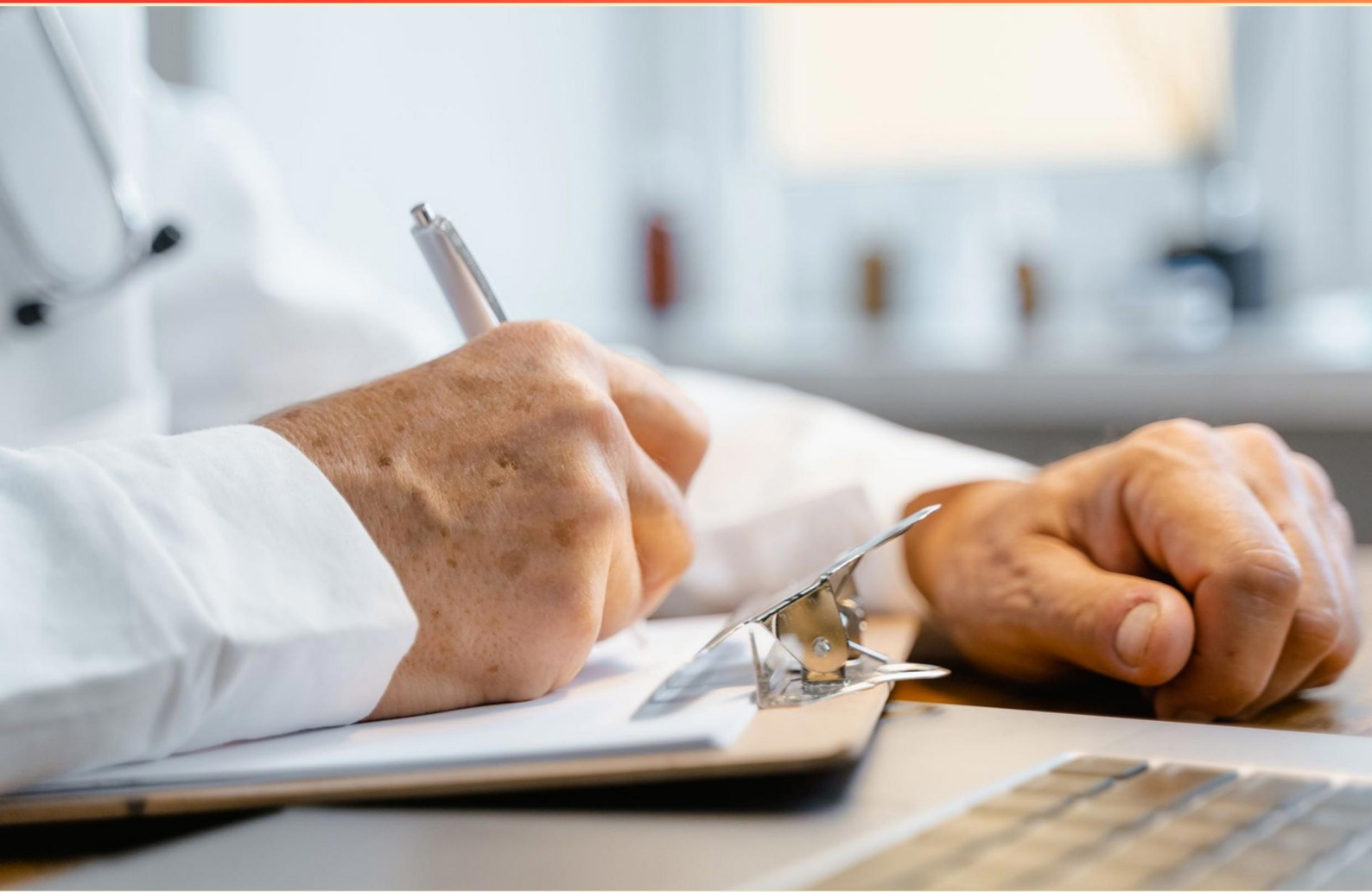


HCCA CERTIFIED IN HEALTHCARE COMPLIANCE (CHC) PRACTICE EXAM (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

**VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE**

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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

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- 1. What is NOT one of the basic elements of compliance monitoring?**
 - A. Auditing
 - B. Training
 - C. Quality Assurance Programs
 - D. Policy Development
- 2. Under the US Federal Sentencing Guidelines, which process should be prioritized for effective compliance?**
 - A. Periodic background checks
 - B. Drug Testing
 - C. Monthly OIG database verifications
 - D. Monthly SAMS GSA Exclusion verifications
- 3. If wrongdoing is identified, what is the FIRST action to take if an overpayment is found?**
 - A. Report to the Board
 - B. Contact the Attorney General
 - C. Refund to the Fiscal Intermediary
 - D. Close the case
- 4. Which organization establishes written policies for Medicaid payment to prevent fraud, waste, and abuse?**
 - A. CMS
 - B. OIG
 - C. DOJ
 - D. OSHA
- 5. What does the anti-kickback statute prohibit?**
 - A. Offering a bonus for employee referrals
 - B. Offering incentives for referring clients in federal health programs
 - C. Accepting gifts from vendors at healthcare events
 - D. None of the above

- 6. Where does the compliance professional typically find guidelines for developing compliance programs?**
- A. Legal Advisory Board
 - B. Office of Inspector General (OIG)
 - C. Department of Health Services
 - D. National Compliance Council
- 7. What should be done after clarifying a suspected fraud violation?**
- A. Report the situation to the media
 - B. Consult with a health care attorney
 - C. Wait for an annual review to address it
 - D. Conduct an internal investigation without oversight
- 8. Which act established the Health Care Fraud and Abuse Control Program?**
- A. Health Insurance Portability and Accountability (HIPAA)
 - B. American Recovery and Reinvestment Act (ARRA)
 - C. Affordable Care Act (ACA)
 - D. Medicare Modernization Act (MMA)
- 9. What is the aim of the Physician Payment Sunshine Act in relation to public transparency?**
- A. To reduce healthcare costs for patients
 - B. To ensure public knowledge of payments made to healthcare providers
 - C. To limit the access of manufacturers to physicians
 - D. To increase competition among healthcare providers
- 10. What can help establish a positive compliance atmosphere within an organization?**
- A. Compliance Hotlines
 - B. Strict employee monitoring
 - C. Decreased transparency
 - D. Limited communication channels

Answers

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

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Explanations

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1. What is NOT one of the basic elements of compliance monitoring?

- A. Auditing
- B. Training
- C. Quality Assurance Programs**
- D. Policy Development

Compliance monitoring is a critical component of a healthcare organization's compliance program, and it typically involves several key elements aimed at ensuring adherence to regulatory requirements and internal policies. Among the options provided, the one that is not considered a basic element of compliance monitoring is quality assurance programs. Auditing serves as a fundamental aspect of compliance monitoring by systematically examining various operations and processes to ensure that they comply with established standards, policies, and regulations. This process helps identify any areas of noncompliance or risk. Training is another integral part of compliance monitoring as it ensures that staff are educated about compliance policies, legal requirements, and best practices. Regular training sessions help reinforce the importance of compliance and keep employees informed of any changes in regulations or internal policies. Policy development is essential as well because it establishes the framework within which compliance occurs. Strong policies provide clear guidelines on expected behaviors, procedures, and compliance requirements that align with legal and regulatory standards. In contrast, quality assurance programs, while important for assessing and improving the quality of care and services provided within a healthcare organization, do not directly fall under the core elements of compliance monitoring. Instead, quality assurance focuses more on outcomes and service delivery rather than the compliance processes themselves. Thus, it is correct to identify quality assurance programs as not

2. Under the US Federal Sentencing Guidelines, which process should be prioritized for effective compliance?

- A. Periodic background checks
- B. Drug Testing
- C. Monthly OIG database verifications
- D. Monthly SAMS GSA Exclusion verifications**

Prioritizing monthly SAMS (System for Award Management) and GSA (General Services Administration) exclusion verifications is crucial for effective compliance under the US Federal Sentencing Guidelines due to the emphasis on ensuring that no individuals or entities that are barred from federal contracts are involved in the organization's operations. These verifications help organizations maintain their compliance standing by avoiding any engagement with excluded or debarred individuals, which could lead to significant legal and financial repercussions. The guidelines encourage a proactive approach to compliance, focusing on risk management and preventing issues before they arise. Regular checks against such exclusion lists are a key component of this preemptive strategy, as they address potential misconduct and ensure ongoing vigilance in upholding ethical standards. This process strengthens an organization's defense against allegations of misconduct by demonstrating a commitment to ethical practices and due diligence. In contrast, while periodic background checks, drug testing, and monthly OIG (Office of Inspector General) database verifications can be valuable for compliance and risk management, they do not specifically target the same critical area of avoiding relationships with excluded individuals as SAMS and GSA verifications do. Therefore, the priority should be placed on the checks that prevent working with banned entities, thereby safeguarding both compliance and the organization's integrity.

3. If wrongdoing is identified, what is the FIRST action to take if an overpayment is found?

- A. Report to the Board
- B. Contact the Attorney General
- C. Refund to the Fiscal Intermediary**
- D. Close the case

When an overpayment is identified, the first action to take is to refund the amount to the fiscal intermediary. This step is crucial because it helps to rectify the financial discrepancy as soon as it is discovered. The overpayment needs to be addressed promptly to comply with healthcare regulations and mitigate potential legal or financial repercussions. In healthcare compliance, the responsibility to return overpayments is guided by laws and regulations to ensure that the integrity of the billing process is maintained. Failing to take immediate action on an overpayment can lead to further complications, including investigations by regulatory bodies or potential penalties. Returning the funds expedites the resolution of the issue and demonstrates a commitment to compliance, which is vital for maintaining trust and adherence to legal standards in healthcare practices. This proactive approach also helps to establish a culture of integrity within the organization by addressing financial discrepancies responsibly.

4. Which organization establishes written policies for Medicaid payment to prevent fraud, waste, and abuse?

- A. CMS
- B. OIG**
- C. DOJ
- D. OSHA

The Office of Inspector General (OIG) plays a pivotal role in establishing written policies and guidelines concerning Medicaid payment to combat fraud, waste, and abuse. The OIG is dedicated to protecting the integrity of the Medicare and Medicaid programs and ensures that federal resources are efficiently utilized. Through its efforts, the OIG develops compliance program guidance, conducts audits and investigations, and issues reports that establish best practices to help providers understand their obligations under the law. This organization specifically focuses on maintaining program integrity and ensuring accountability, thereby preventing fraud and abuse within Medicaid and other federally funded healthcare programs. The development of these policies is crucial as it aids in creating a structured framework that healthcare providers must follow, ultimately leading to improved compliance and ethical practices within the healthcare system. While other organizations such as the Centers for Medicare & Medicaid Services (CMS) also have a role in policymaking and oversight regarding Medicaid, it is the OIG that explicitly focuses on fraud, waste, and abuse prevention measures through written policies. The Department of Justice (DOJ) is more involved in the enforcement of laws and prosecution of wrongful acts, and the Occupational Safety and Health Administration (OSHA) is primarily concerned with occupational health and safety, making them less relevant to this specific question.

5. What does the anti-kickback statute prohibit?

- A. Offering a bonus for employee referrals
- B. Offering incentives for referring clients in federal health programs**
- C. Accepting gifts from vendors at healthcare events
- D. None of the above

The anti-kickback statute is a critical piece of legislation designed to prevent corruption and unethical practices in healthcare. It prohibits the exchange of anything of value in an effort to induce referrals of healthcare services that are reimbursable under federal health programs like Medicare and Medicaid. This means that any form of incentive, whether monetary or otherwise, intended to encourage healthcare providers to refer patients or services can lead to significant legal repercussions. By recognizing the impact of this statute, it becomes clear that offering incentives specifically to refer clients within federally funded health programs constitutes a violation. Such actions can not only distort clinical decision-making but also lead to excessive healthcare costs and compromised patient care. Understanding the importance of this prohibition helps maintain the integrity of the healthcare system and fosters trust in the relationships among patients, providers, and payers.

6. Where does the compliance professional typically find guidelines for developing compliance programs?

- A. Legal Advisory Board
- B. Office of Inspector General (OIG)**
- C. Department of Health Services
- D. National Compliance Council

The Office of Inspector General (OIG) is a critical resource for compliance professionals seeking to establish or enhance compliance programs within healthcare organizations. The OIG provides a wealth of information through its compliance program guidance documents, which outline best practices for specific types of healthcare entities. These guidelines are tailored to align with regulatory requirements and help organizations mitigate risks associated with healthcare compliance. Furthermore, the OIG's recommendations are based on extensive research, investigations, and enforcement actions, making them highly relevant and authoritative. By following OIG guidelines, compliance professionals can ensure their programs are not only compliant with federal regulations but also effective in promoting ethical conduct and preventing fraud, waste, and abuse within their organizations. Other options such as the Legal Advisory Board, Department of Health Services, and National Compliance Council may also offer useful information or support, but the OIG specifically focuses on compliance within the healthcare sector and provides detailed, structured guidance that is fundamental to the development of effective compliance programs.

7. What should be done after clarifying a suspected fraud violation?

- A. Report the situation to the media
- B. Consult with a health care attorney**
- C. Wait for an annual review to address it
- D. Conduct an internal investigation without oversight

Consulting with a healthcare attorney after clarifying a suspected fraud violation is crucial for several reasons. First and foremost, legal counsel can provide expert guidance on the complexities of health care laws and regulations. This is particularly important in cases of suspected fraud, as the legal implications can be significant. An attorney can help navigate the appropriate steps to ensure compliance with reporting requirements while minimizing potential legal repercussions. Additionally, a healthcare attorney can assist in understanding the nuances of federal and state laws related to fraud, such as the False Claims Act or the Anti-Kickback Statute. They can also help in developing a strategy for addressing the violation, including whether it should be reported to authorities and how to conduct any subsequent investigation in a manner that protects the organization from liability. In contrast, options that involve public disclosure, delaying actions until an annual review, or conducting an internal investigation without oversight could lead to serious risks, including damage to the organization's reputation, increased liability, or the possibility of compromising evidence related to the violation. Thus, seeking legal counsel ensures that the organization takes informed and compliant actions in response to suspected fraud.

8. Which act established the Health Care Fraud and Abuse Control Program?

- A. Health Insurance Portability and Accountability (HIPAA)**
- B. American Recovery and Reinvestment Act (ARRA)
- C. Affordable Care Act (ACA)
- D. Medicare Modernization Act (MMA)

The Health Care Fraud and Abuse Control Program was established by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This program was created to coordinate federal, state, and local efforts to combat health care fraud and abuse, and it provided enforcement agencies like the Department of Justice and the Department of Health and Human Services with the tools necessary to investigate and prosecute fraud in the healthcare system effectively. The Act created the framework that allowed for the recovery of funds lost due to fraudulent activities and established mechanisms to penalize those who commit health care fraud. The other acts mentioned also have their respective purposes, but they do not specifically address the establishment of the Health Care Fraud and Abuse Control Program. For instance, the Affordable Care Act does implement numerous reforms to improve health care delivery and insurance coverage, while the American Recovery and Reinvestment Act focuses on economic stimulus measures. The Medicare Modernization Act primarily aimed at expanding Medicare benefits and prescription drug coverage. Therefore, HIPAA stands out as the legislative act directly related to health care fraud and abuse control initiatives.

9. What is the aim of the Physician Payment Sunshine Act in relation to public transparency?

- A. To reduce healthcare costs for patients
- B. To ensure public knowledge of payments made to healthcare providers**
- C. To limit the access of manufacturers to physicians
- D. To increase competition among healthcare providers

The aim of the Physician Payment Sunshine Act is centered on ensuring public knowledge of payments made to healthcare providers. This legislation was enacted to promote transparency in the financial relationships between healthcare providers and pharmaceutical or medical device companies. The act requires these companies to report any payments or other transfers of value made to physicians and teaching hospitals, allowing the public to see the potential influences on medical practice and decision-making. This transparency is intended to help patients and the public better understand the nature of the relationships that healthcare professionals may have with industry, thereby fostering an environment of accountability and trust in the healthcare system. By disclosing these financial transactions, the act serves to curb potential conflicts of interest that can arise when healthcare providers receive monetary incentives from the industry. In contrast, other options presented do not align directly with the primary goal of the Sunshine Act. While reducing healthcare costs and increasing competition among providers might be implied outcomes of greater transparency or accountability, they are not the main objectives of the legislation. Additionally, limiting the access of manufacturers to physicians does not capture the essence of what the Sunshine Act aims to accomplish. Instead, the focus is primarily on creating an informed public regarding the financial interactions between healthcare providers and the industry.

10. What can help establish a positive compliance atmosphere within an organization?

- A. Compliance Hotlines**
- B. Strict employee monitoring
- C. Decreased transparency
- D. Limited communication channels

Establishing a positive compliance atmosphere within an organization is fundamentally rooted in open communication and the ability for employees to report concerns without fear of retaliation. The implementation of compliance hotlines serves as a crucial tool in fostering this environment. These hotlines provide employees with a confidential and accessible method to report potential compliance issues or unethical behavior. By encouraging individuals to voice their concerns, organizations demonstrate their commitment to transparency and adherence to ethical standards. Moreover, when employees feel that their concerns will be heard and addressed, it promotes a culture of trust and accountability. This proactive approach can lead to early identification of compliance risks and the opportunity to address issues before they escalate into more significant problems. A compliance hotline also signifies that the organization values the input and welfare of its employees, which can enhance overall morale and engagement. In contrast, options like strict employee monitoring, decreased transparency, and limited communication channels tend to create an atmosphere of suspicion and fear. Such environments can discourage employees from coming forward with concerns, ultimately undermining the organization's compliance efforts.

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://hccachc.examzify.com>

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

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