RHIT Domain 5 – Compliance Practice Test (Sample)

Study Guide

Everything you need from our exam experts!

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. **If a HIM professional refuses to release emergency room records without written authorization from the patient, is this action compliant?**

   A. No; the records are needed for continued care of the patient, so no authorization is required

   B. Yes; the release of all records requires written authorization from the patient

   C. No; permission of the ER physician was not obtained

   D. Yes; one covered entity cannot request the records from another covered entity

2. **What process ensures the quality and safety of healthcare for patients and employees through ongoing surveillance and prevention of infections?**

   A. Case management

   B. Infection control

   C. Risk management

   D. Utilization management

3. **How is healthcare fraud defined?**

   A. Incorrect billing for services rendered

   B. Misrepresentation that results in unauthorized benefits

   C. Billing for unnecessary services

   D. Failure to obtain patient consent

4. **Which of the following actions is an example of healthcare fraud?**

   A. Billing for services actually rendered

   B. Refiling claims after they are denied

   C. Billing for services not furnished to patients

   D. Using a claim scrubber before submission

5. **What is required of covered entities under the Breach Notification Rule?**

   A. Notify affected individuals when a breach occurs

   B. Provide a new notice of privacy practices to all patients

   C. Create a new health record number for each patient

   D. Assign a privacy officer for breach management

6. In an internal coding audit review program, which risk area is prioritized for auditing?

A. Admission diagnosis and complaints

B. Chargemaster description and medical necessity

C. Clinical laboratory results

D. Radiology orders

7. What is the minimum duration for which HIPAA requires data security policies and procedures to be maintained?

A. 3 years from date of creation

B. 5 years from date of creation

C. 5 years from date of creation or the last date in effect

D. 6 years from date of creation or the last date in effect

8. What is considered unsecured PHI?

A. PHI that is encrypted

B. PHI that is unintelligible to unauthorized persons

C. PHI without any protective measures

D. PHI that is stored securely

9. What risk is associated with copying and pasting patient documentation in electronic health records?

A. Reduction in the time required to document

B. System may not save data

C. Copying the note in the wrong patient's record

D. System thinking the information belongs to the original patient

10. What term describes the overutilization or inappropriate utilization of services and misuse of resources, typically not a criminal act?

A. Fraud

B. Abuse

C. Waste

D. Audit

Answers

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

Explanations

1. If a HIM professional refuses to release emergency room records without written authorization from the patient, is this action compliant?

A. No; the records are needed for continued care of the patient, so no authorization is required

B. Yes; the release of all records requires written authorization from the patient

C. No; permission of the ER physician was not obtained

D. Yes; one covered entity cannot request the records from another covered entity

The action described is compliant because in emergency situations, the release of medical records, such as those from an emergency room, is often permitted under specific regulations even if explicit written authorization from the patient has not been obtained. The rationale for this is that timely access to these records is critical for the continued care of the patient; healthcare providers must share relevant patient information to ensure that proper treatment can be administered without unnecessary delays. In emergencies, laws such as the Health Insurance Portability and Accountability Act (HIPAA) allow for the release of medical records without prior authorization under certain circumstances, emphasizing the need to prioritize patient safety and effective healthcare delivery over administrative barriers. This understanding aligns with the principles of patient care and compliance within healthcare regulations, where the immediate health needs of the patient take precedence.

2. What process ensures the quality and safety of healthcare for patients and employees through ongoing surveillance and prevention of infections?

A. Case management

B. Infection control

C. Risk management

D. Utilization management

The process that ensures the quality and safety of healthcare for patients and employees through ongoing surveillance and prevention of infections is infection control. This practice is critical in healthcare settings as it focuses on the proper measures to prevent the spread of infections, which can include strategies like hand hygiene, sterilization techniques, and monitoring infection rates within the facility. Infection control programs are designed to identify potential sources of infection, implement preventive measures, and educate healthcare staff about best practices. By effectively controlling infections, healthcare facilities not only protect patients but also reduce the risk for healthcare workers, thereby improving overall quality of care. The other options pertain to different aspects of healthcare management. For instance, case management aims to coordinate patient care, ensuring that patients receive the appropriate services efficiently. Risk management focuses on identifying, assessing, and mitigating risks that could harm patients or the organization. Utilization management refers to evaluating the appropriateness and necessity of healthcare services, aiming to optimize resource use and ensure quality outcomes. While these processes contribute to patient safety and care quality, they do not specifically address the infection prevention and control focus outlined in the question.

3. How is healthcare fraud defined?

A. Incorrect billing for services rendered

B. Misrepresentation that results in unauthorized benefits

C. Billing for unnecessary services

D. Failure to obtain patient consent

Healthcare fraud is defined as misrepresentation that results in unauthorized benefits. This means that fraud occurs when individuals or entities deliberately provide false information or manipulate the truth to gain benefits to which they are not entitled. The essence of fraud is the intention to deceive, leading to financial or other personal gains at the expense of the healthcare system or patients. In this context, misrepresentation can encompass a wide range of actions, such as falsifying patient records or billing for services that were not actually provided, with the intended goal of receiving payment or benefits based on misinformation. This definition captures the broader spectrum of fraudulent activities beyond just billing issues, emphasizing the deceptive element that underlies healthcare fraud. Other choices may touch upon specific dishonest practices related to billing or treatment but do not fully encompass the broader definition of fraud that involves manipulation and intention to deceive for unauthorized benefits. For instance, incorrect billing or billing for unnecessary services are actions that may happen within the scope of fraud but do not capture the full concept of misrepresentation and its implications. Similarly, failure to obtain patient consent pertains more to ethical and legal obligations rather than the fraudulent aspect defined in this context.

4. Which of the following actions is an example of healthcare fraud?

A. Billing for services actually rendered

B. Refiling claims after they are denied

C. Billing for services not furnished to patients

D. Using a claim scrubber before submission

Billing for services not furnished to patients is a clear example of healthcare fraud because it involves intentionally deceiving a payer for financial gain. This type of fraudulent activity creates a false record of care that was never provided, which both violates ethical standards and legal regulations. It undermines the trust in the healthcare system and can lead to significant financial and legal repercussions for the provider engaged in such deceitful practices. In contrast, billing for services actually rendered is a standard and lawful practice, ensuring that providers receive payment for the actual care they deliver. Refiling claims after they are denied is a typical administrative action taken by providers to ensure they are fairly compensated for services rendered; this does not constitute fraud if done in compliance with regulations. Using a claim scrubber before submission is a quality control measure aimed at reducing errors in billing and does not pertain to fraudulent activity. Thus, these actions differ significantly from the fraudulent behavior represented by billing for services that were never provided.

5. What is required of covered entities under the Breach Notification Rule?

A. Notify affected individuals when a breach occurs

B. Provide a new notice of privacy practices to all patients

C. Create a new health record number for each patient

D. Assign a privacy officer for breach management

The requirement for covered entities under the Breach Notification Rule is to notify affected individuals when a breach of their protected health information (PHI) occurs. This rule, established under the Health Insurance Portability and Accountability Act (HIPAA), mandates that if a breach affects 500 or more individuals, the covered entity must notify the affected individuals promptly, as well as notify the Secretary of Health and Human Services and the media in certain cases. This process is designed to ensure that individuals are aware of potential risks to their privacy and security and can take necessary actions to protect themselves. The other options involve actions that are not mandated under the Breach Notification Rule. Providing a new notice of privacy practices to all patients is not a requirement specific to breaches, nor is creating a new health record number for each patient related to breach notifications. While having a privacy officer is a best practice for compliance, it is not specifically required by the Breach Notification Rule itself.

6. In an internal coding audit review program, which risk area is prioritized for auditing?

A. Admission diagnosis and complaints

B. Chargemaster description and medical necessity

C. Clinical laboratory results

D. Radiology orders

The prioritization of the Chargemaster description and medical necessity in an internal coding audit review program is significant because it directly impacts the financial and compliance aspects of healthcare facilities. The Chargemaster serves as the comprehensive listing of items billable to a hospital or healthcare facility. A well-maintained Chargemaster ensures that services are accurately coded and billed according to regulations. Auditing the Chargemaster helps identify discrepancies between what services were provided (and documented) versus what is being billed, which is crucial for compliance with reimbursement regulations. Medical necessity is also critical, as services provided must be justified as necessary for patient care according to established clinical guidelines. If claims fail to reflect medical necessity, healthcare providers risk denials from payers and potential legal consequences for fraudulent billing. Focusing on this area for audits helps organizations minimize financial risk, improve billing accuracy, and comply with healthcare regulations, thereby protecting their revenue cycle. This systematic approach to auditing supports the integrity of financial operations while safeguarding against compliance issues.

7. What is the minimum duration for which HIPAA requires data security policies and procedures to be maintained?

A. 3 years from date of creation

B. 5 years from date of creation

C. 5 years from date of creation or the last date in effect

D. 6 years from date of creation or the last date in effect

The correct choice is that HIPAA requires data security policies and procedures to be maintained for a minimum duration of six years from the date of creation or the last date in effect. This requirement ensures that organizations have a comprehensive record of their data security practices, which is essential for compliance and for conducting audits. Maintaining these records for six years helps ensure that covered entities and business associates can demonstrate adherence to HIPAA's privacy and security requirements over an extended period. This duration is significant as it aligns with the broader aim of HIPAA to protect patient information and reinforces the importance of having robust security measures in place. It serves as a safeguard for both patients and healthcare entities, ensuring that there is a clear historical record of policies that were in effect, which can be crucial during investigations or compliance reviews.

8. What is considered unsecured PHI?

A. PHI that is encrypted

B. PHI that is unintelligible to unauthorized persons

C. PHI without any protective measures

D. PHI that is stored securely

Unsecured Protected Health Information (PHI) refers to any health information that is not adequately protected against unauthorized access, use, or disclosure. The correct answer highlights that PHI without any protective measures is considered unsecured because it is vulnerable to breaches and unauthorized access. For instance, if PHI is simply stored in a plain text file without any encryption, password protection, or other safeguards, it is easily accessible to anyone who might gain access to it. This lack of security measures makes it unsecured, as required by health information privacy regulations. In contrast, PHI that is encrypted, is unintelligible to unauthorized persons, or is stored securely has protective mechanisms in place that render it secure. Encryption scrambles data, making it unreadable to those without the appropriate decryption key, while unintelligibility implies that the data cannot be understood without certain authorization. Therefore, those options do not meet the criteria for unsecured PHI.

9. What risk is associated with copying and pasting patient documentation in electronic health records?

A. Reduction in the time required to document

B. System may not save data

C. Copying the note in the wrong patient's record

D. System thinking the information belongs to the original patient

Copying and pasting patient documentation in electronic health records poses a significant risk, particularly the potential for copying a note into the wrong patient's record. This issue arises because clinical information can easily become disassociated from the correct patient, particularly if identifiers are not carefully checked. When notes are copied from one patient to another without context, it can lead to confusion about which patient the information actually pertains to. This practice can result in medical errors, where a healthcare provider may make clinical decisions based on inaccurate or irrelevant information. Misattribution of health information can compromise patient safety, as treatment may be based on an incorrect understanding of a patient's medical history or current condition. This risk emphasizes the importance of ensuring that all documentation is accurate and relevant to the specific patient being treated, thereby maintaining the integrity of health records and improving patient care. While the other options highlight concerns related to efficiency and system functionality, they don't directly address the critical issue of patient safety and accuracy in documentation that arises with the misuse of copy-paste functions in electronic health records.

10. What term describes the overutilization or inappropriate utilization of services and misuse of resources, typically not a criminal act?

A. Fraud

B. Abuse

C. Waste

D. Audit

The term that describes the overutilization or inappropriate utilization of services and misuse of resources, which is typically not a criminal act, is best defined as waste. Waste refers to the inefficient use of resources where services or supplies are used in ways that do not add value to patient care or could be eliminated without affecting health outcomes. Though waste may lead to higher healthcare costs, it is not characterized by intentional wrongdoing. This distinction is particularly important in healthcare compliance and financial management. Understanding waste allows healthcare organizations to identify areas for improvement that can enhance efficiency and reduce unnecessary expenditures. It differs from abuse, which may involve practices that are improper or excessive but could still be within legal boundaries, like billing for services that are not medically necessary or for higher-level services than what was provided.

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://rhitdomain5.examzify.com

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