

Fraud, Waste, and Abuse (FWA) 2 Practice Exam (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 15

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. Section 1557 is a provision within which law?**
 - A. Patient Protection and Affordable Care Act**
 - B. Health Insurance Portability and Accountability Act**
 - C. American with Disabilities Act**
 - D. Social Security Act**

- 2. What is a request for payment for items and services filed under the Medicare program?**
 - A. Appeal**
 - B. Claim**
 - C. Complaint**
 - D. Counterfeit**

- 3. What does the False Claims Act prohibit regarding 'knowing' submission?**
 - A. Prohibits 'knowing' submission of false claims or the use of a false record or statement for payment to Medicare/Medicaid.**
 - B. Requires that all actions be proven to be intentional.**
 - C. Only applies to private insurers.**
 - D. Prohibits misinformation in all patient communications.**

- 4. Which of the following is NOT one of the seven core elements of a compliance program?**
 - A. Maintaining open lines of communication for reporting compliance concerns**
 - B. Designating a compliance officer responsible for the area**
 - C. Conducting annual external patient satisfaction surveys**
 - D. Performing internal evaluations and audits to monitor compliance**

- 5. Which of the following are examples of issues that can be reported to the Compliance Department?**
 - A. Potential health privacy violation**
 - B. Unethical behavior/employee misconduct**
 - C. Suspected Fraud, Waste, and Abuse (FWA)**
 - D. All of the above**

- 6. At a minimum, an effective compliance program includes four core requirements.**
- A. True**
 - B. False**
 - C. At least two**
 - D. It varies by sponsor**
- 7. Under whistleblower protection, the government recovers funds, what reward is described?**
- A. Commentary reward**
 - B. Pension increase**
 - C. Cash bonus to employer**
 - D. None**
- 8. Bribes or kickbacks for services paid under a Federal health care program constitute fraud by the person making them and by the person receiving them.**
- A. True**
 - B. False**
 - C. It depends on the value of the payment**
 - D. Only the payer is liable**
- 9. Section 1557 applies to**
- A. All health programs and activities administered by or receiving federal financial assistance from HHS.**
 - B. All health programs administered by HHS (no federal aid)**
 - C. Private sector health programs**
 - D. All Medicare programs**
- 10. Which practice involves billing for higher service or item codes than those actually performed?**
- A. Fraud**
 - B. Kickback**
 - C. Unbundling**
 - D. Upcoding**

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. Section 1557 is a provision within which law?

- A. Patient Protection and Affordable Care Act**
- B. Health Insurance Portability and Accountability Act**
- C. American with Disabilities Act**
- D. Social Security Act**

Section 1557 is a nondiscrimination provision embedded in the Patient Protection and Affordable Care Act. It prohibits discrimination in health programs or activities that receive federal funds on the basis of sex, race, color, national origin, age, or disability, and it covers related health insurance activities. This is specific to the ACA, whereas HIPAA focuses on privacy and security of health information, the ADA is a broader civil rights law addressing disability discrimination in employment and public life, and the Social Security Act governs Social Security benefits. Therefore, the correct source is the Patient Protection and Affordable Care Act.

2. What is a request for payment for items and services filed under the Medicare program?

- A. Appeal**
- B. Claim**
- C. Complaint**
- D. Counterfeit**

In Medicare, a claim is the request for payment for items and services. After care is provided, a provider or supplier submits a claim to Medicare with details like the services rendered, dates of service, patient information, and billing codes. Medicare then reviews the claim to determine coverage and the payment amount. If a claim is denied or only partially paid, there's an appeal process to challenge that decision. A complaint is simply a grievance about care or service, not a request for payment, and counterfeit refers to fake items or fraud, which is not about requesting payment.

3. What does the False Claims Act prohibit regarding 'knowing' submission?

- A. Prohibits 'knowing' submission of false claims or the use of a false record or statement for payment to Medicare/Medicaid.**
- B. Requires that all actions be proven to be intentional.**
- C. Only applies to private insurers.**
- D. Prohibits misinformation in all patient communications.**

The key idea is that the False Claims Act targets knowingly submitting false claims for government payments, such as to Medicare or Medicaid, or using false records or statements to obtain those payments. "Knowingly" covers actual knowledge of falsity as well as situations of deliberate ignorance or reckless disregard for the truth. Importantly, you don't have to prove that someone intended to defraud; liability can attach even without proof of intent, as long as there is knowledge or a reckless disregard for whether the claim is true. This focuses on government programs and the accuracy of claims and supporting documents, not on misstatements in all patient communications. It also isn't limited to private insurers—the FCA applies to false claims submitted to government health programs by those who participate in or support those programs.

4. Which of the following is NOT one of the seven core elements of a compliance program?
- A. Maintaining open lines of communication for reporting compliance concerns
 - B. Designating a compliance officer responsible for the area
 - C. Conducting annual external patient satisfaction surveys**
 - D. Performing internal evaluations and audits to monitor compliance

The seven core elements of an effective compliance program focus on governance, reporting, training, auditing, enforcement, and corrective action to prevent and detect noncompliance. Maintaining open lines of communication ensures concerns can be raised and addressed promptly. Designating a compliance officer establishes clear accountability and oversight. Performing internal evaluations and audits monitors adherence and helps identify where improvements are needed. Conducting annual external patient satisfaction surveys, while valuable for quality and patient experience, is not part of the core elements of a compliance program. It belongs more to quality improvement activities rather than the governance and oversight framework that drives compliance with laws and regulations.

5. Which of the following are examples of issues that can be reported to the Compliance Department?
- A. Potential health privacy violation
 - B. Unethical behavior/employee misconduct
 - C. Suspected Fraud, Waste, and Abuse (FWA)
 - D. All of the above**

Issues that threaten regulatory compliance, ethics, or integrity are what the Compliance Department is meant to handle. Health privacy violations involve improper handling of protected health information or failing to protect patient privacy, which touches on privacy laws and organizational safeguards. Unethical behavior or employee misconduct includes breaches of the code of conduct, conflicts of interest, harassment, or other improper actions that undermine trust and governance. Suspected Fraud, Waste, and Abuse points to potential misrepresentation, misuse of resources, or inefficiencies that drain resources and violate policy or law. Because each of these areas represents a risk to the organization's compliance, ethics, and fiduciary responsibilities, they all belong in Compliance. Reporting any of them helps detect problems early, trigger investigations, and implement corrective actions. That's why the best answer is that all of these are reportable.

6. At a minimum, an effective compliance program includes four core requirements.

- A. True**
- B. False**
- C. At least two**
- D. It varies by sponsor**

An effective compliance program must be built from a comprehensive set of elements that cover prevention, detection, and response across the organization. The framework regulators and oversight bodies commonly reference includes seven core elements: standards and procedures to prevent and detect misconduct; oversight by high-level personnel; training and education; channels for reporting concerns and for investigations; enforcement of discipline; monitoring, internal audits, and periodic reviews; and timely corrective actions plus ongoing improvement. Because four core requirements do not capture all seven essential components, the statement is not correct. While sponsors can tailor programs to their risk profile, the standard baseline emphasizes these seven elements, not just four, which is why the claim is false.

7. Under whistleblower protection, the government recovers funds, what reward is described?

- A. Commentary reward**
- B. Pension increase**
- C. Cash bonus to employer**
- D. None**

The main idea is that whistleblower programs can offer non-monetary recognition when funds are recovered. A commentary reward refers to official public acknowledgment or recognition for the whistleblower's role, rather than a cash payout. This fits the scenario because the emphasis is on rewarding the act with acknowledgment rather than money. Pension increases or cash bonuses to the employer aren't aligned with whistleblower reward practices, and saying there's no reward would contradict the stated protection.

8. Bribes or kickbacks for services paid under a Federal health care program constitute fraud by the person making them and by the person receiving them.

- A. True**
- B. False**
- C. It depends on the value of the payment**
- D. Only the payer is liable**

Bribes or kickbacks tied to services billed to federal health care programs are illegal under the Anti-Kickback Statute. This rule makes it unlawful to offer, pay, solicit, or receive any remuneration to induce or reward referrals for items or services paid for by federal programs like Medicare or Medicaid. Liability can attach to both sides: the payer who provides the kickback and the recipient who accepts it, because each is participating in a scheme to influence how federal funds are used. The concern isn't the payment's size; any amount intended to influence referrals can trigger penalties, though legitimate arrangements may exist under safe harbors if structured correctly. So the statement is true: both the person offering and the person receiving kickbacks can be liable for fraud.

9. Section 1557 applies to

- A. All health programs and activities administered by or receiving federal financial assistance from HHS.**
- B. All health programs administered by HHS (no federal aid)**
- C. Private sector health programs**
- D. All Medicare programs**

Section 1557 expands nondiscrimination protections to health programs and activities in two broad ways: either the program is administered by HHS, or it receives federal financial assistance from HHS. That means coverage includes health programs run by HHS and also any health program—public or private—that gets federal funds from HHS, such as grants or contracts. Medicare is included here because it is a federal program administered by HHS, and other programs funded by HHS are included as well. Private sector health programs that do not receive federal funds are not covered. So the best description is the one that captures both ways the department's reach extends: health programs and activities administered by HHS or receiving federal financial assistance from HHS.

10. Which practice involves billing for higher service or item codes than those actually performed?

- A. Fraud**
- B. Kickback**
- C. Unbundling**
- D. Upcoding**

Upcoding is billing for a higher-cost code than the service actually performed. In medical coding, each service has a code that reflects its complexity, time, and resources used. When a provider uses a more expensive code than what was delivered, the payer pays more than warranted. This intentional misrepresentation is a form of fraudulent billing and can lead to audits, repayment of funds, and penalties. For context, unbundling would involve billing separate components that should be covered by a single code, which is a different improper practice; kickbacks relate to improper payments for referrals, not the coding itself. So the described practice is upcoding.

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://fraudwasteabuse2.examzify.com>

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

SAMPLE