HCCA Certified in Healthcare Compliance (CHC) Practice Exam (Sample)

Study Guide

Everything you need from our exam experts!

Questions

1. What could happen to a physician who fails to respond to an emergency while on call?

A. Nothing, as they are not obligated to respond

B. The physician may face penalties under EMTALA

C. The hospital will absorb any penalties

D. The physician will be exempt from liability

2. Which of the following statements about the monitoring of internal controls is TRUE?

A. It is solely the responsibility of outside auditors

B. It is a continuous process to ensure control effectiveness

C. It should only occur after the control fails

D. It is primarily handled by operational staff

3. What types of records are excluded from the Designated Record Set (DRS) under HIPAA?

A. Administrative data, incident reports, and quality assurance data

B. Billing information and payment records

C. Patient consent forms and medical histories

D. Demographic information and insurance details

4. When a hotline caller reports coding discrepancies, what should the compliance professional do first?

A. Direct the coding supervisor to follow the applicable policy.

B. Incorporate the coding issue into the next year's risk assessment.

C. Design a review to find facts related to the complaint.

D. Engage outside counsel to protect facts from discovery.

5. What significant event does February 27, 1997, represent in the context of healthcare compliance?

A. The date of OIG publication promoting corporate compliance programs.

B. The date of the first compliance program established by HCFA.

C. The date when all healthcare organizations were mandated to implement compliance policies.

D. The date the Affordable Care Act was signed into law.

6. What is a significant benefit of a Corporate Compliance Program?

- **A. It limits employee engagement**
- **B. It ensures compliance with laws and regulations**
- **C. It reduces operational costs**
- **D. It increases profit margins**

7. What should compliance professionals do in response to discovering a systemic billing error?

- **A. Conceal the error from authorities**
- **B. Notify the affected parties and prepare a report**
- **C. Quickly correct the error without further review**
- **D. Review past incidents for similar errors**

8. What does Attorney-Client Privilege protect?

- **A. Only the client's advice to the attorney**
- **B. Disclosures by a client to an attorney and the attorney's advice to the client**
- **C. Only the underlying facts of the communications**
- **D. Only documents created after an investigation**

9. What should be readily accessible to all coding staff?

- **A. Billing certification**
- **B. CPT® code book**
- **C. All essential coding resources**
- **D. Nursing handbook**

10. What is the first step a Compliance Officer should take when developing goals for a review?

- **A. A. Conduct a probe audit on claims.**
- **B. B. Take a "snapshot" to develop a baseline to assess the current state of compliance.**
- **C. C. Conduct a contemporaneous review.**
- **D. D. Conduct a concurrent audit.**

Answers

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

Explanations

1. What could happen to a physician who fails to respond to an emergency while on call?

A. Nothing, as they are not obligated to respond

B. The physician may face penalties under EMTALA

C. The hospital will absorb any penalties

D. The physician will be exempt from liability

The correct answer is that the physician may face penalties under EMTALA. The Emergency Medical Treatment and Labor Act (EMTALA) mandates that hospitals and physicians provide emergency treatment to patients regardless of their ability to pay or insurance status. When a physician is on call and fails to respond to an emergency situation, they may be violating the provisions of EMTALA, which can lead to significant legal and financial consequences. This includes potential penalties imposed by regulatory bodies, such as fines or loss of Medicare certification, and may also expose the physician to malpractice claims from individuals who were harmed due to the failure to provide timely care. Understanding EMTALA's requirements is crucial for healthcare providers, as non-compliance can severely impact not only individual physicians but also healthcare institutions as they strive to ensure patient safety and uphold the standards of emergency care.

2. Which of the following statements about the monitoring of internal controls is TRUE?

A. It is solely the responsibility of outside auditors

B. It is a continuous process to ensure control effectiveness

C. It should only occur after the control fails

D. It is primarily handled by operational staff

The assertion that monitoring of internal controls is a continuous process to ensure control effectiveness is accurate. Continuous monitoring is essential because it allows organizations to identify and respond to compliance risks and deficiencies in real time. This ongoing process ensures that controls remain effective and adapt to changing regulations and operational environments. It emphasizes the importance of actively overseeing controls rather than waiting for failures to occur before taking action. This proactive approach helps organizations maintain compliance with legal and regulatory standards, mitigate risks, and enhance the overall effectiveness of their internal control systems. Continuous monitoring contributes to a culture of accountability and vigilance, which is critical in healthcare compliance settings where the stakes can be particularly high. By regularly assessing the performance of internal controls, organizations can ensure that they are achieving their compliance objectives and are well-prepared for audits and regulatory reviews.

3. What types of records are excluded from the Designated Record Set (DRS) under HIPAA?

A. Administrative data, incident reports, and quality assurance data

B. Billing information and payment records

C. Patient consent forms and medical histories

D. Demographic information and insurance details

The correct choice highlights that certain types of records are not included in the Designated Record Set (DRS) under HIPAA. Specifically, administrative data, incident reports, and quality assurance data are excluded because they are not directly related to the individual's health information or treatment decisions. The DRS includes medical records and billing information that is necessary for the patient's ongoing care and treatment. However, administrative records, incident reports, and quality assurance data are generally considered internal documents used for management and operational purposes rather than for the patient's direct care. Thus, these records do not fall under the patient's DRS as defined by HIPAA, which focuses on information that patients have a right to access regarding their own health and treatment. Understanding this exclusion is important for compliance professionals as they navigate the complexities of HIPAA regulations and ensure that the rights of individuals are protected while also managing the information necessary for operational integrity.

4. When a hotline caller reports coding discrepancies, what should the compliance professional do first?

A. Direct the coding supervisor to follow the applicable policy.

B. Incorporate the coding issue into the next year's risk assessment.

C. Design a review to find facts related to the complaint.

D. Engage outside counsel to protect facts from discovery.

In cases where a hotline caller reports coding discrepancies, the first action a compliance professional should take is to design a review to find facts related to the complaint. This is essential for several reasons. First, identifying the facts surrounding the reported discrepancies is critical to understanding the scope and nature of the issue. Conducting a review allows the compliance officer to gather pertinent information, assess whether there has been a violation of compliance standards, and understand the context of the discrepancies. This step is foundational in determining the appropriate next steps and ensuring that any corrective actions are based on accurate and thorough information. Moreover, a thorough review helps in documenting the process of addressing the complaint, which is vital for compliance purposes and for potential audits or investigations. It demonstrates the organization's commitment to addressing issues raised by hotline callers and reinforces a culture of compliance and accountability. Simply directing the coding supervisor to follow existing policies or incorporating the issue into a future risk assessment does not address the immediate need to understand the problem at hand. Engaging outside counsel might be necessary later in complex cases involving legal implications, but the first priority should be to establish a clear understanding of the discrepancies reported. Thus, initiating a fact-finding review is the most logical and responsible first step in the compliance process.

5. What significant event does February 27, 1997, represent in the context of healthcare compliance?

A. The date of OIG publication promoting corporate compliance programs.

B. The date of the first compliance program established by HCFA.

C. The date when all healthcare organizations were mandated to implement compliance policies.

D. The date the Affordable Care Act was signed into law.

February 27, 1997, marks a key milestone in healthcare compliance as it is the date when the Office of Inspector General (OIG) published a comprehensive guide promoting the implementation of corporate compliance programs within healthcare organizations. This publication laid the groundwork for the development and establishment of structured compliance initiatives aimed at preventing fraud and abuse in healthcare settings. The guide emphasized the importance of having compliance programs as a proactive approach for organizations to adhere to legal and regulatory requirements, thus enhancing ethical conduct and accountability. It served as a significant push for healthcare entities to develop effective compliance infrastructures, which would ultimately help mitigate risks associated with non-compliance and improve overall operational integrity. The other options, while relevant to healthcare compliance in various contexts, do not specifically correspond to the significance of February 27, 1997. The mention of the first compliance program by HCFA or a mandated compliance policy implementation does not tie directly to this particular date, and the Affordable Care Act was signed into law much later, in March 2010. Therefore, option A is the most relevant and correct response regarding the historical context of healthcare compliance.

6. What is a significant benefit of a Corporate Compliance Program?

A. It limits employee engagement

B. It ensures compliance with laws and regulations

C. It reduces operational costs

D. It increases profit margins

A significant benefit of a Corporate Compliance Program is that it ensures compliance with laws and regulations. This is essential for healthcare organizations, as they operate within a complex framework of federal, state, and local regulations designed to protect patient rights, maintain safety standards, and promote ethical practices. A compliance program provides structured guidelines and oversight to prevent legal violations and ethical breaches. By actively implementing and maintaining a compliance program, organizations can identify potential risks, educate employees about compliance matters, and establish protocols to address any violations. This proactive approach not only helps avoid substantial fines and legal issues but also contributes to the organization's reputation, ultimately fostering trust with patients and stakeholders. The presence of a strong compliance program demonstrates the organization's commitment to ethical standards and accountability, which is vital in the healthcare industry.

7. What should compliance professionals do in response to discovering a systemic billing error?

A. Conceal the error from authorities

B. Notify the affected parties and prepare a report

C. Quickly correct the error without further review

D. Review past incidents for similar errors

In the context of compliance in healthcare, when a systemic billing error is discovered, the most appropriate and responsible response is to review past incidents for similar errors. This approach allows compliance professionals to understand the root cause of the error, assess the extent of potential impact, and implement corrective action that addresses systemic weaknesses. By examining past incidents, compliance professionals can identify patterns or recurring issues, which can inform broader improvements in billing practices and compliance protocols. This proactive analysis can help prevent similar errors in the future, strengthen controls, and ensure that the organization adheres to legal and regulatory standards. It also demonstrates the organization's commitment to compliance and accountability, reinforcing trust with stakeholders and regulatory bodies. The importance of reviewing past incidents cannot be overstated, as it forms the basis for a comprehensive compliance strategy. Addressing systemic issues rather than merely correcting individual errors indicates a robust compliance culture focused on continuous improvement and risk management.

8. What does Attorney-Client Privilege protect?

A. Only the client's advice to the attorney

B. Disclosures by a client to an attorney and the attorney's advice to the client

C. Only the underlying facts of the communications

D. Only documents created after an investigation

Attorney-Client Privilege is a legal concept designed to protect the confidentiality of communications between a client and their attorney. This privilege applies to any disclosures made by the client to the attorney as well as the advice given by the attorney in response. The essence of this privilege is to foster open and honest communication between clients and their lawyers, allowing clients to disclose all relevant information without fear that it will be later used against them in legal proceedings. This means that if a client shares sensitive information or seeks legal guidance, those communications are protected from disclosure in court. The privilege encourages clients to share all pertinent details, which enables attorneys to provide the best possible legal counsel. Therefore, the correct answer encompasses both the client's disclosures and the attorney's responses, emphasizing the two-way nature of the communications protected under this privilege. The other options do not fully capture the scope of the privilege. For example, only focusing on the client's advice to the attorney ignores the crucial aspect of the attorney's advice back to the client. Similarly, limiting the privilege to underlying facts or only documents created post-investigation misrepresents its comprehensive application to any relevant communication made in the ordinary course of seeking legal advice.

9. What should be readily accessible to all coding staff?

A. Billing certification

B. CPT® code book

C. All essential coding resources

D. Nursing handbook

The correct choice is the one that emphasizes the importance of ensuring that all essential coding resources are readily accessible to coding staff. This encompasses a wide range of materials, tools, guidelines, and references that are necessary for accurate and compliant coding practices. Having access to all essential resources, such as coding manuals, regulatory guidelines, software tools, and compliance documents, empowers coding staff to perform their responsibilities effectively. While a CPT® code book is indeed a critical resource specifically related to Current Procedural Terminology codes, limiting access to just this book does not address the broader needs of coding staff who require a comprehensive toolkit to manage their work accurately. Billing certification and a nursing handbook also serve specific functions but do not provide the comprehensive support necessary for coding operations. By ensuring that all essential coding resources are available, coding staff can stay up-to-date with the latest coding practices, regulatory changes, and compliance requirements, ultimately enhancing the quality of care documentation and billing accuracy.

10. What is the first step a Compliance Officer should take when developing goals for a review?

A. A. Conduct a probe audit on claims.

B. B. Take a "snapshot" to develop a baseline to assess the current state of compliance.

C. C. Conduct a contemporaneous review.

D. D. Conduct a concurrent audit.

The first step a Compliance Officer should take when developing goals for a review is to take a "snapshot" to develop a baseline to assess the current state of compliance. Establishing a baseline is crucial because it provides a clear understanding of where the organization currently stands in terms of compliance. This snapshot allows the Compliance Officer to identify existing gaps, weaknesses, or areas that need improvement, which are essential for setting realistic and pertinent goals. By evaluating the current state, the Compliance Officer can prioritize areas that require immediate attention and tailor the review goals to specifically address these needs. This foundational step ensures that subsequent audits, reviews, or compliance activities are informed by accurate data, helping to monitor progress effectively over time. In contrast, conducting a probe audit on claims, contemporaneous review, or a concurrent audit are important assessments in their own rights but are typically initiated after establishing a baseline. They serve different purposes, such as verifying specific claims or checking compliance during ongoing operations, but they do not effectively establish the initial framework needed for successful goal development in compliance reviews.