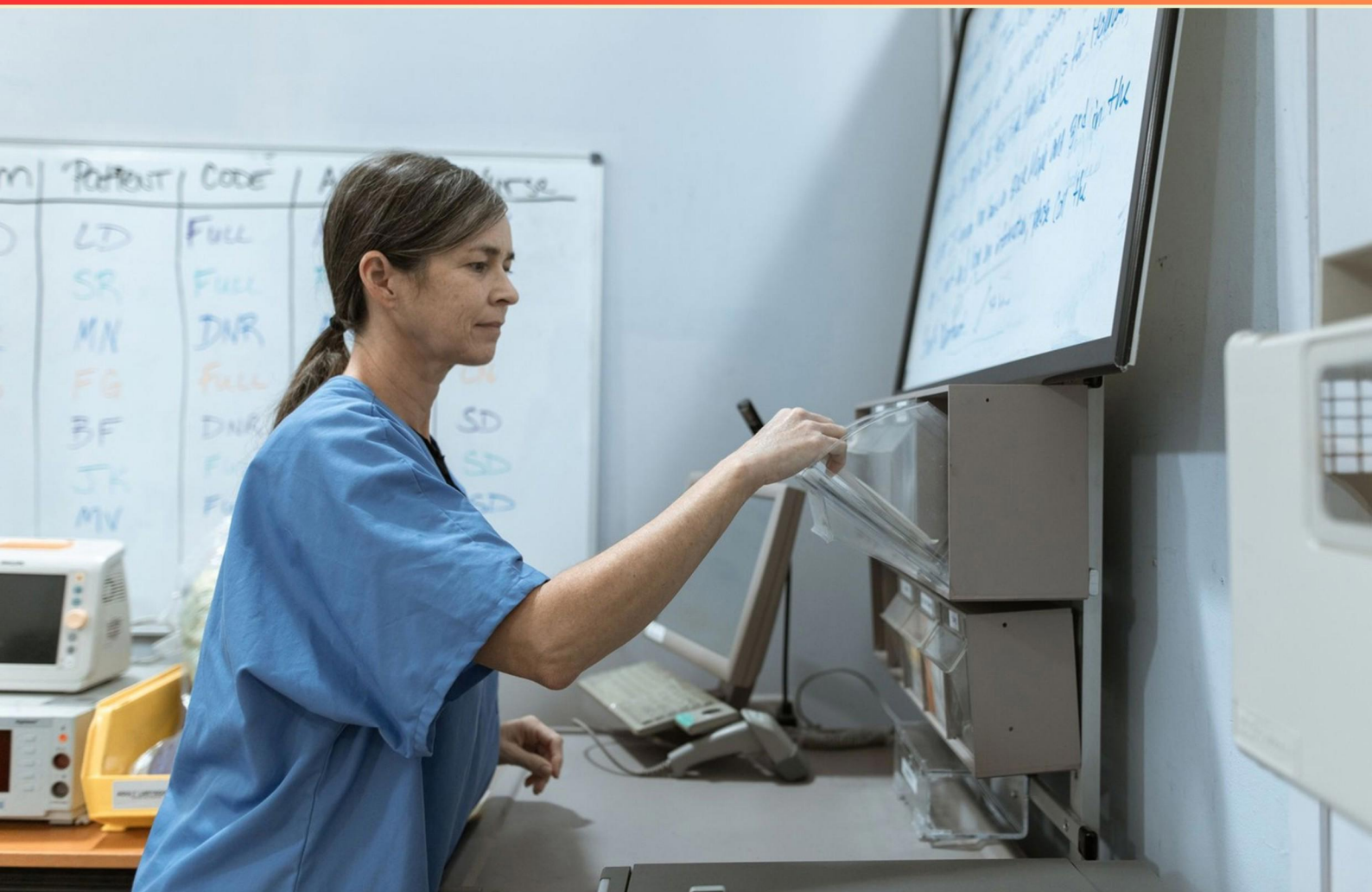


AAHAM CERTIFIED REVENUE CYCLE EXECUTIVE (CRCE) PRACTICE EXAM (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

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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. What defines factoring of receivables without recourse?**
 - A. The provider has no liability for non-payment
 - B. The provider must repay the loan if payments are delayed
 - C. The patient is required to pay upfront for services
 - D. The factoring process is done with strict credit evaluations
- 2. Who are the primary recipients of the Medicare program?**
 - A. Children under 18
 - B. Individuals with temporary illnesses
 - C. Individuals aged 65 or older and those with disabilities
 - D. All working-age adults
- 3. What is the term for when a claim is rejected entirely, allowing billing teams to correct and resubmit it, but not appeal?**
 - A. Claim Suspension
 - B. Claim Rejection
 - C. Compliance Violation
 - D. Charity Care
- 4. What does CMS stand for in the context of healthcare regulations and services?**
 - A. Centers for Medical Services
 - B. Certification of Medical Specialists
 - C. Centers for Medicare and Medicaid Services
 - D. Community Medical Services
- 5. Which file contains Medicare patient eligibility and utilization data?**
 - A. Patient Eligibility File
 - B. Common Working File (CWF)
 - C. Data Utilization Report
 - D. Medicare Claims Database

- 6. What does ACL stand for in the context of HHS Operating Divisions?**
- A. Administrative Community League
 - B. Administration for Community Living
 - C. American Community Life
 - D. Agency for Community Living
- 7. Which of the following is included in Durable Medical Equipment?**
- A. Wheelchairs and prosthetic limbs
 - B. Diagnostic imaging machines
 - C. Emergency respiratory devices
 - D. Surgical instruments
- 8. Which act is primarily concerned with preventing fraud in federal healthcare programs?**
- A. Fraud Enforcement and Recovery Act
 - B. Anti-Kickback Statute
 - C. False Claims Act
 - D. Healthcare Fraud Prevention Act
- 9. What type of payment arrangements are made to prevent beneficiaries from paying out of pocket initially?**
- A. Conditional payments
 - B. Capitated payments
 - C. Retrospective payments
 - D. Pre-authorized payments
- 10. 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

Answers

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

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Explanations

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1. What defines factoring of receivables without recourse?

- A. The provider has no liability for non-payment**
- B. The provider must repay the loan if payments are delayed
- C. The patient is required to pay upfront for services
- D. The factoring process is done with strict credit evaluations

Factoring of receivables without recourse refers to a financial arrangement where a provider sells their accounts receivable to a third party (the factor) and transfers the risk of non-payment. The key characteristic of this arrangement is that the provider retains no liability for non-payment; if the patient fails to pay, it is the factor that assumes the loss. This distinction is crucial because it allows the provider to receive immediate cash flow from the receivables, effectively offloading the risk associated with collecting those payments. In contrast, other choices involve scenarios where the provider retains some level of liability, such as needing to repay a loan if there are delays in payment or requiring upfront payment from the patient. These do not accurately describe the concept of factoring without recourse, which is all about relinquishing responsibility for potential non-payment to a third party. Additionally, conducting factoring with strict credit evaluations pertains to the due diligence a factor may perform but does not define the essence of factoring without recourse. Therefore, the clarity that the provider has no liability for non-payment encapsulates the fundamental principle of this financial decision.

2. Who are the primary recipients of the Medicare program?

- A. Children under 18
- B. Individuals with temporary illnesses
- C. Individuals aged 65 or older and those with disabilities**
- D. All working-age adults

The primary recipients of the Medicare program are individuals aged 65 or older, as well as those under 65 who have certain disabilities or specific medical conditions. Medicare is designed to provide health insurance primarily to seniors, reflecting the program's intent to support a vulnerable population that often faces increased health care needs due to aging. Additionally, people with disabilities qualify for Medicare after receiving Social Security Disability Insurance (SSDI) benefits for a specified period, typically 24 months. This dual focus on older adults and those with qualifying disabilities highlights the program's role in covering those at greater risk for health complications. The other groups mentioned do not typically fall under the Medicare umbrella. Children under 18 and individuals with temporary illnesses generally do not qualify for Medicare, which is specifically tailored for older adults and those with long-term disabilities. Working-age adults, while they may have other coverage options or programs available, are not the primary focus of Medicare's design and objectives. This understanding reinforces the importance of Medicare as a significant resource for older adults and individuals with long-term support needs.

3. What is the term for when a claim is rejected entirely, allowing billing teams to correct and resubmit it, but not appeal?

- A. Claim Suspension
- B. Claim Rejection**
- C. Compliance Violation
- D. Charity Care

The term that best describes the scenario where a claim is rejected entirely, permitting billing teams to correct and resubmit it without the option for appeal, is known as claim rejection. A claim rejection typically occurs when the claim fails to meet the required criteria for processing and is not accepted by the payer. This rejection provides the billing team a clear indication of what needs to be adjusted or fixed, allowing them the opportunity to rectify the issues identified in the submission. Claim suspension, on the other hand, refers to situations where a claim is temporarily put on hold, often pending further investigation or additional information, and does not imply immediate corrective action. Compliance violations typically involve breaches of regulatory or legal standards and do not pertain specifically to the state of the claim itself. Charity care relates to provisions made for individuals who cannot afford to pay for medical services, which is unrelated to the processing status of claims. In summary, understanding the distinction between these terms helps clarify the processes within revenue cycle management, reinforcing the billing team's capabilities in handling claims effectively.

4. What does CMS stand for in the context of healthcare regulations and services?

- A. Centers for Medical Services
- B. Certification of Medical Specialists
- C. Centers for Medicare and Medicaid Services**
- D. Community Medical Services

In the context of healthcare regulations and services, CMS stands for Centers for Medicare and Medicaid Services. This federal agency plays a critical role in administering the nation's major healthcare programs, particularly Medicare and Medicaid, which provide health coverage to eligible individuals, including seniors, low-income families, and people with disabilities. CMS oversees the implementation of healthcare policies, sets standards for quality and care delivery, and ensures compliance with regulations. It is also involved in initiatives to improve healthcare outcomes, manage costs, and streamline services across the healthcare system. By understanding the role of CMS, one can appreciate its significant influence on healthcare delivery and funding in the United States. This knowledge is essential for anyone working in the revenue cycle management field, as it affects reimbursement processes, regulatory compliance, and the overall financial health of healthcare organizations.

5. Which file contains Medicare patient eligibility and utilization data?

- A. Patient Eligibility File
- B. Common Working File (CWF)**
- C. Data Utilization Report
- D. Medicare Claims Database

The Common Working File (CWF) is the correct choice because it serves as a crucial resource for Medicare administrative functions. This file contains comprehensive information about Medicare beneficiaries, including their eligibility status and utilization of services. It is designed to support the processing of claims and facilitate data sharing between different healthcare providers and payers, ensuring accurate reimbursement and care coordination. The CWF houses eligibility data that confirms whether a patient qualifies for Medicare benefits, as well as information on what services those patients have accessed. This allows providers to verify eligibility before services are rendered, helping to streamline the billing process and reduce claims denials. While the Patient Eligibility File and other options may contain relevant data, they do not encompass the full scope of Medicare patient eligibility and utilization data as effectively as the Common Working File does. Thus, the CWF stands out as the primary file used for managing Medicare beneficiaries' eligibility and service utilization.

6. What does ACL stand for in the context of HHS Operating Divisions?

- A. Administrative Community League
- B. Administration for Community Living**
- C. American Community Life
- D. Agency for Community Living

The correct answer, Administration for Community Living, refers to a specific agency within the U.S. Department of Health and Human Services (HHS). This agency focuses on enhancing the quality of life for older individuals and people with disabilities, promoting their independence and inclusion in community life. The Administration for Community Living combines the efforts of several programs that aim to support these populations, ensuring they have access to vital services and resources. This aligns with the goals of HHS in providing comprehensive health and social services, promoting community engagement, and improving the health and well-being of vulnerable populations. Understanding the role of the Administration for Community Living is essential for professionals in the revenue cycle management field, as it impacts service delivery and funding for programs that serve these individuals. The other options do not pertain to an existing agency within HHS, making them less relevant in this context. Recognizing the correct terminology and agency structure is important for professionals navigating the health sector and managing interactions with various operating divisions.

7. Which of the following is included in Durable Medical Equipment?

A. Wheelchairs and prosthetic limbs

B. Diagnostic imaging machines

C. Emergency respiratory devices

D. Surgical instruments

Durable Medical Equipment (DME) specifically refers to equipment that provides therapeutic benefits to a patient in need due to certain medical conditions and illnesses. Items classified as DME are intended for long-term use and can withstand repeated use. Wheelchairs and prosthetic limbs are quintessential examples of DME because they are designed to aid in patient mobility and recovery, significantly enhancing patients' quality of life. These devices are durable, can be used repeatedly, and are primarily used for medical purposes. In contrast, diagnostic imaging machines are not categorized as DME because they are not used directly by patients in a home setting for their ongoing care but rather as part of medical diagnostic procedures. Emergency respiratory devices may be used during acute care but are generally not classified as durable equipment intended for ongoing use. Surgical instruments, while important in clinical settings, are one-time use items or require sterilization and handling that fall outside the definition of durable medical equipment. Therefore, the identification of wheelchairs and prosthetic limbs as part of DME aligns perfectly with the criteria for durable equipment, making it the correct answer.

8. Which act is primarily concerned with preventing fraud in federal healthcare programs?

A. Fraud Enforcement and Recovery Act

B. Anti-Kickback Statute

C. False Claims Act

D. Healthcare Fraud Prevention Act

The primary purpose of the Anti-Kickback Statute is to prevent fraud and abuse in federal healthcare programs by prohibiting the payment or receipt of any remuneration to induce or reward patient referrals or the generation of federal healthcare program business. This statute is crucial because it addresses practices that can compromise the integrity of the healthcare system, ensuring that medical decisions are made based on patient needs rather than financial incentives. The Anti-Kickback Statute is broadly defined, covering a wide range of activities that may be considered as kickbacks. It aims to protect patients and federal healthcare programs from undue influence that could lead to unnecessary services or inflated costs due to improper financial arrangements among healthcare providers. While other acts, such as the False Claims Act and the Fraud Enforcement and Recovery Act, deal with various aspects of healthcare fraud, their focus is different. The False Claims Act addresses false claims submitted to the government for reimbursement, while the Fraud Enforcement and Recovery Act provides additional resources and tools to combat healthcare fraud rather than specifically targeting the inducement aspect of kickback arrangements. The focus of the question emphasizes the prevention of fraudulent activities related to financial incentives, making the Anti-Kickback Statute the most appropriate answer.

9. What type of payment arrangements are made to prevent beneficiaries from paying out of pocket initially?

- A. Conditional payments**
- B. Capitated payments
- C. Retrospective payments
- D. Pre-authorized payments

Conditional payments represent a specific type of payment arrangement designed to protect beneficiaries from having to pay out of pocket at the onset of receiving care. This type of arrangement is typically seen in situations involving Medicare and Medicaid, where payments are made on behalf of beneficiaries when they are eligible for coverage, even if the ultimate determination of coverage has not yet been established. By using conditional payments, a health care provider can receive reimbursement while the patient's eligibility for insurance coverage is being verified. This ensures that beneficiaries can access necessary medical services without the burden of upfront payments, which might present a financial barrier to care. In contrast, capitated payments involve a fixed amount paid to providers per patient, retrospective payments occur after services are rendered based on actual costs, and pre-authorized payments require prior approval for services before payment can be approved. While each of these methods has its specific use cases, they do not primarily focus on preventing out-of-pocket costs at the time of service in the direct manner that conditional payments do.

10. 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.

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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