

CERTIFIED REVENUE CYCLE SPECIALIST PRACTICE TEST (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 is the primary function of Utilization Review (UR) in healthcare?**
 - A. To perform surgical procedures on patients
 - B. To manage the patient's medication regimen
 - C. To reduce unnecessary admissions and manage the length of stay
 - D. To provide diagnostic imaging services
- 2. What does an increase in percentage of occupancy typically signify about a healthcare facility?**
 - A. Available resources
 - B. High demand for services
 - C. Low operational costs
 - D. Low patient turnover
- 3. What does DHHS stand for?**
 - A. Department of Health and Human Services
 - B. Department of Health and Hospital Services
 - C. Department of Health and Human Safety
 - D. Department of Health and Homeland Security
- 4. Local Coverage Determination (LCD) is developed by which type of contractors?**
 - A. Private healthcare providers
 - B. Medicare area contractors
 - C. State health departments
 - D. Insurance companies
- 5. Which form is used specifically to submit physician and professional service claims to Medicare?**
 - A. CMS 1000
 - B. CMS 1500
 - C. UB-04
 - D. Medical Claim Form 5010

- 6. What is the primary use of the term 'imprest' in financial contexts?**
- A. Budget allocation for payroll
 - B. Emergency funds set aside for major projects
 - C. Petty cash management for small expenses
 - D. Investment funds for future projects
- 7. What is the Omnibus Budget Reconciliation Act (OBRA) of 1989 best known for in healthcare?**
- A. Implementing the Affordable Care Act
 - B. Providing for the Resource Based Relative Value Scale
 - C. Overhauling the Medicare system
 - D. Establishing patient insurance mandates
- 8. What does Average Daily Census measure in a hospital?**
- A. The total number of patients in the hospital
 - B. The average number of inpatients maintained daily
 - C. The total revenue generated per day
 - D. The number of procedures done each day
- 9. What does UCR stand for in medical billing?**
- A. Uniform Cost Review
 - B. Usual, Customary, and Reasonable
 - C. United Care Regulations
 - D. Universal Claim Revision
- 10. Which aspect is NOT typically covered by Medigap insurance?**
- A. Deductibles and coinsurance
 - B. Emergency healthcare outside of the U.S.
 - C. Long-term care services
 - D. Copayments for medical services

Answers

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

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Explanations

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1. What is the primary function of Utilization Review (UR) in healthcare?

- A. To perform surgical procedures on patients
- B. To manage the patient's medication regimen
- C. To reduce unnecessary admissions and manage the length of stay**
- D. To provide diagnostic imaging services

Utilization Review (UR) primarily focuses on evaluating the appropriateness of the services provided to patients within the healthcare system. Its main goal is to ensure that patients receive the necessary care while minimizing unnecessary procedures and hospitalizations. By focusing on reducing unnecessary admissions and managing the length of stay, UR helps healthcare facilities control costs while maintaining quality patient care. In this context, UR analyzes various aspects such as the necessity of services, efficiency of the patient's treatment plan, and adherence to established protocols. This not only optimizes resource utilization but also enhances patient outcomes by ensuring that patients are only admitted or kept in a facility when it is medically justified. By actively managing these factors, UR plays a crucial role in improving the overall efficiency of the healthcare delivery system. Other options relate to specific clinical tasks or functions that do not align with the overarching objective of UR, which is focused on oversight and management of healthcare services rather than direct patient treatment or diagnostics.

2. What does an increase in percentage of occupancy typically signify about a healthcare facility?

- A. Available resources
- B. High demand for services**
- C. Low operational costs
- D. Low patient turnover

An increase in the percentage of occupancy in a healthcare facility generally indicates a high demand for services. When more beds are occupied, it suggests that the facility is experiencing an influx of patients seeking care, which often reflects positively on the quality of services or the reputation of the facility in the community. A high occupancy rate implies that the facility is utilized effectively and can be an indicator of the facility's ability to meet patient needs. While this situation can also affect other areas such as resource allocation and operational costs, the primary significance of high occupancy is the heightened demand for healthcare services, reflecting the facility's role in addressing public health needs. This is especially important for healthcare facilities, as it can drive future planning and resource management decisions to continue providing adequate care.

3. What does DHHS stand for?

- A. Department of Health and Human Services
- B. Department of Health and Hospital Services
- C. Department of Health and Human Safety
- D. Department of Health and Homeland Security

The term DHHS stands for the Department of Health and Human Services, which is a significant government agency in the United States. Its primary responsibility is to enhance the health and well-being of Americans by providing effective health and human services. This includes overseeing numerous programs related to public health, medical research, and social services. The focus of the DHHS is on a wide range of issues, including healthcare access, food safety, disease prevention, and the well-being of families and children. It plays a crucial role in formulating policies and implementing programs that aim to improve the overall health of the nation's population. By understanding the correct name and the scope of DHHS, those studying for the Certified Revenue Cycle Specialist can better comprehend how government agencies influence healthcare revenue cycles and related services. Other options do not accurately reflect the established agency known as DHHS, as they either create confusion with unrelated departments or misrepresent the focus and mission of the agency.

4. Local Coverage Determination (LCD) is developed by which type of contractors?

- A. Private healthcare providers
- B. Medicare area contractors
- C. State health departments
- D. Insurance companies

Local Coverage Determinations (LCDs) are established by Medicare Administrative Contractors (MACs), specifically the regional contractors that manage claims and processes for Medicare in designated geographic areas. These contractors are responsible for determining the medical necessity and appropriateness of services and items based on the needs of the Medicare population they serve in their specific areas. By focusing on the regional or local context, these contractors can address the unique healthcare needs, treatment trends, and medical practices of the providers and beneficiaries in their jurisdiction, ensuring that Medicare coverage aligns with current standards and practices. This process helps create a more tailored healthcare service provision, as each area may have different clinical needs and standards of care. In contrast, private healthcare providers, state health departments, and insurance companies do not create these determinations. Private healthcare providers might implement the guidelines provided by LCDs but do not have the authority to create them. State health departments may have a role in public health policy and guidelines but do not directly relate to Medicare coverage decisions. Insurance companies operate independently of Medicare in terms of coverage criteria and determinations, as they have their own rules and guidelines specific to their insurance plans. Thus, the role of Medicare area contractors is crucial for the establishment and implementation of LCDs.

5. Which form is used specifically to submit physician and professional service claims to Medicare?

- A. CMS 1000
- B. CMS 1500**
- C. UB-04
- D. Medical Claim Form 5010

The form specifically used to submit physician and professional service claims to Medicare is the CMS 1500. This form is designed for billing various healthcare providers, including physicians, non-physician practitioners, and other healthcare professionals. It allows healthcare providers to report services, procedures, and supplies provided to patients, making it essential for accurate billing and reimbursement. The CMS 1500 form includes critical information such as the patient's demographic details, provider details, diagnosis codes, and the services rendered. Accurate completion of this form is crucial for processing claims with Medicare efficiently, ensuring that claims are submitted in accordance with the guidelines established by Medicare. The other forms mentioned in the options serve different purposes. The CMS 1000 does not correspond to a standard form used in the Medicare billing process. The UB-04 form is utilized for institutional claims, typically submitted by hospitals and other facility-based providers, for services provided to patients. The Medical Claim Form 5010 is not specific to Medicare and is more generic, often used for electronic claims submission in various contexts. Thus, the CMS 1500 is the correct choice for submitting physician and professional service claims to Medicare.

6. What is the primary use of the term 'imprest' in financial contexts?

- A. Budget allocation for payroll
- B. Emergency funds set aside for major projects
- C. Petty cash management for small expenses**
- D. Investment funds for future projects

The term 'imprest' primarily refers to a system of managing petty cash, specifically for small expenses. Under an imprest system, a fixed amount of cash is advanced to a custodian for minor expenditures. The custodian is responsible for keeping track of these expenses and providing receipts or documentation for each transaction. When the cash is nearly depleted, the custodian submits receipts to replenish the fund back to the original amount. This method streamlines cash handling and helps maintain control over minor expenditures, reducing the likelihood of discrepancies or misuse. In this context, the other options do not align with the specific use of 'imprest.' Budget allocation for payroll involves regular financial planning unrelated to petty cash. Emergency funds for major projects are typically larger reserves set aside for significant financial needs rather than day-to-day expenses. Investment funds for future projects pertain to financial allocations for growth or development rather than managing small operational costs. Thus, the focus of the term 'imprest' on petty cash management establishes clarity on its primary function within financial contexts.

7. What is the Omnibus Budget Reconciliation Act (OBRA) of 1989 best known for in healthcare?

- A. Implementing the Affordable Care Act
- B. Providing for the Resource Based Relative Value Scale**
- C. Overhauling the Medicare system
- D. Establishing patient insurance mandates

The Omnibus Budget Reconciliation Act (OBRA) of 1989 is best known for providing for the Resource Based Relative Value Scale (RBRVS). This legislation introduced a system that reformed the reimbursement process for healthcare services provided to Medicare beneficiaries. The RBRVS is essential as it established a way to determine payment amounts based on the resources required to provide various services, rather than simply the historical costs associated with those services. This shift aimed to create a more equitable and sustainable Medicare payment system by considering the complexity and time involved in delivering care rather than just the fee-for-service model prevalent before its implementation. The focus of OBRA on RBRVS marked a significant change in how healthcare providers were reimbursed, aligning payment more closely with the work and resources necessary for different procedures and evaluations. This approach intends to ensure that healthcare services are adequately valued and compensated, which helps maintain a balance within the healthcare system regarding access and quality of care for patients.

8. What does Average Daily Census measure in a hospital?

- A. The total number of patients in the hospital
- B. The average number of inpatients maintained daily**
- C. The total revenue generated per day
- D. The number of procedures done each day

Average Daily Census is a critical metric in hospital management that assesses the average number of patients admitted and maintained in the hospital each day over a specific period, typically expressed on a yearly basis. This measurement provides valuable insights into hospital occupancy rates, resource allocation, and operational efficiency. Understanding the Average Daily Census helps hospital administrators in various ways, such as evaluating staffing needs, planning for future capacity, and managing hospital resources effectively. For instance, knowing the average number of inpatients will inform decisions about the necessity for additional staff, equipment, or services to enhance patient care. The other choices do not accurately reflect what Average Daily Census measures. While the total number of patients in the hospital at any given time could relate to census, it does not account for the average aspect over a specified timeframe. Total revenue generated per day and the number of procedures done each day pertain to financial performance and operational output, respectively, rather than patient occupancy.

9. What does UCR stand for in medical billing?

- A. Uniform Cost Review
- B. Usual, Customary, and Reasonable**
- C. United Care Regulations
- D. Universal Claim Revision

In medical billing, UCR stands for Usual, Customary, and Reasonable. This term is used to describe the standard rates that healthcare providers typically charge for specific services in a particular geographical area. Insurance companies often utilize UCR rates to determine the amount they will reimburse for services rendered to patients, especially in out-of-network situations. Understanding UCR is crucial as it helps in predicting the financial aspects of medical services and ensuring that providers are compensated fairly relative to the prevailing rates in their locale. It also assists patients in understanding their potential out-of-pocket expenses when they receive care. When claims are processed, the UCR rates serve as a benchmark, guiding decisions on payment structures and negotiation strategies between providers and insurers.

10. Which aspect is NOT typically covered by Medigap insurance?

- A. Deductibles and coinsurance
- B. Emergency healthcare outside of the U.S.
- C. Long-term care services**
- D. Copayments for medical services

Medigap insurance, also known as Medicare Supplement Insurance, is designed to fill in the gaps in coverage provided by Medicare. It primarily helps cover costs such as deductibles, coinsurance, and copayments associated with Medicare services. Medigap plans often offer additional coverage for certain emergency situations, including healthcare needed while traveling outside the United States. However, one of the key aspects that Medigap does not typically cover is long-term care services. Long-term care generally includes assistance with daily living activities over an extended period, which is not included in standard Medigap policies. Individuals needing long-term care often must seek alternative types of insurance or government assistance programs designed specifically for that purpose. Therefore, the correct answer highlights a crucial distinction in what Medigap insurance provides versus what is necessary for long-term support and 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://certrevenuecycle.examzify.com>

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

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