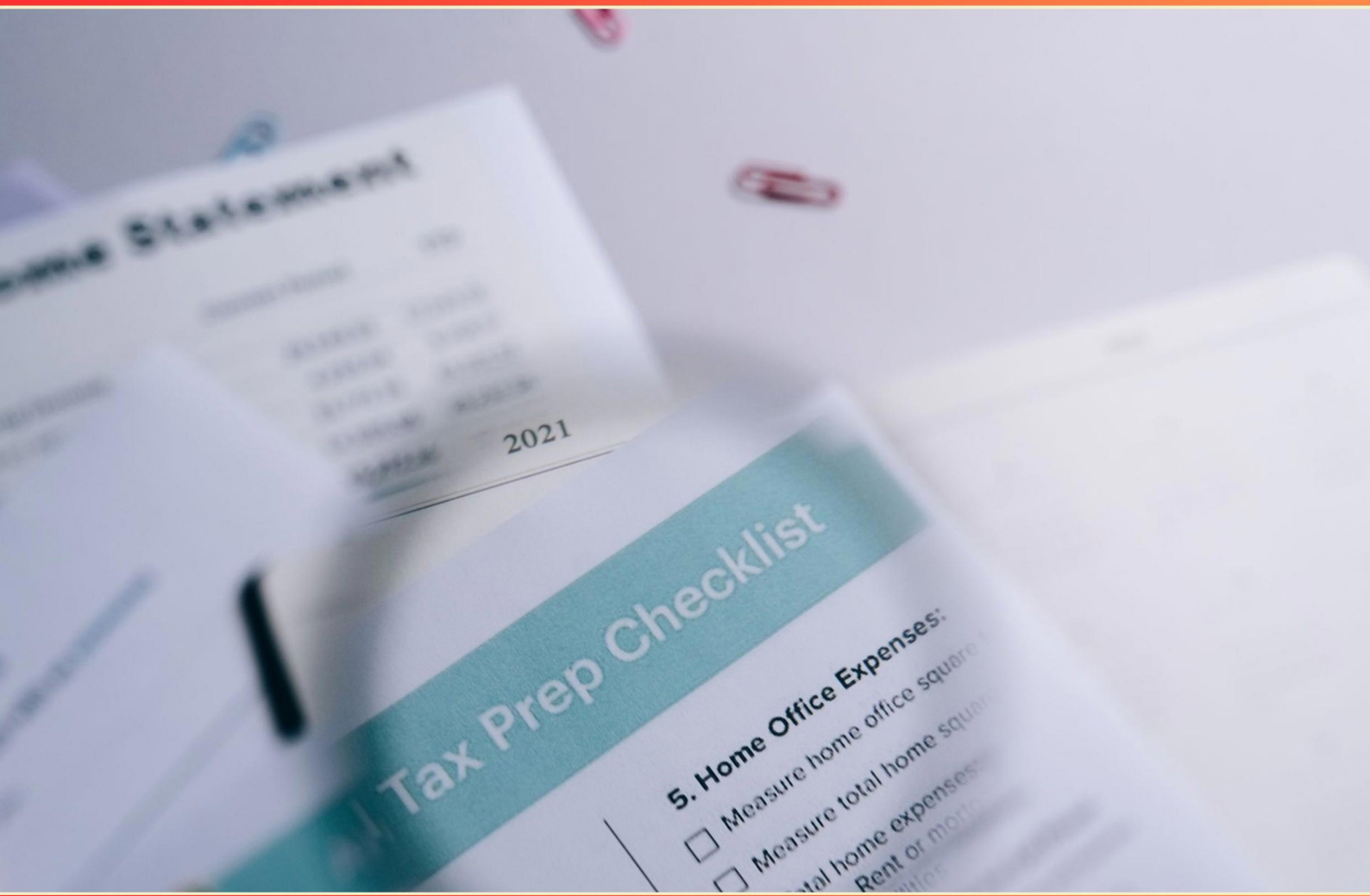
FRAUD, WASTE, AND ABUSE (FWA) 2 PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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https://fraudwasteabuse2.examzify.com

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

1. Are Medicare Parts C and D plan Sponsors required to have a compliance program?

A. True

B. False

C. Only if they have FWA

D. Not specified

2. Which statement is most accurate about responsibility for compliance?

A. It is the responsibility of the Compliance Officer only

B. It is a shared responsibility across all employees

C. It rests with external regulators

D. It is the responsibility of the vendor

3. Which statement best describes the role of standards of conduct in Medicare Parts C and D sponsor operations?

A. They define the expected behavior of employees

B. They are legally binding laws

C. They are optional guidelines with no real impact

D. They only apply to top management

4. What is the role of language assistance under ACA Section 1557?

A. Must be provided at no cost

B. It is optional

C. It covers only written communications

D. It is only for emergencies

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

A. Fraud

B. Kickback

C. Unbundling

D. Upcoding

6. Complete the sentence: Correcting non-compliance _____.

A. Increases penalties

B. Protects enrollees, avoids recurrence of the same non-compliance, and promotes efficiency

C. Delays corrective actions

D. Is optional

7. Which statement best describes the scope of ACA Section 1557 nondiscrimination protections?

A. They apply to health plans and their coverage of participants

B. They apply to all private sector employers

C. They apply only to hospitals

D. They apply only to prescription drugs

8. Fraud is defined as what?

A. Intentional deception or misrepresentation to gain a benefit to which one is not entitled

B. Unintentional mistakes in billing

C. Providing medically unnecessary care

D. Privacy violations

9. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

A. True

B. False

C. Not specified

D. Depends

10. For the person filing the fraud report, what should they do for themselves?

A. Continue filing the problematic bills.

B. Immediately cease filing the problematic bills.

C. Seek knowledgeable legal counsel only.

D. Ignore the issue and hope it resolves.

Answers

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

Explanations

1. Are Medicare Parts C and D plan Sponsors required to have a compliance program?

A. True

B. False

C. Only if they have FWA

D. Not specified

Medicare Parts C and D sponsors are expected to have strong controls to prevent fraud, waste, and abuse, but there isn't a statutory or regulatory mandate that every sponsor must operate a formal, written compliance program. Guidance from CMS and the OIG outlines what an effective compliance program should include—written policies and procedures, a designated compliance officer, ongoing training, monitoring and auditing, enforcement with corrective actions, and procedures for investigations and open reporting. Since the requirement to have a formal compliance program isn't explicitly imposed by law or regulation, the statement is not correct. That said, implementing a formal program aligns with CMS expectations and helps reduce risk, support program integrity, and improve oversight.

2. Which statement is most accurate about responsibility for compliance?

A. It is the responsibility of the Compliance Officer only

B. It is a shared responsibility across all employees

C. It rests with external regulators

D. It is the responsibility of the vendor

Compliance is a collective obligation. While the Compliance Officer leads the program—establishing policies, providing training, monitoring activities, and guiding corrective action—the daily success of compliance hinges on every employee's actions. When everyone understands policies, follows established procedures, and feels empowered to speak up about concerns, the organization creates a culture that deters fraud, waste, and abuse and reduces risk. Regulators enforce rules and can hold the organization accountable, and vendors must meet contractual requirements, but the ultimate responsibility for staying compliant rests with the organization and its people at all levels.

3. Which statement best describes the role of standards of conduct in Medicare Parts C and D sponsor operations?

A. They define the expected behavior of employees

B. They are legally binding laws

C. They are optional guidelines with no real impact

D. They only apply to top management

Standards of conduct establish the baseline for how everyone in the sponsor should behave to stay in compliance with Medicare rules and to prevent fraud, waste, and abuse. In Medicare Parts C and D operations, they communicate the ethical and legal expectations to all employees and contractors, guiding daily decisions, training, and how issues are investigated and addressed. They aren't laws themselves, but internal requirements that carry real consequences if violated, and they apply across the organization, not just to top management. That's why defining the expected behavior of employees best captures their purpose.

4. What is the role of language assistance under ACA Section 1557?

A. Must be provided at no cost

B. It is optional

C. It covers only written communications

D. It is only for emergencies

Under ACA Section 1557, language assistance ensures meaningful access to health services for people with limited English proficiency or disabilities. This means providing interpreters for spoken language, translating vital written materials, and offering accessible formats so patients can understand and participate in their care. These services must be provided at no cost to the patient. It is not optional, nor is it limited to emergencies or to written communications alone. Facilities should use qualified interpreters rather than relying on family members or minors. In short, the role is to remove language and disability barriers to equal access in health care by offering free language and accessibility services.

5. 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.

6. Complete the sentence: Correcting non-compliance _____.

A. Increases penalties

B. Protects enrollees, avoids recurrence of the same non-compliance, and promotes efficiency

C. Delays corrective actions

D. Is optional

Correcting non-compliance is about remedy and prevention: addressing the issue protects enrollees from harm, ensures the right services are delivered, and prevents the same non-compliant behavior from happening again. It also boosts efficiency by fixing the process weaknesses that allowed the non-compliance to occur, reducing waste and delays. Increasing penalties is not the primary aim of corrective action; penalties may come later, but the focus is on remedying the problem and preventing recurrence. Delaying corrective actions undermines protection and allows issues to persist, and making corrective action optional would leave enrollees at risk and undermine program integrity.

7. Which statement best describes the scope of ACA Section 1557 nondiscrimination protections?

A. They apply to health plans and their coverage of participants

B. They apply to all private sector employers

C. They apply only to hospitals

D. They apply only to prescription drugs

Section 1557 nondiscrimination protections cover health programs or activities that receive federal funds or are administered by HHS, and that includes private-sector entities involved with health plans. In practice, this means private employers that sponsor or administer employee health plans must meet these nondiscrimination requirements, not just hospitals or drug programs. That broader reach across private employers offering health coverage is why the statement describing the protections as applying to all private sector employers is the best fit: the protections aren't limited to a single setting like hospitals or to drugs, but extend to the private sector wherever a health plan or health program is involved.

8. Fraud is defined as what?

A. Intentional deception or misrepresentation to gain a benefit to which one is not entitled

B. Unintentional mistakes in billing

C. Providing medically unnecessary care

D. Privacy violations

Fraud hinges on intentional deception or misrepresentation to gain a benefit you're not entitled to. That deliberate intent to deceive for financial or other advantage is the defining feature. For example, billing for services not provided, upcoding to secure higher payments, or misrepresenting a diagnosis to obtain more reimbursement are fraudulent because they involve purposeful falsehoods to gain something of value. Unintentional mistakes in billing are errors without the element of intent, so they're not fraud. Providing medically unnecessary care fits more with abuse—care that is excessive or inappropriate and drives up costs, but not necessarily driven by a deliberate lie to gain benefits. Privacy violations involve misuse of patient information and are a separate concern; they're not defined by the fraud element of intentional deception for gain. The key idea is that fraud requires a deliberate attempt to deceive for personal benefit.

9. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

A. True

B. False

C. Not specified

D. Depends

Abuse is about improper billing practices that violate accepted medical or business standards and can drive up costs, but it does not depend on there being no entitlement to payment, nor does it hinge on the provider intentionally misrepresenting facts. Fraud requires intentional deception to obtain payment. So the statement is not correct: abusive billing can occur even when there is some entitlement, and abuse does not require a lack of misrepresentation (though if there is misrepresentation, that would be fraud).

10. For the person filing the fraud report, what should they do for themselves?

A. Continue filing the problematic bills.

B. Immediately cease filing the problematic bills.

C. Seek knowledgeable legal counsel only.

D. Ignore the issue and hope it resolves.

When you suspect or witness fraud, the first and most important action is to stop participating in the wrongdoing. Flooing or continuing to file fraudulent bills only compounds the misconduct and can expose you to criminal or civil liability. By immediately ceasing the problematic bills, you protect yourself, reduce ongoing harm, and keep evidence intact for investigators. After stopping, you should escalate through the proper channels (compliance, internal audit, or your supervisor) and seek legal counsel if you're unsure about protections or liabilities. While obtaining legal guidance is important, it doesn't address the immediate risk of ongoing fraud the moment you realize it.

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!