

AAHAM Certified Compliance Technician (CCT) Practice Test (Sample)

Study Guide



Everything you need from our exam experts!

Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.

ALL RIGHTS RESERVED.

No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.

Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.

SAMPLE

Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	16

SAMPLE

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

SAMPLE

- 1. ASCA stands for which of the following?**
 - A. Administrative Simplification and Compliance Act**
 - B. Administrative Simplification Compliance Act**
 - C. Administrative Simplification Compliance Agreement**
 - D. Association for Software Compliance Act**

- 2. What is automated review in this context?**
 - A. A manual chart review by a human auditor**
 - B. A RAC review using various types of analytics to identify improper payments; usually done without a human review of the medical records**
 - C. A random audit performed quarterly**
 - D. A procedure to audit only hospital claims**

- 3. Which activity is NOT part of the CMS survey process for CLIA compliance?**
 - A. Observations of lab practices**
 - B. Interviews with lab personnel**
 - C. Review of documented records**
 - D. Audit of financial statements**

- 4. Under EMTALA, hospitals with emergency departments must provide which of the following to individuals who come to the ED and request it?**
 - A. A private examination by a physician**
 - B. A medical screening examination to any individual who comes to the emergency department and requests such an examination**
 - C. A follow-up appointment**
 - D. A payment waiver**

- 5. Submitting bills to Medicare that are the responsibility of other insurers is an example of**
 - A. An example of abuse**
 - B. An example of fraud**
 - C. A clerical error**
 - D. A permissible billing practice**

- 6. HIPAA stands for which act?**
- A. Health Insurance Portability and Accountability Act**
 - B. Health Insurance Protection and Access Act**
 - C. Health Information and Privacy Act**
 - D. Health Insurance and Administrative Act**
- 7. Which entity renders advisory opinions, issues fraud alerts, and provides guidance to the healthcare industry concerning the federal Anti-Kickback Statute and OIG sanctions?**
- A. The Office of Inspector General (OIG)**
 - B. The Centers for Medicare & Medicaid Services**
 - C. The Office of Counsel to the Inspector General (OCIG)**
 - D. The Department of Justice**
- 8. Violating the Anti-Kickback Statute can result in which penalties?**
- A. Nonpayment of claims only**
 - B. Nonpayment of claims, civil monetary penalties, exclusion from Medicare, liability for false claims, imprisonment, and criminal fines**
 - C. Exclusive civil penalties only**
 - D. None of the above**
- 9. Unbundling or 'exploding' charges is an example of**
- A. A clerical error**
 - B. An example of abuse**
 - C. A permissible billing practice**
 - D. An example of fraud**
- 10. A full denial occurs when the RAC determines that the service billed to CMS was not rendered or was not reasonable or necessary. Which term does this describe?**
- A. Full denial**
 - B. Partial denial**
 - C. Administrative denial**
 - D. Non-covered denial**

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. ASCA stands for which of the following?

- A. Administrative Simplification and Compliance Act**
- B. Administrative Simplification Compliance Act**
- C. Administrative Simplification Compliance Agreement**
- D. Association for Software Compliance Act**

ASCA stands for Administrative Simplification Compliance Act. This is the official title of the federal law tied to HIPAA's administrative simplification provisions, aimed at standardizing electronic health care transactions, code sets, and identifiers to improve efficiency and protect patient information. The other wordings don't match the actual statute: one option alters the wording, another uses Compliance Agreement instead of Act, and the last refers to an association rather than a federal act.

2. What is automated review in this context?

- A. A manual chart review by a human auditor**
- B. A RAC review using various types of analytics to identify improper payments; usually done without a human review of the medical records**
- C. A random audit performed quarterly**
- D. A procedure to audit only hospital claims**

Automated review relies on data analytics to identify potentially improper payments across large sets of claims without first having a person read every medical record. In this RAC context, analytics, rules, and pattern recognition flag payments that look suspicious, and those flagged claims are then candidates for further investigation. The initial step is data-driven screening, not manual chart-by-chart review, which is what makes it different from a purely human process. This approach is not a random quarterly audit and is not limited to hospital claims, and it's not simply a manual chart review.

3. Which activity is NOT part of the CMS survey process for CLIA compliance?

- A. Observations of lab practices**
- B. Interviews with lab personnel**
- C. Review of documented records**
- D. Audit of financial statements**

The CMS CLIA survey concentrates on how a laboratory conducts testing and maintains quality and regulatory compliance, using on-site observation, staff interviews, and review of records to verify that procedures are followed and standards are met. Auditing financial statements isn't part of this process because CLIA focuses on clinical operations, not the lab's finances. Records like QC logs, proficiency testing results, equipment maintenance, and personnel qualifications are the kinds of documentation the survey examines. So auditing financial statements falls outside the scope of the CMS CLIA survey.

4. Under EMTALA, hospitals with emergency departments must provide which of the following to individuals who come to the ED and request it?

- A. A private examination by a physician**
- B. A medical screening examination to any individual who comes to the emergency department and requests such an examination**
- C. A follow-up appointment**
- D. A payment waiver**

The main idea tested is that EMTALA requires a medical screening examination for anyone who presents to an emergency department and requests such an examination. This screening must be provided by a qualified medical professional to determine whether an emergency medical condition exists, and it must be offered regardless of the person's ability to pay or other financial considerations. It isn't about a private examination by a specific physician, a follow-up appointment, or a payment waiver as part of the initial screening. If the screening reveals an emergency condition, the hospital must stabilize or appropriately transfer the patient; if not, they may discharge or provide whatever non-emergency care is appropriate.

5. Submitting bills to Medicare that are the responsibility of other insurers is an example of

- A. An example of abuse**
- B. An example of fraud**
- C. A clerical error**
- D. A permissible billing practice**

The situation tests how billing practices are categorized in how Medicare is billed relative to other insurers. Submitting bills to Medicare when another insurer should be primary is considered abuse because it reflects an improper billing practice that can lead to improper payments. It often stems from unintended consequences of sloppy processes or gaps in payer determination, rather than a deliberate attempt to defraud. Fraud would require knowing misrepresentation or deception to obtain payment, which isn't necessarily shown in this scenario. A clerical error would be a simple mistake, but abuse covers patterns of improper practices that aren't strictly fraud. And this isn't a permissible billing practice because payer responsibility rules are being ignored.

6. HIPAA stands for which act?

- A. Health Insurance Portability and Accountability Act**
- B. Health Insurance Protection and Access Act**
- C. Health Information and Privacy Act**
- D. Health Insurance and Administrative Act**

The main point here is knowing the exact full name behind the acronym HIPAA. HIPAA stands for Health Insurance Portability and Accountability Act. This name reflects three ideas: making health insurance more portable when people change jobs, addressing fraud and abuse in healthcare, and protecting the privacy and security of individuals' health information. The other options don't fit because they alter the key terms—using Information instead of Insurance, or swapping Portability with Protection or Accountability with Administrative—so they don't match the official act.

7. Which entity renders advisory opinions, issues fraud alerts, and provides guidance to the healthcare industry concerning the federal Anti-Kickback Statute and OIG sanctions?

- A. The Office of Inspector General (OIG)**
- B. The Centers for Medicare & Medicaid Services**
- C. The Office of Counsel to the Inspector General (OCIG)**
- D. The Department of Justice**

The Office of Counsel to the Inspector General (OCIG) is the part of the HHS Office of Inspector General that provides legal guidance on the federal Anti-Kickback Statute and OIG sanctions. It issues advisory opinions to particular parties about whether a proposed arrangement could violate the AKS, publishes fraud alerts to highlight current enforcement concerns and emerging schemes, and offers guidance to the healthcare industry on compliant practices. Advisory opinions help providers structure their arrangements to avoid violations, while fraud alerts warn about risky practices and potential penalties. The OCIG's work in issuing these opinions and alerts directly addresses how to navigate AKS and OIG sanctions in real-world scenarios. The broader OIG oversees enforcement and sanctions, CMS handles payment policies, and the DOJ prosecutes violations, but the function described—advisory opinions, fraud alerts, and industry guidance on AKS and sanctions—is specific to the OCIG.

8. Violating the Anti-Kickback Statute can result in which penalties?

- A. Nonpayment of claims only
- B. Nonpayment of claims, civil monetary penalties, exclusion from Medicare, liability for false claims, imprisonment, and criminal fines**
- C. Exclusive civil penalties only
- D. None of the above

Violating the Anti-Kickback Statute brings a mix of criminal and civil consequences because the statute is meant to deter improper payments tied to referrals in federal health care programs. On the criminal side, violations can lead to fines and imprisonment, with penalties that can apply per violation and can be severe for repeat offenses. Civilly, the government can impose civil monetary penalties and, importantly, can exclude the individual or entity from participating in Medicare and other federal programs, which effectively stops them from billing those programs. If a kickback leads to false claims being submitted, liability under the False Claims Act can also attach, exposing the party to civil penalties and damages. Nonpayment of claims isn't a direct penalty itself, but can result from exclusion or enforcement actions. So the full suite of penalties—civil monetary penalties, exclusion from Medicare, False Claims Act liability, imprisonment, and criminal fines—captures the range of consequences, making it the best answer.

9. Unbundling or 'exploding' charges is an example of

- A. A clerical error
- B. An example of abuse
- C. A permissible billing practice
- D. An example of fraud**

Unbundling or exploding charges is a deceptive billing practice where separate components of a service are billed as individual items instead of as a single bundled charge. This inflates the amount paid because payers reimburse each item separately when a bundled code would cover the whole service. The key idea is intentional misrepresentation of the services provided to receive higher reimbursement, which is why this is classified as fraud. It isn't a clerical error, which would be accidental, nor a permissible billing practice, since proper coding rules require bundling when appropriate. While there can be abusive coding patterns in healthcare, the defining factor here is the deliberate attempt to misstate charges to obtain improper payment, aligning with fraud rather than a simple error or allowed practice.

10. A full denial occurs when the RAC determines that the service billed to CMS was not rendered or was not reasonable or necessary. Which term does this describe?

- A. Full denial**
- B. Partial denial**
- C. Administrative denial**
- D. Non-covered denial**

When a RAC review finds that the service billed to CMS was not rendered or was not reasonable or necessary, the claim is denied in full. This means the entire submission is rejected for reimbursement, because the service either wasn't performed or didn't meet the medical necessity standard for payment. The full denial outcome signals that no portion of the claim is payable under Medicare rules for that service. It's helpful to contrast with other denial types: a partial denial would deny only specific line items or CPT codes while others could be paid; an administrative denial covers procedural issues such as missing documentation or timing problems; and a non-covered denial occurs when the service is never payable under Medicare policies, regardless of its medical necessity.

SAMPLE

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://aahamcct.examzify.com>

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

SAMPLE