MEDICARE ETHICS AND COMPLIANCE PRACTICE TEST (SAMPLE)

STUDY GUIDE

SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR THE FULL VERSION STUDY GUIDE

https://medicareethicscompliance.examzify.com

Table of Contents

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. What describes Scope of Appointment?

A. The agreement obtained no less than 48 hours prior to the start of the appointment identifying the scope of products that can be discussed at a personal/individual marketing appointment

B. A list of all plans available

C. A medical clearance form required before enrollment

D. A contract outlining legal responsibilities

2. Which statement best reflects compliant handling when a consumer mentions a benefit from an ad during a call?

A. Do not rely on one benefit; conduct a needs assessment to determine best fit.

B. Always enroll the consumer in the plan that matches the ad benefit.

C. Explain every ad benefit in detail and enroll immediately.

D. Ignore the consumer's mention of benefits and proceed based on the plan's general features.

3. What is an example of a Stark Law exception for physician-owned entities?

A. Outsourcing agreements

B. In-office ancillary services (IOAS)

C. Marketing agreements

D. Unrelated party ownership

4. When a consumer asks about a plan during a call, you should:

A. Provide clear, accurate information and tailor recommendations to the consumer's needs

B. Provide the most expensive plan to maximize commissions

C. Recommend multiple plans without assessing needs

D. Delay the discussion until you have complete medical history

5. Which statement best describes the Office of Inspector General's (OIG) role in Medicare compliance?

A. It solely handles hospital billing disputes.

B. It Oversees program integrity; conducts audits and investigations; issues advisory opinions; maintains LEIE; guides compliance program expectations.

C. It regulates patient safety.

D. It determines physician licensure.

6. Which statement is true regarding the interaction between Medicare Advantage plans and prescription drug coverage?

A. MA plans can never include drug coverage.

B. MA plans with drug coverage replace the need for a separate PDP.

C. PDP can run concurrently with MA if the patient wants.

D. MA plans with drug coverage require a separate Medigap policy.

7. Which of the following qualifies as a designated health service (DHS) under Stark law?

A. Administrative services

B. Inpatient psychiatric care

C. Imaging services

D. Ambulance transport

8. Which item is NOT a component of a thorough needs assessment?

A. Identifying healthcare coverage attributes important to the consumer and tradeoffs

B. Identifying current providers (including primary care, specialists, hospitals, and pharmacies) and the medications they take

C. Learning about current coverage, lifestyle and financial characteristics

D. Identifying the consumer's credit score

9. Which statement about LEIE is true?

A. It lists all licensed clinicians nationwide.

B. It identifies individuals and entities excluded from federal health care programs.

C. It provides reimbursement rates for contractors.

D. It is used for marketing purposes.

10. A consumer turns 65 soon and calls; On the day of the call, what can Gene do?

A. Enroll in a different Medicare Advantage plan with an effective date of March 1

B. Wait until after birthday

C. Enroll in any plan with an effective date of March 1

D. Cancel enrollment and stay with current plan

Answers

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

Explanations

1. What describes Scope of Appointment?

A. The agreement obtained no less than 48 hours prior to the start of the appointment identifying the scope of products that can be discussed at a personal/individual marketing appointment

B. A list of all plans available

C. A medical clearance form required before enrollment

D. A contract outlining legal responsibilities

Scope of Appointment is the formal agreement that defines, before a marketing conversation begins, which product areas can be discussed with a Medicare beneficiary. It identifies the specific categories of plans or benefits that may be covered in the meeting, and it is typically required to be completed and signed no less than a certain window before the appointment. This advance consent protects the beneficiary by ensuring they know in advance what topics will be discussed and prevents conversations about products outside the approved scope. It's not a list of every plan available, not a medical clearance form, and not a contract outlining legal responsibilities—the form is specifically about limiting the discussion to approved product areas during the appointment.

2. Which statement best reflects compliant handling when a consumer mentions a benefit from an ad during a call?

A. Do not rely on one benefit; conduct a needs assessment to determine best fit.

B. Always enroll the consumer in the plan that matches the ad benefit.

C. Explain every ad benefit in detail and enroll immediately.

D. Ignore the consumer's mention of benefits and proceed based on the plan's general features.

When a consumer mentions a benefit from an ad, the best approach is to slow down and perform a full needs assessment to determine the plan that truly fits their situation. Ads can highlight a feature that sounds appealing, but it may not apply to the consumer's medications, providers, or budget. By starting with a needs assessment, you gather key information—prescribed drugs, preferred pharmacies, calendar of care, and out-of-pocket priorities—and you compare plans based on overall fit, including formulary coverage, network access, and true costs. This keeps the interaction patient-centered and compliant, avoiding steering toward a plan simply because of a single advertised benefit. Enrolling based on that one benefit without assessing needs can mislead the consumer and may violate marketing and suitability guidelines. Explaining every ad benefit in detail and enrolling immediately can overwhelm or confuse the consumer and still may misrepresent plan limitations. Ignoring the consumer's mention and proceeding with general features misses the opportunity to address their real concerns and could lead to a poor fit.

3. What is an example of a Stark Law exception for physician-owned entities?

A. Outsourcing agreements

B. In-office ancillary services (IOAS)

C. Marketing agreements

D. Unrelated party ownership

In-office ancillary services arrangements are an example of a Stark Law exception for physician-owned entities. This allows a physician practice to furnish and bill for certain ancillary services—like imaging, laboratory tests, or other designated health services—through an entity that is owned by the physicians in the practice, as long as specific safeguards are met. The services must be provided in the office or in a closely related setting, and the arrangement must be structured so that referrals are not driven by financial incentives. Key elements include ownership by physicians in the group, fair market value compensation, a prearranged plan, and the services being truly ancillary to the physician's core practice. When these conditions are satisfied, the IOAS setup stands as a recognized exception to Stark's self-referral rule. Outsourcing agreements, marketing agreements, and ownership by unrelated parties do not automatically qualify as Stark Law exceptions for physician-owned entities in the same way, so they are not considered examples of the IOAS exception.

4. When a consumer asks about a plan during a call, you should:

A. Provide clear, accurate information and tailor recommendations to the consumer's needs

B. Provide the most expensive plan to maximize commissions

C. Recommend multiple plans without assessing needs

D. Delay the discussion until you have complete medical history

Providing clear, accurate information about plan options and tailoring recommendations to the consumer's needs on a call is essential. This means explaining how each plan works, including premiums, deductibles, copays, drug coverage, and network or formulary details that affect the medicines the consumer uses. It also means asking targeted questions about the consumer's prescription needs, budget, doctors, and travel or care patterns so you can match options to what they actually require. By focusing on the consumer's situation, you help them compare plans meaningfully and make an informed choice. This approach aligns with ethical and compliance expectations, which prohibit steering toward higher-priced plans for personal gain or pushing plans the consumer doesn't need. It also respects the consumer's time by discussing plan options without requiring complete medical history, since that information isn't necessary to evaluate plan coverage and fit. If multiple plans seem appropriate after assessing needs, you can present them clearly and explain how each one fits the consumer's circumstances.

5. Which statement best describes the Office of Inspector General's (OIG) role in Medicare compliance?

A. It solely handles hospital billing disputes.

B. It Oversees program integrity; conducts audits and investigations; issues advisory opinions; maintains LEIE; guides compliance program expectations.

C. It regulates patient safety.

D. It determines physician licensure.

This describes the Office of Inspector General's role in Medicare compliance, focusing on safeguarding the program from fraud, waste, and abuse. The OIG oversees program integrity across Medicare by setting and enforcing standards, conducting audits and investigations to uncover improper payments or vulnerable processes, and issuing advisory opinions that spell out OIG's official positions on proposed arrangements and practices that could raise compliance concerns. It also maintains the List of Excluded Individuals/Entities (LEIE), which helps organizations screen out providers and entities that have been excluded from federal health care programs, and it guides providers on what compliant behavior looks like by outlining expectations for effective compliance programs. Together, these functions create a comprehensive framework for detecting issues, guiding safe practices, and promoting strong internal controls within Medicare programs. Other roles listed don't fit because patient safety regulation is handled by different CMS-related bodies and health system regulators, not the OIG. Physician licensure is determined by state medical boards, not by the OIG. And while the OIG does pursue issues related to billing and improper payments, its mandate is broader than resolving hospital billing disputes alone, encompassing system-wide program integrity and compliance guidance.

6. Which statement is true regarding the interaction between Medicare Advantage plans and prescription drug coverage?

A. MA plans can never include drug coverage.

B. MA plans with drug coverage replace the need for a separate PDP.

C. PDP can run concurrently with MA if the patient wants.

D. MA plans with drug coverage require a separate Medigap policy.

Medicare Advantage plans that include prescription drug coverage bundle both medical and drug benefits into one plan, so you receive Part D–like coverage through that MA plan rather than a separate stand-alone Part D plan. This means you don't enroll in a separate PDP while you're in an MA plan with drug coverage; the MA plan takes care of your prescription drug benefits within the same plan. If you want drug coverage but stay with Original Medicare, you would enroll in a standalone Part D plan. In addition, Medigap is designed to supplement Original Medicare, not Medicare Advantage, so you wouldn't pair a Medigap policy with an MA plan. So the correct idea is that MA plans with drug coverage replace the need for a separate PDP.

7. Which of the following qualifies as a designated health service (DHS) under Stark law?

A. Administrative services

B. Inpatient psychiatric care

C. Imaging services

D. Ambulance transport

Imaging services are designated health services because radiology falls squarely into the list of services that Stark law treats as DHS. When a physician has a financial relationship with an entity providing imaging, referrals to that entity can trigger Stark restrictions unless an exception applies. The other options don't fit the DHS category, so they aren't treated as designated health services under Stark.

8. Which item is NOT a component of a thorough needs assessment?

A. Identifying healthcare coverage attributes important to the consumer and tradeoffs

B. Identifying current providers (including primary care, specialists, hospitals, and pharmacies) and the medications they take

C. Learning about current coverage, lifestyle and financial characteristics

D. Identifying the consumer's credit score

A thorough needs assessment focuses on understanding what Medicare coverage and benefits will best meet a consumer's health needs and budget. You gather information about which coverage attributes matter to them and what tradeoffs they're willing to accept, such as balancing premiums against out-of-pocket costs or formulary choices. You also collect details about current providers—primary care, specialists, hospitals, and pharmacies—and the medications they take, so you can ensure the plan's network and drug coverage fit their care needs. Learning about current coverage, lifestyle, and financial characteristics helps assess affordability, access, and any gaps in care, enabling realistic, personalized recommendations. The consumer's credit score, however, doesn't influence a plan's benefits, network adequacy, or drug coverage, and including it would add an unrelated privacy concern without improving the needs analysis.

9. Which statement about LEIE is true?

A. It lists all licensed clinicians nationwide.

B. It identifies individuals and entities excluded from federal health care programs.

C. It provides reimbursement rates for contractors.

D. It is used for marketing purposes.

LEIE identifies individuals and entities excluded from federal health care programs. It's a database kept by the Department of Health and Human Services Office of Inspector General that flags people and organizations that cannot participate in programs like Medicare and Medicaid. The purpose is to help providers, suppliers, and organizations screen so they don't do business with someone barred from billing federal programs, protecting program integrity. It's not a directory of licensed clinicians, it doesn't set or provide reimbursement rates, and it isn't used for marketing.

10. A consumer turns 65 soon and calls; On the day of the call, what can Gene do?

A. Enroll in a different Medicare Advantage plan with an effective date of March 1

B. Wait until after birthday

C. Enroll in any plan with an effective date of March 1

D. Cancel enrollment and stay with current plan

Enrollment windows determine when you can change Medicare Advantage plans. When someone is turning 65, there's a window around the birthday to enroll or switch plans, and there's a dedicated period for making changes to Medicare Advantage plans in the new year. If you're calling during that period, you're allowed to switch to a different Medicare Advantage plan, and the new plan can have an effective date at the start of March if you complete the switch in time for that month. That's why enrolling in a different MA plan with March 1 as the start date is the correct option here. Waiting until after the birthday would miss opportunities available during the enrollment window. Enrolling in "any" plan with March 1 isn't accurate because plan availability varies by location and specific plan choices. Cancelling and staying with the current plan would forego the chance to take advantage of the open enrollment period to adjust coverage.

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://medicareethicscompliance.examzify.com

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