

AHIP Fraud, Waste, and Abuse (FWA) Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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SAMPLE

Questions

- 1. Who among Miles' clients qualifies for the opt-in simplified enrollment mechanism?**
 - A. Charles, who just turned 65.**
 - B. Adam and Betty, who have continuous coverage.**
 - C. Diedre, who has coverage through another company.**
 - D. All clients qualify for the mechanism.**
- 2. How does the transition to retirement impact Mrs. Peña's Medicare enrollment?**
 - A. She can only enroll during the general enrollment period**
 - B. She has an extra enrollment period following her employer's coverage**
 - C. She is required to finalize enrollment before retirement**
 - D. All enrollment options are available regardless of retirement**
- 3. What benefit do Special Needs Plans (SNPs) provide for enrollees with chronic conditions?**
 - A. SNPs offer lower premiums compared to regular plans.**
 - B. SNPs include specialized services and prescription drug coverage.**
 - C. SNPs restrict access to certain healthcare providers.**
 - D. SNPs are available only to low-income beneficiaries.**
- 4. What should be done upon identifying a recurring pattern of unusual claims from a provider?**
 - A. Report to the appropriate compliance department**
 - B. Adjust reimbursement rates**
 - C. Ignore the pattern**
 - D. Refrain from further involvement**
- 5. Which items and services are generally not covered by Medicare?**
 - A. Emergency ambulance services**
 - B. Vision care including glasses**
 - C. Hearing aids**
 - D. Durable medical equipment**

- 6. When is Mrs. Reynolds's Medicare Advantage plan coverage likely to start?**
- A. Immediately upon enrollment**
 - B. The first day of the next month**
 - C. The day she returns from vacation**
 - D. Within three days of enrollment**
- 7. What must compliance programs strive to enhance according to federal guidelines?**
- A. Enforcement of stringent penalties**
 - B. Efficiency and protection of enrollees**
 - C. Marketing and sales tactics**
 - D. Financial management only**
- 8. What is an important consideration for Mrs. Chi regarding her current Part D coverage?**
- A. She should cancel it before enrolling in any new plan**
 - B. She can keep it while joining an MA MSA plan**
 - C. It must cover all of her prescription drugs**
 - D. It does not relate to her healthcare choices**
- 9. What is required for Ms. Henderson to obtain Medicare Part B coverage?**
- A. She must pay a standard monthly premium**
 - B. She does not need to pay any premium due to her work history**
 - C. She will have a premium waiver until she turns 70**
 - D. She must qualify based on her medical history only**
- 10. What is a significant change to Medigap plans that took effect recently?**
- A. The Part B deductible is now covered for all enrollees**
 - B. The Part B deductible is no longer covered for newly eligible Medicare beneficiaries**
 - C. All Medigap plans will cover preventive services without a deductible**
 - D. Medigap plans can no longer be purchased after 65**

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. Who among Miles' clients qualifies for the opt-in simplified enrollment mechanism?

- A. Charles, who just turned 65.**
- B. Adam and Betty, who have continuous coverage.**
- C. Diedre, who has coverage through another company.**
- D. All clients qualify for the mechanism.**

The opt-in simplified enrollment mechanism is designed for individuals who have a consistent history of health coverage, as it streamlines the enrollment process for them. In the case of Adam and Betty, their continuous coverage means they have maintained health insurance without significant gaps, which qualifies them for this mechanism. This is important because continuous coverage demonstrates stability in their health insurance status, making the enrollment process smoother and more efficient. For the other scenarios, such as Charles, who has just turned 65, this does not automatically qualify him for the simplified mechanism since it typically applies to those with established continuous coverage, and new beneficiaries may not have this history. Diedre, who holds coverage through another company, may also face different criteria that do not align with the opt-in mechanism unless her coverage history meets specific conditions under the regulations. Lastly, not all clients automatically qualify, as the mechanism is specifically tailored for those like Adam and Betty who demonstrate continuous coverage. Thus, identifying clients with maintained health insurance history is central to qualifying for this option.

2. How does the transition to retirement impact Mrs. Peña's Medicare enrollment?

- A. She can only enroll during the general enrollment period**
- B. She has an extra enrollment period following her employer's coverage**
- C. She is required to finalize enrollment before retirement**
- D. All enrollment options are available regardless of retirement**

Mrs. Peña's transition to retirement impacts her Medicare enrollment in a specific way. When an individual retires and has been covered by an employer-sponsored health plan, they typically have special enrollment periods available to them. This means that she won't have to wait for the general enrollment period to sign up for Medicare, as she has a qualifying event (her retirement) that allows her additional time to enroll. This special enrollment period is significant as it helps ensure that individuals who have maintained coverage through their employer do not face gaps in health insurance when they retire. They can enroll in Medicare without incurring late enrollment penalties, as long as they sign up within the specified time after losing employer coverage. This flexibility is crucial for retirees seeking to transition smoothly to Medicare without lapses in coverage. By having this additional enrollment period following her employer's coverage, Mrs. Peña can make informed choices about her healthcare needs as she enters retirement, which is essential for accessing necessary medical services under Medicare.

3. What benefit do Special Needs Plans (SNPs) provide for enrollees with chronic conditions?

- A. SNPs offer lower premiums compared to regular plans.**
- B. SNPs include specialized services and prescription drug coverage.**
- C. SNPs restrict access to certain healthcare providers.**
- D. SNPs are available only to low-income beneficiaries.**

Special Needs Plans (SNPs) are designed to cater specifically to individuals with chronic conditions, ensuring that they receive coordinated and tailored healthcare services. This includes specialized services that are essential for managing their specific health needs more effectively than what might be available through regular Medicare plans. The inclusion of comprehensive prescription drug coverage within SNPs further supports enrollees in managing their conditions by making necessary medications more accessible and affordable. The focus of SNPs on personalized care is crucial for those with chronic illnesses, as it helps address their unique health issues and circumstances. By streamlining their access to specialized services, these plans can lead to better health outcomes and a more comprehensive approach to patient care, which is vital for those with ongoing health challenges. The holistic support provided by SNPs enables enrollees to navigate the complexities of their healthcare more efficiently.

4. What should be done upon identifying a recurring pattern of unusual claims from a provider?

- A. Report to the appropriate compliance department**
- B. Adjust reimbursement rates**
- C. Ignore the pattern**
- D. Refrain from further involvement**

Upon identifying a recurring pattern of unusual claims from a provider, the appropriate action is to report to the compliance department. This step is crucial because unusual claims may be indicative of potential fraud, waste, or abuse. By bringing these patterns to the attention of the compliance department, you enable the organization to investigate further and, if necessary, take corrective actions to safeguard the integrity of the healthcare system. The compliance department is equipped to handle such reports, conducting thorough investigations and implementing necessary measures to address any issues found. Reporting ensures that the organization remains compliant with regulations and protects patients and the healthcare system from potential harm linked to fraudulent activities. This proactive approach can help mitigate risks and promote ethical practices within the healthcare industry.

5. Which items and services are generally not covered by Medicare?

- A. Emergency ambulance services**
- B. Vision care including glasses**
- C. Hearing aids**
- D. Durable medical equipment**

Medicare generally does not cover routine vision care, which includes the cost of eyeglasses and contact lenses for most beneficiaries. While Medicare Part B provides coverage for certain vision-related services, such as eye exams for diagnosis and treatment of eye diseases (like glaucoma) and cataract surgery, it does not extend to the routine eye exams or the purchase of glasses and contacts. Therefore, glasses and vision care are typically out-of-pocket expenses for enrollees. In contrast, emergency ambulance services are covered under Medicare when medically necessary, as well as durable medical equipment, which includes items like wheelchairs and oxygen equipment when prescribed. Hearing aids, while essential for many, are not covered under traditional Medicare, but there may be some limited coverage under certain Medicare Advantage plans. However, the most consistent exclusion across Medicare's coverage policies is related to routine vision care and glasses.

6. When is Mrs. Reynolds's Medicare Advantage plan coverage likely to start?

- A. Immediately upon enrollment**
- B. The first day of the next month**
- C. The day she returns from vacation**
- D. Within three days of enrollment**

In general, for individuals enrolling in a Medicare Advantage plan, the coverage typically begins on the first day of the month following the enrollment. This aligns with standard Medicare enrollment practices, where effective dates are often set to coincide with the beginning of a month, particularly for those who enroll during specific periods such as the Annual Election Period or when they become newly eligible for Medicare. In the case of Mrs. Reynolds, if she makes her enrollment decision during an open enrollment period and her application is processed promptly, her coverage would likely commence on the first day of the next month. This timing allows for administrative processes and ensures that coverage is consistent with regulatory standards.

7. What must compliance programs strive to enhance according to federal guidelines?

- A. Enforcement of stringent penalties**
- B. Efficiency and protection of enrollees**
- C. Marketing and sales tactics**
- D. Financial management only**

Compliance programs are designed to promote ethical practices and ensure that organizations adhere to relevant laws and regulations. According to federal guidelines, these programs must focus on enhancing efficiency and protection of enrollees. This emphasis reflects a commitment to safeguarding the rights and health of beneficiaries while also ensuring that services are delivered effectively and responsibly. By improving efficiency, compliance programs can help streamline processes, reduce waste, and ensure that resources are allocated appropriately to meet the needs of enrollees. Protection of enrollees involves safeguarding them from fraud, waste, and abuse, ensuring that they receive the appropriate care and services without being subjected to deceptive practices. The other options do not align with the core objectives laid out in federal guidelines for compliance programs. While enforcing penalties, focusing solely on financial management, and emphasizing marketing tactics may play roles in an organization's strategy, they do not encompass the primary goal of efficiently safeguarding enrollees. The focus must remain on ethical practices and the welfare of individuals receiving health care services.

8. What is an important consideration for Mrs. Chi regarding her current Part D coverage?

- A. She should cancel it before enrolling in any new plan**
- B. She can keep it while joining an MA MSA plan**
- C. It must cover all of her prescription drugs**
- D. It does not relate to her healthcare choices**

The choice that indicates Mrs. Chi can keep her current Part D coverage while joining a Medicare Advantage Medical Savings Account (MA MSA) plan is significant due to the way these plans operate. When a beneficiary enrolls in an MA MSA plan, they typically do not lose their existing prescription drug coverage (Part D) immediately. This flexibility allows them to have coverage for prescriptions through Part D while enjoying the benefits of the MA MSA plan, which might focus more on the management of overall health care costs and preventive services. Moreover, this choice reflects an understanding of the options available to Medicare beneficiaries. Maintaining separate Part D coverage could be beneficial if her new MA MSA plan does not offer robust drug coverage, ensuring that her prescription needs remain met without interruption. Therefore, this consideration is vital in planning her healthcare strategy effectively.

9. What is required for Ms. Henderson to obtain Medicare Part B coverage?

- A. She must pay a standard monthly premium**
- B. She does not need to pay any premium due to her work history**
- C. She will have a premium waiver until she turns 70**
- D. She must qualify based on her medical history only**

To obtain Medicare Part B coverage, individuals generally must pay a standard monthly premium. This monthly premium is a requirement for those who are enrolling in Part B, which provides coverage for outpatient services, preventive services, and other medically necessary treatments not covered by Part A. While some beneficiaries may qualify for premium-free Part A based on their work history, Part B always requires a premium for those who choose to enroll. This ensures that the program is funded and remains sustainable. The standard premium can be adjusted based on income, but every beneficiary who opts into Part B must account for this expense as part of their healthcare planning. Understanding these criteria is essential for individuals like Ms. Henderson to ensure that they meet the eligibility requirements and understand the costs associated with Medicare coverage.

10. What is a significant change to Medigap plans that took effect recently?

- A. The Part B deductible is now covered for all enrollees**
- B. The Part B deductible is no longer covered for newly eligible Medicare beneficiaries**
- C. All Medigap plans will cover preventive services without a deductible**
- D. Medigap plans can no longer be purchased after 65**

The correct answer highlights a crucial update regarding Medigap plans, specifically that the Part B deductible is no longer covered for newly eligible Medicare beneficiaries. This change reflects an important shift aimed at managing costs within the Medicare system. Prior to this change, certain Medigap plans had provisions that covered the Part B deductible, allowing beneficiaries to face lower out-of-pocket expenses. However, with the implementation of this new regulation, newly eligible individuals who enroll in these plans will not have the Part B deductible covered, which subsequently alters the cost-sharing structure and may influence beneficiaries' decisions regarding their Medigap options. This adjustment underscores the ongoing evolution of Medicare benefits and the importance of staying informed about changes that affect coverage. The absence of coverage for the Part B deductible may lead beneficiaries to consider other options or supplemental plans that can better address their financial needs and healthcare expenses after they become eligible for Medicare. Other options provided do not accurately reflect the significant recent changes to Medigap plans regarding beneficiary coverage for the Part B deductible.