Healthcare Financial Management Association

Certified Revenue Cycle Representative (CRCR)
Key Concepts Guide

hfma
healthcare financial management association

Certified Revenue Cycle Representative (CRCR) Key Concepts Guide
Supplement to HFMA's Online CRCR Program

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1. Introduction – Key Concepts Approach and Focus

HFMA's Certified Revenue Cycle Representative (CRCR) program is an online, self-directed, interactive program that provides a comprehensive overview of best practice revenue cycle approaches. It offers you the opportunity to expand your knowledge of contemporary revenue cycle issues and serves as part of a career ladder for your ongoing professional development. By becoming a CRCR, you, your team, and colleagues attain the designation that proves a high level of current health care revenue cycle knowledge and expertise.

This document embodies a "key concepts" approach, which presumes that you have a basic understanding of the revenue cycle and how it influences the financial outcomes of a healthcare organization.

This guide is intended for those who wish to make focused notes and capture important concepts while working with online study materials. Taking the time to use and/or customize the guide can help you to develop a handy review tool. The concept guide identifies important ideas and is a supplement to the online study program. It is not a replacement for the online materials nor a summary of the online course. It is intended to help you summarize your personal learning.

Blank Space: You will notice blank space within the pages; these are intentional for individual note-taking.

Before You Start

Please note that there are four distinct units within the online program, and there are review questions throughout those units in the online material. Those questions are separate and distinct from the exam, or assessment, which covers content from all four units.

Working through this concept guide will not, in and of itself, prepare you to sit for the CRCR certification assessment. Review of the online material is important as assessment questions do tie back to the content presented. Test taking tips are available on page 47 of this guide.

Upon successful completion of the assessment, you will be recognized as a Certified Revenue Cycle Representative (CRCR). To help guide you in your studies, we have also included the exam content outline on the next page.

Best wishes on taking this next step in your professional development through HFMA's CRCR program.

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CRCR Content Outline and Areas of Exam

Subject Area	Topics	Weight in Exam
Patient Centric Revenue Cycle Unit One (1)	1.1 Revenue Cycle Overview 1.2 Health Care Dollars & Sense 1.3 Patient Experience & Satisfaction 1.4 Collaboration & Continuum of Care 1.5 Compliance & HIPAA Regulations 1.6 Medicare Compliance & Regulations 1.7 Ethics 1.8 Volume to Value Payment Models 1.9 Healthcare Financial Reporting 1.10 Key Performance Indicators in the Revenue Cycle	30%
Pre-Service Financial Care Unit Two (2)	2.1 Types of Patients 2.2 Scheduling 2.3 Pre-Registration & Insurance Verification 2.4 Health Plans - An Overview 2.5 Health Plans - Managed Care 2.6 Price Transparency - NSA 2.7 Patient Financial Communication	22%
Point of Service Financial Care Unit Three (3)	3.1 Patient Arrival & Intake 3.2 Case Management 3.3 Revenue Capture & Recognition 3.4 Health Information Management (HIM) & Coding 3.5 Claim Form Requirements, Edits & Electronic Data Interchange (EDI) 3.6 Basic Billing Rules & Payment Methodologies 3.6a COVID-19 Regulatory & Practice Changes 3.7 Health Plan Contracts	23%
Post Service Financial Care Unit Four (4)	4.1 Cash Posting, Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) 4.2 Credit Balances 4.3 Exception Based Processing – Denied Claim 4.4 Exception Based Processing - Non-Paid 4.5 Self-Pay Follow Up 4.6 IRS Regulation Section 501(r) 4.7 Patient Debt Regulations 4.8 Medical Account Resolution 4.9 Outsourcing	25%

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CRCR Learning Objectives

After this program, you will be able to:

- Identify processes and techniques for both enhancing the patient experience and improving financial performance

- Explore the most effective ways to reduce denials and simplify collections

- Review regulations to assure compliance

- Outline effective ways to increase interdepartmental cooperation, heighten staff confidence and improve work satisfaction

- Create effective ways to measure revenue cycle staff proficiency, recognize staff knowledge and expertise, and decrease turnover

About the Course

CRCR is divided into 4 sections:

- Revenue Cycle Introduction
- Pre-Service Financial Care
- Time of Service Financial Care
- Post Service Financial Care

Each module consists of a varied number of individual units designed to present revenue cycle materials in focused e-learning programs. At the beginning of each module, a series of questions, a pre-test; used to measure the learner's preparation to complete each module. All questions are based on material included in this course.

Upon completion of review of the content the learner will take the CRCR assessment which consists of 75 multiple choice questions. 90 minutes is allowed for this assessment.

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CRCR Section 1: The Patient-Centric Revenue Cycle

1.1 Revenue Cycle Overview

The Patient-Centric Revenue Cycle.
The Revenue Cycle includes all of the major processing steps required to process a patient account from the request for service through closing the account with a zero balance and purging it from the system.

Pre-Service

Time-of-Service

Post-Service

Notes:

1.2 HFMA's Healthcare Dollars and Sense

Healthcare Dollars and Sense is the name given to three HFMA revenue cycle initiatives:

Patient financial communications best practices

Best practices for price transparency

Medical account resolution

Financial counseling

If appropriate, the patient may be referred to a financial counselor and/or offered information regarding the provider's financial counseling services and assistance policies. Providers should have a widely publicized toll-free number for patients to call to receive assistance in financial matters and address any concerns they may have.

Patient share

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Prior Balances

Balance resolution

Price Transparency

Pricing transparency has evolved based on providers' need to easily provide pricing information to patients. The Affordable Care Act legislated the development of a Health Insurance Marketplace, also known as Health Insurance Exchange, where individuals and small businesses can compare and purchase qualified health benefit plans.

The Need for Pricing Transparency

As part of these consumer driven programs, patients need pricing information to make informed health care decisions.

- Price Transparency in Health Care

- Understanding Healthcare Prices: A Consumer Guide

Medical Account Resolution

HFMA partnered with ACA – not the Affordable Care Act – the Association of Credit and Collections Professionals International – and brought together provider organizations, our business partners in the collection agencies, and patient advocates to form the medical debt task force. This group developed a best practice workflow that builds off of HFMA's previous Patient-Friendly Billing ® work and spans the patient-centric revenue cycle. The goal was to improve both the efficiency of the revenue cycle and the patient experience.

Medical Account Resolution — Best Practices

Educate

Bills

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Policies

Consistency

Coordinate

Judgment

Timing

Report and Track

Concluding Medical Account Resolution — Best Practices

Implementing these best practices involves close coordination with all early out and/or collection agencies to ensure that the appropriate screening for coverage and/or financial assistance eligibility occurs at each point in the account resolution process.

Notes:

1.3 Patient Experience and Satisfaction

Patient Satisfaction Metric within the Industry (HCAHPS)

The Center for Medicare and Medicaid Services (CMS) implementation of the value-based purchasing program has increasingly highlighted a focus on core measures, one of which is the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) initiative.

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The objective of the HCAHPS initiative is to provide a standardized method for evaluating patients' perspective on hospital care.

HCAHPS Survey

Many of the 27 questions on the HCAHPS survey are related to clinical care and patient engagement; however, one question encompasses the entire patient experience, including registration, billing, collection and other revenue cycle activities. This question is as follows:

“Would you recommend this hospital to your friends and family?”

Revenue Cycle Team Members Role in Patient Satisfaction

It is important to go the extra mile by creating patient-friendly processes aimed at improving the overall patient experience.

Improving the overall patient experience requires revenue cycle leadership and staff to simultaneously be inquisitive, responsive, innovative and flexible. Leadership and staff must always remember the following points.

Implement

Educate

Communicate

Impact of Communication and Customer Service Revenue cycle team members play a critical role in retaining patients as customers. Recognizing this fact, staff should provide clear communication and good customer service, which will give the provider a competitive edge. A key element to clear revenue cycle communication is helping patients and families understand their financial responsibilities for care, and what services or programs are available to help them if needed. The paramount customer service guideline is to treat the patient as you would wish to be treated.

Cost of Poor-Quality Patient Experiences

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The cost of dissatisfied customers can be summarized in terms of hard and soft costs.

Hard

Soft

Quality

Nearly 40% of billing information is obtained during the registration process (access service).

When the data is missing or inaccurate, delayed payment or nonpayment for services occurs thus impacting the patient's experience.

Quality: Billing Communication

Within this area, revenue cycle activities for improving communication and customer service include:

- Modifying billing formats and statements for easier patient comprehension.
- Extending normal business hours for patient inquiries and complaints.
- Making sure that all staff answers the telephone courteously and gives the customer his/her name for future reference.
- Resolving questions or complaints without transferring the customer to another person whenever possible.
- Following up on all customer inquiries or complaints within 48 hours.
- Including customer service responsibilities in every staff member's performance plan and holding staff accountable during performance reviews.

Payments are negatively affected if appropriate authorization information is not provided on the claim. This missing information may be discovered during final pre-bill editing. To rectify this issue, missing information should be retrieved and entered into the claim, or the claim can just be submitted with missing or incorrect information, thus passing the responsibility on to another department. In either

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case, valuable time is spent retrieving the correct or missing information before submitting or resubmitting the claim.

Rework

Physician Impacts

Physician Identification

Patient Identification

Billing Information

Many physicians, especially hospital-based physicians, use the hospital's registration record to complete their billing. If patient information is incomplete or missing, it affects physicians' billing costs.

Service Delays

Notes:

1.4 Collaboration and Continuum of Care

Collaboration with Information Technology

Healthcare providers today are faced with an increasingly complex operating environment. Information technology provides a competitive advantage in several areas, including:

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Streamlining operations

increasing productivity

Assessing profitability by health plan and patient type

Providing quality care

Information Technology: Software Applications

Many functions within the healthcare revenue cycle are (or can be) streamlined through automation.

Let us look at the various functions within the revenue cycle that may benefit from outsourcing.

Appointment and resource scheduling:

- Admit, discharge, and transfer system (ADT) – Registration.

Patient account systems:

- Pre-bill editing
- Electronic claim generation – insurance and patient billing
- Payment tracking and automated follow-up queues
- Accounts receivable
- Cash posting
- Denials management
- Refund processing
- Collection account transfers

Additional Software May Include:

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- Contract management
- Decision support
- Quality assurance
- Chart tracking
- Transcription
- Order entry
- Bed management
- Document imaging
- Electronic health record
- Online interfaces to health plan’s enrollment eligibility screens
- Online access to health plan’s benefit screens
- Referral authorization
- Utilization and productivity management
- Radiology clinical systems
- Laboratory clinical systems
- Pharmacy clinical systems
- Case mix and decision support

Information Technology: Emerging Technology

Revenue cycle managers must continually research new technologies to maintain operating efficiencies necessary to compete in today’s evolving environment.

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Online Patient Services

Identification Systems

Collaboration with Clinical Services

Collaboration with Finance

Collaboration with Health Plan Contracting

Continuum of Care Provider

Physician

Skilled Nursing Facility

Home Health Agency

Durable Medical Equipment

Hospice

Assisted Living

Continuum of Care Provider

- Physician

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1.5 Compliance & HIPAA Regulations

Essential Elements in a Corporate Compliance Program

The burden of proof is generally on the healthcare facility; therefore, it is imperative to:

- Have a Plan.
- Follow the Plan.
- The Plan is a Corporate Compliance Program.
- Know What Happens if You Do not Follow the Plan.

Review the Code of Conduct to Verify You Follow the Plan.

- Chief Compliance Officer Role Oversees Code of Conduct.
- Know the Benefits of the Code of Conduct.
- The code of conduct represents the organization’s compliance program as well as the organization’s culture.

Notes:

Corporate Compliance Program Elements

Element 1 –

Element 2 –

Element 3 –

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Element 4 –

Element 5 –

Element 6 –

Element 7 –

Element 8 –

Element 9 –

Element 10 –

Element 11 –

Element 12 –

Element 13 –

Element 14 –

Element 15 –

Element 16 –

Code of Conduct

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Area of Focus of Code of Conduct

- Human resources
- Privacy/confidentiality
- Quality of care
- Billing/coding
- Conflicts of interest
- Laws/regulation

Notes:

The Office of inspector General

The Office of Inspector General (OIG) was created to protect the integrity of the Health and Human Services (HHS) Department programs and operations and the well-being of beneficiaries by detecting and preventing fraud, waste, and abuse.

OIG Responsibilities

OIG Work Plan

2020 Work Plan Example 1

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2020 Workplan Example 2

Violations of the OIG Work plan

Goals of HIPAA

HIPAA contains the following goals:

- Expand health coverage by improving the portability and continuity of health insurance coverage in group and individual markets.

- Give patients access to their health files and the right to request amendments or make corrections.

- Facilitate the electronic exchange of medical information with respect to financial and administrative transactions carried out by health plans, healthcare clearinghouses, and healthcare providers.

Notes:

1.6 Medicare Compliance & Regulations

Medicare Compliance Rules
Medicare compliance rules include the following:

Violation of the DRG Window Rule

Medical Necessity Screening and ABNs

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Advanced Beneficiary Notification Requirements

The Two-Midnight Rule

Medicare Secondary Payer (MSP)

<u>Secondary Payer Situations:</u>

Working Aged

Disability

End-Stage Renal Disease (ESRD)

Correct Coding Initiative:

Modifiers

Level I Modifiers

Level II Modifiers

1.7 Ethics

What To Talk About?

Law and Ethics

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Healthcare Complexity

Resources to Review

Ethics Issue Awareness

Interpretation of Ethical Behavior

Ethics Violations Examples

Privacy Violation

1.8 Volume to Value Payment Models

Overview of the Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act, also known as the Affordable Care Act or ACA, was passed and signed into law in 2010. It was designed to reform the healthcare system into a system that rewards greater value, improves the quality of care and increases efficiency in the delivery of services. The ACA includes provisions to:

- Improve the quality of care.
- Reform the healthcare delivery system.
- Encourage pricing transparency and modernized financing systems.
- Address the issues of waste, fraud, and abuse.

Accountable Care Organizations

An Accountable Care Organization (ACO) is a delivery system of physicians, hospitals, and other healthcare providers, who work collaboratively to manage and coordinate the care of a patient population. The point of this collaboration is to ensure:

- Appropriateness of care;
- Elimination of duplicate services; and

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- Prevention of medical errors for a population of patients.

Medicare Shared Savings Program

Next Gen ACO

Investment Model ACO

Comprehensive ESRD Care Model; comprehensive ESRD Care Model

Physician Quality Reporting

Hospital Value-Based Purchasing

Hospital Readmission Reduction Program

Bundle Payment for Care Improvement - BPCI

Model 1:

Model 2:

Model 3:

Model 4:

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1.9 Healthcare Financial Reporting

Balance Sheet

This statement is a summary of the organization’s wealth as of the date of the statement. It represents the summary of the organization’s assets, liabilities and accumulated excesses from operations less any accumulated losses. Note that the net value of excesses and losses may be known as net assets.

Income Statement

This statement is related directly to the Balance Sheet and is the summary of the organization’s revenues and expenses and any excess or loss from operations.

Cash Flow Statement

This statement is a summary of how cash was used and where it was obtained.

What is Gross Revenue?

What is Net Revenue?

Determining Net Revenue under ASC 606

Estimating Net Receivables

Notes:

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Bad Debts vs. Charity Care

1.10 Key Performance Indicators

Key Performance Indicators (KPIs) set standards for accounts receivables (A/R) and provide a method of measuring the collection and control of A/R. Benchmarking is used to compare KPIs in an organization to an agreed upon average, or expected standard, within the same industry.

HFMA's Map Keys

Importance of Benchmark

Techniques to Measure Accounts Receivables

Days of Revenue in Receivables

A/R Aging Analysis

Techniques to Measure Accounts Receivables

Credit balances — days outstanding

Notes:

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CRCR Section 2: Pre-Service — Financial Care

2.1 Types of Patients

Scheduled, Unscheduled, and Other Patient Types

Scheduled

Unscheduled: Outpatient, walk-in, emergent

Types of Patients — Scheduled

Non-Acute Types

Skilled Nursing

Hospice Care

Home Health Services

Durable Medical Equipment (DME)

Clinic

Notes:

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2.2 Scheduling

Scheduling:

Patient Information

Critical Patient Information

Patient Identification Information

Requested Service

Patient Instructions

Review and Validation

Information to Review

Order Requirements

ABN:

When is an ABN needed?

What Must Appear on the ABN?

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2.3 Preregistration & Insurance Verification

The Pre-Registration Purpose and Process

Reasons for Pre-Registration

Benefits of Pre-Registration

Data Collection

MPI and Data Collection

2.4 Health Plans – An Overview

Many people under age 65 receive health insurance through an employer. Others buy their own insurance through the individual insurance market or the Insurance Marketplace (also known as insurance exchange) created by the Affordable Care Act. In addition, there are Federal and State health insurance programs available to qualifying individuals.

Medicare

Medicaid

TRICARE

Indian Health Service (IHS)

Blue Cross/Blue Shield

Managed Care Plans

Commercial Indemnity Plans

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Self-Insured Plans

Liability claims

Notes:

Let us look at program features for Medicare and Medicaid.

Medicare

Medicaid

The Medicare insurance program has features unique from other health plans. It is government sponsored and financed through taxes and general revenue funds.

Medicare Types

Medicare Part A Benefits

Medicare Part B Coverage

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Medicare Claim Submission

Medicare Claim Status

Medicare Part A

Medicare Part B

Medicare Part C

Medicare Part D

Medicaid

Eligibility Requirements

Other Health Plans

Apart from Medicare, Medicaid, and TRICARE, patients also opt for other health plans.

- Indian Health Service
- Blue Cross/Blue Shield
- Managed Care Plans
- Commercial Indemnity Plans

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- Self-Insured Plans
- Liability Claims

Notes:

2.5 Health Plans - Managed Care
Managed Care Plans

Health Maintenance Organization (HMO)

In-Network and Out-of-Network

Preferred Provider Organization (PPO)

Exclusive Provider Organization (EPO)

Point-of-Service Plan (POS)

Consumer Directed Health Plans (CDHP)

Medicare Advantage Plans

Medicaid HMO Plans

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Specific Managed Care Requirements

Managed care health plans use prior authorizations and utilization management procedures to determine if care is medically necessary. The various tools and how they are used to manage utilization are listed below.

Pre-certification/pre-authorization

Referrals

Notification

Site-of-Service Limitations

Case Management

Discharge Planning

2.6 Price Transparency

What is Price Transparency?

The Elements of Determining a Price — Health Plan Information

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2.7 Patient Financial Communications

Patient Financial Communications Best Practices

Patient Financial Communications Best Practices address patient communications regarding health plan coverage, financial counseling, financial responsibility for service, and unpaid balances and were developed by a task force of industry leaders.

Anticipating Charges and Determining the Patient's Financial Responsibility

Financial Assistance

Demographic

Income

Assets

Expenses

Negotiating Account Resolution

Payment Options

Full Payment

Short-term Payment

Bank Loan Program

Medicaid Eligibility Screening

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Financial Assistance Program (FAP)

Time-of-Service Collections Steps

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CRCR Section 3: Point-of-Service Financial Care

3.1 Patient Arrival & Intake

EMTALA Requirements:

Emergency Department Registration

Registration for Unscheduled Patients – Emergency Department

Discharge Processing for Unscheduled Patients – Emergency Department

MPI and Data Collection:

Physician Identification

Notes:

Registration systems allow for the documentation of several physicians who may be involved with a patient's care. Each physician type along with a description is listed below:

Primary Care Physician

Referring Physician

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Attending Physician

Consulting Physician

Admission Orders

Types of Registration Forms

Consent to Treat

Conditions of Admission

Privacy Notice

Important Message from Medicare

Medicare Outpatient Observation Notice

Advance Directive/Medical Power of Attorney

Patient Bill of Rights

Bed Control

Bed Control: Assignment

Bed Control: Transfer Procedure

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3.2 Case Management

Case Management Responsibilities

Types of Case Management Review

Case Management Responsibilities

Denials and Appeals

These appeals may include not only a letter explaining what the clinical documentation indicates about the patient's condition, but also a copy of relevant medical records. For more information on clinical denials, see course 4.3.

3.3 Revenue Capture & Recognition

Charge Capture

How Charges Are Recorded

Importance of Charges

What is the Charge master?

Core Elements of a Charge master

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Typical data elements in a charge master.

Charge Description Master (CDM) Number

Department Number

Billing and/or Charge Description

Charge Amount

CPT/HCPCS Code

Modifiers

Revenue Codes

General Ledger (GL) Number

Charge master Challenges

Charge master Maintenance

Notes:

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HCPCS Codes

Modifiers are used with HCPCS codes to indicate that a procedure was altered by a circumstance but not changed in its definition or code. There are three levels of HCPCS modifiers.

Level I

Level II

Level III

HCPCS Modifiers

Level I Modifiers

Level II Modifiers

Level II Modifiers

Common Revenue Code, CPT Code, and Revenue Code Unit Issues

3.4 Health Information Management (HIM) & Coding

What is HIM?

Why is HIM Required?

Responsibilities of HIM

Importance of HIM

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Important Activities of HIM

Electronic Health Record (EHR)

EHR System

EHR and Claim Generation

Coding and the Revenue Cycle

Finance

Senior Leadership

Patient Access

Patient Accounting/Billing

3.5 Claim Forms Requirements, Edits & Electronic Data Interchange (EDI)

Clean Claims

Prompt Payment

Patient Access Processing:

UB-04 Source of Data Summary

UB-04 Codes to Know

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CSM 1500 Source of Data Summary

Compiled from Locator Data

3.6 Basic Billing Rules & Payment Methodologies
Common Billing Requirements:

Counting Inpatient Days

Outpatient Series

Time Limits for Billing

Provider Type Billing Rules

Rural Health Clinic

Hospice

Skilled Nursing Facility (SNF)

Ambulance Billing

Hospital-Based Physicians

Clinics

Telehealth

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Notes:

3.6a COVID-19 Regulatory & Practice Changes

Notes:

3.7 Health Plan Contracts

All contracts include some type of "discounted" payment methodology. These discounted payment models can be as simple as a percentage discount to complex case rates with outliers. The most common payment models are:

- Per Diem Discount
- Per Diem Payment
- Diagnosis Related Group
- Ambulatory Payment Classification
- Fee Schedule
- Case Rates
- Package (Episodic) Pricing
- Bundled Payments (Medicare)
- Capitation

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Silent PPOs

This refers to a scheme where health plans that do not offer preferred provider organization (PPO) policies apply contracted PPO discounted rates to patient's bills that are not part of the PPO network.

The Silent PPO works in the following way:

1.

2.

3.

4.

5.

Knowledge of red -flags that signal potential silent -PPO activity include:

Notes:

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CRCR Section 4: Post-Service Financial Care

4.1 Cash Posting, Electronic Funds Transfer (EFT), and Electronic Remittance Advice (ERA)

Cash Handling Controls, Fraud, and Policies and Procedures

Fraud

Policies and procedures

Cash Posting Mail Receipt of Checks

Cash Receipts

Lock Box

Cash Posting: Payments Received at Registration, Reception or Another Location

Processing General Ledger Cash

Notes:

4.2 Credit Balances

Credit Balances-Netted

Credit Balances-Liability

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Reasons and Resolutions

Incorrectly posted allowances or incorrect payment estimates

Duplicate payments

Late charge credits processed after a claim is billed

The primary and secondary payers both paying as primary

Inaccurate upfront collections based on incorrect estimates of patient liability

Resolution Process

Small Credit Balances

Notes:

4.3 Exception-Based Processing – Denied Claim

Claims Rejections

Types of Denials

Technical Denials

Clinical Denials

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Underpayment Denials

<u>Outpatient Reasons for Denial</u>

Inpatient: Reasons for Denial

Denials in revenue cycle

Pre-service Denials

Time-of-service Denials

Post-service Denials

Recovery Audit Contractors

4.4 Exception-Based Processing – Non-Paid
Follow-up Workflow - Open Third-Party Balance

Insurance clean claim timeline

Fast forward 60 days

4.5 Self-Pay Follow-Up
Shifted liability

Effective Receivables Management

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Priority

Reports

Tools used to Impact Payment Turnaround

Notes:

4.6 IRS Regulation Section 501(r)
ACA Legislation

The Affordable Care Act (ACA) legislation lays out requirements for:

- Community health needs assessments
- Policies related to financial assistance
- Emergency medical care
- Billing and collections activities

Compliance with ACA

Objective of ACA

Community Health Needs Assessment

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Financial Assistance Policy

Extraordinary Collections Actions (ECAs)

Notes:

4.7 Patient Debt Regulations

Title I—Truth in Lending Act

Regulation Z Information Disclosed

Title III— Restrictions on Garnishment

Title VI—Fair Credit Reporting Act

Title VIII — Fair Debt Collection Practices Act (FDCPA)

Bankruptcy

Types of Bankruptcy

Chapter 7: Straight bankruptcy

Chapter 11: Debtor reorganization

Chapter 13: Debtor rehabilitation

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Test Taking Strategies for HFMA Certification Exams

Test taking should not be intimidating. One of the most important things you can do is relax. It is okay to be a little stressed when you take a test. Actors and athletes all face the same thing when they perform. The difference is how we react to that stress. You can acknowledge it and just be confident in your preparation. The exam preparation materials provided when you sign up for the certification relate to the questions on the exam. There are practice questions in the HFMA training materials online. If you have tried those questions, then you are already somewhat familiar with what the exam looks like.

These strategies will help you build your confidence as you take your exam(s). You will learn a few general ground rules for HFMA certification tests, about questions and how they are developed by course authors, a few ideas about how to deal with questions that you are not sure about, and some strategies to boost your confidence as you tackle the exam you signed up for. So, let's get started!

High Level Study Tips on preparing for the CRCR certification assessment:

- Take the pre-tests at the beginning of each of the 4 sections; this will help determine what areas to focus your studies.
- Set aside time to study and review – uninterrupted, without distraction. If you're multitasking while reviewing the course, you won't retain the information.
- Capture your notes for areas you need to focus more on. You can do this within the course under the "Notes" section or in the Key Concepts Guide. You can print out the Key Concepts Guide from the course.
- Make sure you understand the learning objectives that are presented at the start of each course. The learning objectives of the eLearning course can be an excellent road map during online learning.
- At the end of your review look at those objectives again and make sure you can achieve them (Recognize, Identify, etc.).
- Ensure you thoroughly read the material as the assessment questions do tie back to the content you've learned.
- There are checkpoints to check your understanding in each section presented. Be sure to answer those and if you get one wrong, understand why it was wrong.
- Review and Revise - regular revisions of the things you have already studied will not only improve your memory, but they will also help you better understand what you are learning.

HFMA Exam "Ground Rules"

First and foremost, HFMA and the Board of Examiners **want you to succeed** in your certification effort. No one wins if exams are full of "trick questions" or items not covered in training materials. That reflects poorly on HFMA and the training resources they provide. It also diminishes the value of certification and training.

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The exams for HFMA certification have some common rules that you should know about before you take the exams. The majority of the HFMA certification exams consist of 4-part multiple choice questions.

- First, when you mark an answer, the answer is automatically saved, and you are prompted to **move to the next question**.
- Secondly, **there is a time limit**. The amount of time you get for each exam varies based on the types of things you have to do on an exam. However, the time limit should not cause you stress. The time allowance is reasonable and is backed up with some research into the psychology of test taking (known as "psychometrics"). The time limit keeps you focused on task to complete the examination and makes it unlikely that a test taker would have a chance to look up answers on an exam.
- Next, the exam is "one way" – once you move on from a question, **you cannot go back and re-visit a question**. As with the time limit, this rule is in place to protect the integrity of the exam and the credential associated with the exam. Once a question is answered, that is all you will see of that question.
- Finally, the exams have **no penalty for guessing**. Be sure to answer every question – even if you do not know the answer. There may be a question that you are just not clear on. After trying to work out the answer if nothing seems right, give the question your best guess before moving to the next question. Think about it this way – if you have no penalty for guessing and you have four options for answers - then your best guess gives you at least a 25% chance of getting the right answer. Also, as you review the answer options, you may have been able to eliminate some options for that question. Each answer response you eliminate before you guess improves your odds of getting the question correct up to as much as 50%.

The Anatomy of a Test Question

Let's talk about test questions. Depending on the exam you take, the questions may be created by the HFMA Board of Examiners or subject matter experts in the area for which you are taking an exam. Either way, the questions come from people like you that are working in health care finance. They identify a key concept in the training materials or something in the field that relates to the course and then write a sentence about that concept in the form of a question. In the test writing field, we call that the "stem". The question writer usually has the correct answer in mind for the stem and so that immediately becomes one of the test answer options. The correct answer is known as the "key". Those two parts – the stem and the key are the easy parts.

Exam Overview

- You will have 90 minutes to complete the exam and it must be completed in one sitting.
- The exam consists of 75 multiple choice questions randomly obtained from a larger question pool (may differ by exam)
- You are required to select an answer before proceeding to the next question.
- There is no option to flag questions in the exam for review prior to submitting.
- Your answers to the exam questions will be recorded immediately.
- The passing score for the exam is 70% (may differ by exam).
- If you do not pass the exam, you may retake it after a 30-day waiting period

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Before the Exam

The key to success on any exam is to be relaxed and confident in your preparations. There is a lot of research in the psychology of test taking that tells us that test takers that are calm do far better than other test takers. When you are nervous, the neurons in your brain firing rapidly and sometimes randomly. Effectively this creates a sort of “traffic jam” in your brain – the thoughts that help you do well on an exam are “stuck in traffic” with all of your other thoughts worrying about the exam or your preparation. However, someone who is relaxed has a brain that is clearer and can remember answers better or can work through options to get the correct answer. The following steps can help you get more of that “calm” when you take an exam.

- First of all, **trust your preparation** and the training materials you have reviewed. Exam questions are indeed related to your preparation materials. If you know what is in the course materials, then you know what is in the test. Take some confidence in your preparations. Relax and let the knowledge you have gained be able to come out on your exam.
- While preparing for the examination, **prepare a “budget” of time and questions**. Understand what the examiners are expecting from you for that exam. For example, on the Business of Healthcare exam that is part one of the Certified Healthcare Financial Professional credential, there are 75 questions on the exam, the time limit for the exam is 90 minutes, and the passing score is 70%. Determine how much time you have per question by dividing the time allowed for the exam by the number of questions. So, the Business of Healthcare exam gives you 1.2 minutes (or 72 seconds) per question. That is plenty of time to read the question and do what has been described here in this guide.
- **Do not “cram”** up to the point you are ready to start the exam. Odds are your brain will not recall the facts you just read before starting the exam. Your brain needs time to process the information you give it and to store it away for recall. Instead of “cramming” review information before the exam but then step away from your computer and allow your brain a bit of a rest and give it a chance to file away any information you have reviewed.
- **Breathe**. Your brain needs oxygen. A few deep breaths before going to that first question and then occasionally as you pass milestones in the exam (like every five questions), take another deep breath. Your brain will work better with more oxygen. That will help you relax too.
- **Do not worry about your score**. Many HFMA members who seek certification are people that may have been highly motivated students in school and got good grades. When they take a certification exam and do not get a perfect (or even a high) score, they worry that someone may think badly of them. Do not do this when taking an HFMA certification exam. No one sees your score unless they have a legitimate need to see both the score and your identity (and no one in your chapter has such a need). So, let’s say you pass the exam by one point. Congratulations! You passed. If you stop to think about it, for purposes of HFMA certification the passing score is no different than a perfect score. Using the example of the Business of Healthcare exam where the passing score is 70%, then 70% = 100% - the result is the same. You earned the certification. So, you can take confidence in knowing that even if you did not have your best day on a particular exam, you passed, the score is your secret. Do not stress about a perfect score – just focus on the budget you established to pass the exam and aim there. Anything else is just a “bonus”!

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- Finally, remember the exam is completed **one question at a time**. So, take it that way. Focus on one question, address it to the best of your ability and then move on to the next. Once you answered that question and moved to the next, there is nothing more that you can do with that question. Leave it in the past and move on. The result of that one will be what it is. Focus on the next question and address it to the best of your ability. Keep moving along until you reach the end – one question at a time.

Conclusion

Certification with HFMA is not easy. If it were, anyone could do it and the value of **your** certification would be diminished. Use this guide as a resource to help completely prepare you for this next challenge in your career. You likely work with much of the content in these exams and so it should not be unfamiliar to you. You just need to show that you know what is involved with your work in the great field of healthcare finance. So, use the fact that the best within HFMA achieve certification and then take on that challenge to join the best of HFMA membership – as a **certified member**!

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