Certified Healthcare Internal Audit Professional®
Sample Questions - Answer Key

1.) Which of the following departments would be considered an ancillary service at an acute care hospital?

a. Sleep Lab Services
b. Telehealth
c. Nutritional Counseling
d. Medical staff services

Correct Answer: A

Rationale:
A- **Sleep Lab Services are an ancillary service**.
B- Telehealth is a delivery format of services.
C- Nutritional Counseling is a support service.
D- Medical staff services are support services.

BOK Category: 1A2: Business Aspects of Care Setting/Core Care Settings/ Acute Care Hospitals
Cognitive Level: Recall

2.) An auditor is testing Emergency Room wait times. Wait times have increased from 1-2 hours to 10 hours over the last year. Which of the following is most likely a reason for increased wait times?

a. The hospital has had trouble in recruiting speech therapists.
b. The Pharmacy is behind in mixing Total Parenteral Nutritional (TPN) orders
c. Late meal delivery from Food Services
d. Shortage of triage nurses

Correct Answer: D

Rationale:
A- Speech therapy is not likely to be delivered in an ER setting.
B- Total Parenteral Nutritional (TPN) orders are not likely to be delivered in an ER setting.
C- Meal delivery is a support service and patients are not likely to receive meals in the ER.
D- The role of the triage nurse is critical for patient throughput.

BOK Category: 1A2: Business Aspects of Care Setting/Core Care Settings/ Acute Care Hospitals
Cognitive Level: Analysis

3.) An auditor works for a large not-for-profit hospital, struggling to raise capital. In order to gain access to more capital funds, which of the following would be a reasonable solution:

a. Issuing common or preferred stock
b. Seek private investors
c. Negotiating a joint venture with another affiliated partner
d. Building a hotel as another revenue source

Correct Answer: C

Rationale:
A- Common or preferred stock cannot be issued by a not-for-profit hospital.
B- Only a for-profit organization can seek private investors.
C- A joint venture with an affiliated partner can allow access to capital funds.
D- A struggling hospital would be unlikely to build a hotel. This would be a luxury.

BOK Category: 4A7: Core Business Functions/Operational/Financial/Joint Ventures
Cognitive Level: Application

4.) A hospital is sponsoring a dance marathon which results in significant cash donations. The dancers and the event are staffed with volunteers. Which would be a significant risk regarding those donations?

a. The hospital is not fully compliant with Payment Card Industry (PCI) standards.
b. The bank makes an error due to the volume of small donations.
c. Cash donations might be skimmed from the till.
d. Dancing participants become workers compensation risks.

Correct Answer: C

Rationale:
A- PCI Standards are not applicable for cash donations.
B- Bank errors are not a significant risk.
C- Whenever cash is involved there is an increased risk of theft or fraud.
D- Dancers would not qualify for worker compensation.

BOK Category: 4A5: Core Business Functions/Operational/Financial/Cash Management
Cognitive Level: Application

5.) The auditor works for a hospital and is conducting an audit to review the controls in the Supply Chain function. Which would be considered a significant segregation of duties conflict in the Materials Management/Supply Chain process?

a. Large dollar requisitions are only approved 50% of the time
b. The Radiology Department only has one clerical employee who can order and receive supplies.
c. The clerk who posts cash payments also takes the deposit to the bank.
d. Buyers cannot receive on their purchases orders but have receiving functionality.

Correct Answer: B

Rationale:

A- This would be a significant control risk, but not a segregation of duties issue.
B- Ordering and receiving is a segregation of duties issue.
C- This could be a conflict, but not in Materials Management/Supply Chain.
D- If a buyer cannot receive on their own PO, it is not a significant concern.

BOK Category: 4A3: Core Business Functions/Operational/Financial/Materials Management
Cognitive Level: Analysis

6.) An auditor is testing for proper recording of expenses at fiscal year-end. The auditor is reviewing payroll, medical supplies, and drug costs. Which of the following scenarios could result in the understatement of drug costs:

a. Three employees have been quarantined for two weeks and did not turn in timesheets.
b. Accounts Payable did not pay a large invoice timely.
c. Pharmacy personnel did not enter the receipt for the last delivery of the month.
d. A large credit received in the month was not applied until the following month.

Correct Answer: C

Rationale:

A- This scenario would be an understatement of salary costs.
B- The timing of the payment may impact drug costs. If late fees were charged it could result in an increase of drug costs.
C- If the receipt was not entered it would not have been properly recorded, which would result in an understatement of drug costs.
D- This would result in increased drug costs.

BOK Category: 4A8: Core Business Functions/Operational/Financial/Finance/Accounting
Cognitive Level: Analysis

7.) An auditor is completing a dashboard review. Which of the following would help the auditor evaluate the patient access function?

a. Daily patient census
b. Financial profitability
c. Denials based on patient demographics
d. Month to date ER visits

Correct Answer: C

Rationale:

A- The daily patient census would not appear on patient access dashboard. It would be on a financial dashboard.
B- Financial profitability would not appear on patient access dashboard. It would be on a financial dashboard.
C- Entering patient demographics is a function of patient access and denials would reflect the accuracy.

D- Denials based on patient demographics would not appear on patient access dashboard. It would be on an ER dashboard.

BOK Category: 2C3: Revenue Cycle/Health Care Provider Revenue Cycle Elements/Registration/Patient Access
Cognitive Level: Recall

8.) In a large healthcare system, which function is typically part of Payroll?

a. Addressing documentation regarding workers compensation for remote employee's states
b. Supporting the back end of the payroll application
c. Recovering incentive payments for employees who terminated before fulfilling their obligations
d. Processing voluntary deductions and garnishments

Correct Answer: D

Rationale:
A- This is part of risk management, not payroll.
B- This is part of information technology, not payroll.
C- This is part of Human Resources or Finance, not payroll.
D- Payroll is responsible for processing employee earnings, voluntary deductions, and garnishments.

BOK Category: 4A1: Core Business Function/Operation/Financial/Payroll
Cognitive Level: Recall

9.) Which of the following is typically referenced in a Business Continuity Plan?

a. Joint Commission Study
b. Community Health Needs Assessment
c. Diversity and Inclusion Goals
d. Hazard and Vulnerability Assessment

Correct Answer: D

Rationale:
A- Joint Commission Study is not part of a Business Continuity Plan.
B- Community Health Needs Assessment is typically not referenced in a Business Continuity Plan.
C- Diversity and Inclusion Goals are not part of a Business Continuity Plan.
D- Hazard and Vulnerability is referenced or part of the plan

BOK Category: 4A10: Core Business Functions/Operational/Financial/Business Continuity
Cognitive Level: Recall

10.) Which of these emerging revenue cycle system challenges most impacts a health system's profitability?

a. New consumer debt rules
b. Price transparency
c. Back-end revenue cycle management
d. High patient financial responsibility

Correct Answer: D

Rationale:
A- New consumer debt rules impact the collections process but not necessarily profitability.
B- Fines can be accessed related to price transparency, but it does not have the most impact on profitability.
C- Emerging revenue cycle management challenges involve improving the patient experience by focusing on front-end processes to solve revenue cycle management issues rather than waiting for them on the back end.
D- High patient financial responsibility can impact a health system's profitability.

BOK Category: 4B2: Core Business Function/Information Technology/Revenue Cycle Systems
Cognitive Level: Application

11.) Medicare Part D is what type of insurance?

a. A Medicare Advantage program managed by private insurers
b. Hospital coverage available to all Medicare Beneficiaries
c. Prescription drug coverage available to all Medicare Beneficiaries
d. Physician coverage requiring monthly premiums

Correct Answer: C

Rationale:
A- Medicare Advantage plans are offered by private insurance companies contracted with Medicare to provide program benefits.
B- Long-Term Care Hospital stays count towards the beneficiary's Part A inpatient hospital stay allotment per benefit period.
C- Medicare Part D is a prescription drug coverage program available to all Medicare beneficiaries. Private companies approved by Medicare provide the coverage.
D- A premium is an agreed upon fee paid for coverage of medical care benefits for a defined period of time (usually 1 year).

BOK Category: 2B1: Revenue Cycle/Health Care Provider Reimbursement/Medicare
Cognitive Level: Recall

12.) The patient was seen by a specialist and the nurse was asked to provide information such as name, date of birth, medical history specially blood test results to their primary care physician. What must the nurse verify before sending a fax to the primary care physician?

a. Physician Name and Office Location
b. Physician National Provider Identifier (NPI)
c. Provider Tax Identification Number (TIN) and Phone
d. Physician Medicare Number and Date of Birth

Correct Answer: A

Rationale:

A- The physician name and office location must both be verified in order to prevent improper disclosure under HIPAA privacy rules.
B- The Physician National Provider Identifier (NPI) does not guarantee sending and disclosing to the proper physician.
C- The Provider Tax Identification Number (TIN) is not information needed to verify disclosure to the proper physician.
D- The Physician Medicare Number and Date of Birth does not guarantee sending and disclosing to the proper physician.

BOK Category: 3B1: Regulatory Environment/ Regulations/ HIPAA
Cognitive Level: Application

13.) An auditor has been assigned to conduct an IT security review. Which of the following would the auditor expect to find in the organization's IT security policy?

a. Vision statement
b. Industry Regulations
c. Data Analytics
d. IT Support Staff

Correct Answer: B

Rationale:

A- A vision statement is a statement or short paragraph that outlines an organization's goals or aspirations. This would be a stand-along statement, not part of a company's IT-specific security
B- Applicable industry regulations should be included in an organization's security policy, especially f regulations deal with the use of how data is handled, such as healthcare or personal records
C- Data analysis focuses on the manipulation of large data sets from which insight can be drawn. This process is not part of the IT security policy
D- IT support staff are employees who help maintain an IT environment after it has been designed and implemented

BOK Category: 4B4: Core Business Functions/Information Technology/Cybersecurity
Cognitive Level: Application

14.) Which of the following statements is correct regarding information technology (IT) governance?

a. A primary goal of IT governance is to align with organizational objectives
b. IT governance is an appropriate issue for organizations at the level of the board of directors only

c. IT goals should be independent of strategic goals
d. IT governance requires that the Control Objectives for Information and related Technology (COBIT) framework be adopted and implemented

Correct Answer: A

Rationale:

A- An organization with its strategic goals tied to IT governance practices will be able to reach its objectives more effectively. Therefore, companies often formally adopt certain aspects of IT governance into their vision and mission. A primary goal of IT governance is aligning policies and practices with organizational objectives.

B- IT governance is an issue for all levels of the organization, including the board of directors, executive and senior level management, mid-level management, IT steering committees, IT staff, etc.

C- Strategic alignment refers to the linkage between business and IT planning, which implies that IT goals should be very aligned with overall strategic goals for the organization

D- COBIT is a best practice framework rather than a requirement that must be in place in order to implement and IT governance structure.

BOK Category: 4B3: Core Business Functions/Information Technology/Information Governance
Cognitive Level: Analysis

15.) Which of the following is the responsibility of an information technology (IT) steering committee?

a. An IT steering committee plan shows how a project will be completed, including the modules or tasks to be performed and who will perform them, the dates they should be completed, and projects costs
b. An IT steering committee must develop clear specifications. Before third parties bid on a project, clear specifications must be developed, including exact descriptions and definitions of the system, explicit deadlines, and precise acceptance criteria
c. An IT steering committee must assess the operations of IT using system performance measurements. Common measurement include throughput (output per unit of time), utilization (percentage of time the system is being productively used), and response time (how long it takes the system to respond)
d. An IT Steering committee is a committee of senior executives to direct, review, and approve IT strategic plans, oversee major initiatives, and allocate resources.

Correct Answer: D

Rationale:

A- IT project planning and monitoring is the responsibility of the committee or group charged with project controls

B- Development of specifications and acceptance criteria is the responsibility of the committee or group charged with post implementation review

C- Evaluating IT performance using system performance measurements is the responsibility of managers involved in IT operations, not the direct responsibility of the information technology steering committee.

D- A steering committee has broad objectives that include the oversight of systems development and acquisition after an assessment of data processing needs An IT Steering committee is a committee of senior executives to direct, review, and approve IT strategic plans, oversee major initiatives, and allocate resources.

BOK Category: 4BC: Core Business Functions/Information Technology/ Information Governance

Cognitive Level: Analysis

16.) The Enterprise Risk Management (ERM) - Integrated Framework of the Committee of Sponsoring Organizations (COSO) is best defined as:

a. A process which replaces the COSO internal control framework.
b. The culture, capabilities, and practices, integrated with strategy-setting and performance, that organizations rely on to manage risk in creating, preserving, and realizing value.
c. A process which applies a control-based approach to an organization.
d. A serial process in which one component affects only the next component.

Correct Answer: B

Rationale:
A- The COSO internal control framework assists organizations in developing assessments for internal controls effectiveness. This is separate from enterprise risk management, which is used for developing a response to risk management.
B- The verbatim definition provided by COSO for enterprise risk management (ERM) is that it" is the culture, capabilities, and practices, integrated with strategy-setting and performance, that organizations rely on to manage risk in creating, preserving, and realizing value." The culture, capabilities, and practices, integrated with strategy-setting and performance, that organization rely on to manage risk in creating, preserving, and realizing value.
C- takes a risk-based approach to an organization.
D- ERM is comprehensive, in that one component affects many other components of an organization.

BOK Category: 4D2: Core Business Functions/Administrative Functions/ Enterprise Risk Management (ERM)
Cognitive Level: Recall

17.) An auditor is performing a walkthrough of a patient first facility. Which of the following is a preventive supervisory and monitoring control?

a. Conducting performance reviews
b. Requiring mandatory vacations
c. Performing audits
d. Providing hiring guidelines

Correct Answer: D

Rationale:
A- Control is a detective supervisory and monitoring control because it's done after the performance.
B- Control is a detective supervisory and monitoring control because it will identify potential errors or fraud in the absence of the employee.
C- Control is a detective supervisory and monitoring control because it will identify any control gaps.
D- Hiring guidelines are considered a preventative supervisory and monitoring control. Organizations develop strict hiring guidelines so that only competent and capable employees are hired to perform key business processes.

BOK Category: 4D1: Core Business Functions/Administrative Functions/Risk Management
Cognitive Level: Application

18.) A whistleblower reported via a government hotline that two nurses at your hospital were diverting oxycodone for personal use. An internal review showed controls were not operating effectively. What governmental agency is most likely to do an investigation and assess fines?

a. Center for Medicare and Medicaid Services (CMS)
b. Drug Enforcement Agency (DEA)
c. Office of Civil Rights (OCR)
d. The Joint Commission (TJC)

Correct Answer: B

Rationale:
A- CMS normally investigates healthcare fraud; however, they would likely delegate to the DEA since the situation deals with controlled substances.
B- The DEA investigates controlled substance situations.
C- The OCR investigates HIPAA violations among others.
D- The Joint Commission would ask about any investigations but would not level any fines nor do an investigation.

BOK Category: 3A4: Regulatory Environment/Regulatory Bodies/DEA
Cognitive Level: Analysis

19.) Your hospital just had the closing conference of its Joint Commission inspection with no significant deficiencies. As a result, which of the following would be a likely scenario? The Joint Commission will schedule:

a. its next inspection in four years at the closing conference.
b. Receive a one-year moratorium on tracking data values for Joint Commission Measures.
c. Since there were no deficiencies receive the certification at the closing conference.
d. State regulators will accept the Joint Commission's certification and not do an inspection of their own.

Correct Answer: D

Rationale:
A- The next inspection would be due in three years and would not be scheduled at that time.
B- Organizations are required to provide quarterly data.
C- IT typical takes 2 weeks to 2 months to get the JCAHO certification.
D- State healthcare agencies respect the JCHAO inspection and not perform one of their own.

BOK Category: 3A6: Regulatory Environment/Regulatory Bodies/The Joint Commission
Cognitive Level: Application

20.) A healthcare organization is required to perform a Community Health Needs Assessment (CHNA) by which of the following:

a. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
b. CMS Conditions of Payment
c. Section 501(r)(3) of the IRS Code
d. Stark and Anti-Kickback rules

Correct Answer: C

Rationale:
A- HIPAA applies to all hospitals and requires a risk assessment, but not a CHNA.
B- A Community Health Needs Assessment (CHNA) is not required to participate in Medicare/Medicaid.
C- This tax code requires the community needs assessment to make sure that the organization is providing services to the community to maintain their non-exempt status.
D- Stark and Anti-Kickback rules relate to the relationships between physicians and hospitals or vendors. They do not require a CHNA.

BOK Category: 3B9: Regulatory Environment/Regulations/IRS Regulation 501(r)
Cognitive Level: Application

21.) Qai tam lawsuits are typically filed under:

a. Physician Payment Sunshine Act
b. Stark and Anti-Kickback rules
c. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
d. The False Claims Act

Correct Answer: D

Rationale:
A- The Physician Payment Sunshine Act is a healthcare law to increase transparency of financial relationships between health care providers and pharmaceutical manufacturers.
B- The Stark law prohibits physicians from referring patients to receive certain designated health services (DHS) payable by Medicare from entities with which the physician or an immediate family member has a financial relationship unless an exception applies.
C- HIPAA is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.
D- Qai Tam lawsuits are a type of whistleblower lawsuit that is under the False Claim Act.

BOK Category: 3B3: Regulatory Environment/ Regulations/False Claims Act
Cognitive Level: Recall

22.) An auditor is performing an audit of the hospital's freestanding Emergency Rooms (FSER). Which of the following would be most concerning to the auditor?

a. Different prices are charged for Level IV ER visits between the FSER and the hospital.
b. The FSER is not within 10 miles from the hospital.
c. A Medicare patient transferred from the FSER to the hospital was billed for the FSER copayment and inpatient deductible.
d. A commercial patient gets two separate bills for the physician and FSER charges.

Correct Answer: C

Rationale:
A- Hospitals and FSERs can charge different prices, as there would be different cost structures.
B- FSERs are not required to be within a specified proximity to the hospital.
C- If a Medicare patient is admitted there is no co-pay for the FSER.
D- Physician charges are often billed separately from the ER bill.

BOK Category: 1B4: Business Aspects of Care Setting/Other Care Settings/Freestanding Emergency Departments
Cognitive Level: Application

23.) An auditor is testing the reimbursement of a Hospital's Medicare Advantage (MA) Program. Which of the following would be most useful in determining if the hospital is being reimbursed properly?

a. The hospital's most recent cost report.
b. The latest CMS regulations in the Federal Register.
c. Current Medicare Physician Fee Schedule Final Rule.
d. The commercial third party's Medicare Advantage contract.

Correct Answer: D

Rationale:
A- The cost report provides Medicare settlement and financial statement data and is separate from a MA plan contract which acts like a commercial insurance plan.
B- The Federal Register discloses the Medicare rates.
C- This final rule would not list a hospital's reimbursement.
D- The MA plan's contract would have the negotiated rates for reimbursement.

BOK Category: 2B3: Revenue Cycle/Health Care Provider Reimbursement/Advantage Programs
Cognitive Level: Application

24.) An auditor is performing an audit of an ambulatory surgical center (ASC). Which of the following would warrant additional follow-up by the auditor?

a. Anesthesia services are billed separately from the “packaged” service.
b. Pacemaker insertion is covered as part of the ASC charge.
c. The ASC uses a combination of physician and hospital billing, employing CPT and HCPCS codes.
d. Medicare ASC billing is done electronically using the UB92 bill format.

Correct Answer: D

Rationale:

A- Anesthesia services are billed separately for ASCs.
B- Pacemakers are not billed separately.
C- Both CPT and HCPCS codes are used in billing ASC charges.
D- Medicare ASC billing is billed on the CMS form 1500.

BOK Category: 2C8: Revenue Cycle/HealthCare Provider Revenue Cycle Elements/Billing
Cognitive Level: Application

25.) Which of the following would a hospital's Patient and Financial Services track as a key performance indicator (KPI) that the department's coding is performed timely?

a. Monthly administrative write-offs.
b. Discharged but not final billed charges.
c. Patient refunds are paid within 30 days.
d. Quarterly quality coding audits by an independent third party.

Correct Answer: B

Rationale:

A- Monthly admin write-offs are unrelated to performing coding timely.
B- Discharge but not final billed charges are a KPI for billing timeliness as the patients have been discharged and are awaiting coding/review to be billed.
C- Patient refunds are unrelated to coding.
D- Quality coding audits are unrelated to discharged not final billed.

BOK Category: 2D7: Revenue Cycle/HealthCare Provider Revenue Deductions/Key Performance Indicators
Cognitive Level: Analysis

26.) An auditor is testing revenue charge capture as it relates to hospital reimbursement. In which of the following reimbursement type contracts is revenue charge capture most critical to reimbursement?

a. Value-based reimbursement
b. Bundled payments
c. Shared savings
d. Discount from billed discharges

Correct Answer: D

Rationale:

A- Under a value-based reimbursement contract, providers are compensated under a fee-for-service model with a quality and efficiency component.
B- With bundled payments, healthcare providers are reimbursed for specific episodes of care.
C- Shared savings provides upside and lowers risk for providers to improve the coordination of care.

D- In a discount from billed charges contract, a missed charge would result in direct loss of reimbursement.

BOK Category: 2C5: Revenue Cycle/HealthCare Provider Revenue Cycle Elements/Charge Capture
Cognitive Level: Application

27.) Which of the following healthcare related governmental entities does the Centers for Medicare and Medicaid Services (CMS) have jurisdiction over?

a. The Affordable Care Act
b. Drug Enforcement Agency
c. National Institute of Health
d. The Federal Drug Administration

Correct Answer: A

Rationale:
A- CMS oversees the Affordable Care Act.
B- CMS does not have jurisdiction.
C- CMS does not have jurisdiction.
D- CMS does not have jurisdiction.

BOK Category: 3A1: Regulatory Environment/Regulatory Bodies/CMS
Cognitive Level: Recall

28.) An auditor is reviewing the hospital's physicians' payments received from equipment and drug manufactures under the Physician Payments Sunshine Act (PPSA) on the Centers for Medicare and Medicaid Services (CMS) website. Which scenario is the most concerning?

a. Physicians receiving payments under the False Claims Act.
b. CMS Conditions of Payment are met.
c. Physicians not performing at least 10% of services for patients receiving services under the Affordable Care Act.
d. A physician received a $500 honorarium from a manufacturer for speaking at a medical conference.

Correct Answer: D

Rationale:
A- The False Claims Act does not involve payments to physicians. The False Claim Act is a federal law that makes it a crime for any person or organization to knowingly make a false record or file a false claim regarding any federal health care program.
B- The CMS Conditions of Payment do not involve payments to physicians. A condition of payment is a rule, regulation, or requirement that must be met in order for a healthcare provider to lawfully request and receive reimbursement from a federal healthcare coverage provider (e.g., Medicare, Medicaid, or TRICARE).
C- Physicians are not required to provide any percentage of their services to ACA patients.
D- Payments made to physicians by manufactures could bias physicians' care decisions.

BOK Category: 3B7: Regulatory Environment/Regulations/Physician Payment Sunshine Act
Cognitive Level: Analysis

29.) A patient learns that their healthcare provider shared their protected health information with their family member when they had not given consent for their information to be shared. Which agency should the patient contact with their complaint?

a. Centers for Medicare and Medicaid Services (CMS)
b. Department of Health and Human Services' Office for Civil Rights (OCR)
c. Food and Drug Administration (FDA)
d. The Joint Commission

Correct Answer: B

Rationale:

A - While CMS has administrative responsibilities for HIPAA, OCR is the agency that investigates complaints.

B - Sharing protected health information with unauthorized individuals represents a HIPAA violation and OCR is the agency responsible for investigating HIPAA complaints.

C - HIPAA does not fall under the FDA jurisdiction.

D - HIPAA does not fall under the Joint Commission jurisdiction.

BOK Category: 3A3: Regulatory Environment: Regulatory Bodies: OCR
Cognitive Level: Application

30.) A potential new hire has a name that appears to be on the Office of Inspector General's (OIG) Exclusion list. What should the hiring organization do before moving forward with onboarding?

a. Run a criminal background check.
b. Immediately rescind the job offer.
c. Contact the organization's legal department.
d. Verify exclusion status using Social Security number.

Correct Answer: D

Rationale:
A - While criminal background checks are a common step in hiring, they are a separate process from OIG Exclusion checks.
B - Just because the name matches does not mean that the job candidate is the excluded individual. There is no need to rescind the offer until it is proven via SSN that the candidate actually is the same individual that is excluded. The organization may continue with hiring if SSN shows that the candidate is not excluded.
C - Exclusion status should be verified via SSN before taking any additional actions.
D - OIG's Tips page states "Always remember to take the final step of identity verification using the Social Security Number (SSN) for an individual or Employer Identification Number (EIN) for an entity. It is not sufficient to simply find a matching name on the LEIE." The candidate's Social Security number will verify if they truly are the excluded individual or not.

BOK Category: 3A2: Regulatory Environment: Regulatory Bodies: OIG
Cognitive Level: Application

31.) The auditor for a Medicare Advantage-Prescription Drug Plan is conducting a Program Integrity audit. Which of the situations below would the Centers for Medicare and Medicaid Services (CMS) consider as potential fraud indicator?

a. The provider submitted unbundled codes when billing for a procedure.
b. The provider ordered unnecessary lab tests for beneficiary bloodwork.
c. The provider billed the plan for an appointment that the beneficiary did not keep.
d. The provider sent beneficiary information to the plan via an unsecured email.

Correct Answer: C

Rationale:

A - This is an example of abuse.

B - This is an example of waste.

C - Fraud requires deliberate intent to obtain payments under false pretenses. This is potentially fraud as it demonstrates that the provider may have knowingly billed for services they did not provide since the patient did not keep the appointment. The plan should investigate further and take additional action, such as reporting the fraud to regulators and recouping payments, if this is confirmed to be fraud.

D - This is a privacy and security concern, and the provider should be educated to send information securely, but it does not represent a Fraud Waste and Abuse concern.

BOK Category: 3A1: Regulatory Environment: Regulatory Bodies: CMS
Cognitive Level: Application

32.) Mary is a non-exempt hospital employee. She goes to the breakroom to take her 30-minute lunch break and she does not have to clock out since her company's timekeeping system utilizes an auto-deduct feature. While on break, her supervisor stops in and asks questions about a patient for over 10 minutes. How should Mary's timecard reflect this lunchbreak?

a. 10 minutes as time worked and 20 minutes as time off.
b. 30 minutes as time worked, since she was interrupted during her break.
c. 30 minutes as time off, since the company utilizes auto-deduct.
d. 30 minutes as time off, since Mary was in the lunchroom for the full 30 minutes and did not have to return to her station.

Correct Answer: B

Rationale:

A - Break was interrupted, therefore, is considered a short break (5-20 minutes) and is compensable time worked.

B - Interrupted meal breaks are fully compensable.

C - Auto-deduct does not constitute regulatory compliance.

D - An employee is not relieved if he or she is required to perform any duties, whether active or inactive, while on the meal break.

BOK Category: 4A1: Core Business Functions: Operational/Financial: Payroll
Cognitive Level: Application

33.) An auditor wants to validate the propriety of travel expenses for an employee and is reviewing a department's P-card transactions. While examining the receipts, the auditor identifies entertainment expenses for several out-of-town dinners. The attendees, business purpose and business relationship are documented, and the expense was approved by the employee's manager. What is the next best step for this auditor?

a. Conclude the expense is inappropriate since there is no way to validate that the attendees were at the dinner as listed on the receipt.
b. Conclude the expense was appropriate and properly documented, since the receipts were complete, and expenses were approved.
c. Review other transactions for this P-card to determine if there are red flags with any other transactions before concluding.
d. Review the employee's travel expense reports to see if these dinner expenses were submitted for reimbursement.

Correct Answer: D

Rationale:

A - Documentation meets the IRS documentation for entertainment expenses so it may be appropriate.

B - While the documentation was complete, there is a risk of double expense reimbursement.

C - Fraud may still have occurred, even if all other transactions are appropriate.

D – Reviewing both the receipts and travel expense report validates that double dipping of expenses has not occurred and expense reimbursement is appropriate.

BOK Category: 4A2: Core Business Functions: Operational/Financial: Procurement
Cognitive Level: Analysis

34.) An auditor is performing a review of controlled substances and has documented the process flow and reviewed drug record documentation. Which of the following would the auditor deem as a potential issue?

a. Documentation of the sole individual who wasted the drug is present on the drug record.
b. Controlled substance waste is returned to the pharmacy from patient care areas.
c. A reverse distributor is used for returns and recalls.
d. Orders received are documented with a date and signed by both witnesses, but only one of the receivers is a licensed pharmacist.

Correct Answer: A

Rationale:
A - A witness is required and should be documented for wasting of all controlled substances
B - Appropriate control
C - Appropriate control
D - Appropriate control

BOK Category: 4A3: Core Business Functions: Informational/Financial: Materials Management
Cognitive Level: Application

35.) An auditor has been asked to inventory risk management efforts made by their organization. Which of the following efforts undertaken by the organization would be included on the list?

a. A strategic planning session by leadership to identify future growth opportunities.
b. The hiring of external auditors to ensure financial statements are presented in accordance with GAAP.
c. The hiring of a new Chief Operating Officer who is experienced in healthcare.
d. The implementation of a robust cybersecurity system to protect PHI.

Correct Answer: D

Rationale:

A - Strategic planning is not risk management.

B - Auditing is not risk management.

C - A leader is not risk management.

D - Risk management for healthcare entities can be defined as an organized effort to identify, assess, and reduce, where appropriate, risk to patients, visitors, staff, and organizational assets.

BOK Category: 4D1: Core Business Functions: Administrative Functions: Risk Management
Cognitive Level: Application

36.) A CAE has been asked for their Internal Audit group to be involved in the entity's Enterprise Risk Management (ERM) program. How should they respond?

a. The Internal Audit function should not be involved, since this impairs independence of the audit function.
b. Internal Audit should not be involved, since their detailed knowledge of the entity may unfairly impact risk rankings and results.
c. Internal Audit should be involved, since day-to-day risk management and risk mitigation is their responsibility.
d. Internal Audit should be involved, since they are in a position to support ERM efforts and may gain important information for their audit plan.

Correct Answer: D

Rationale:

A - The internal audit function is uniquely positioned to support ERM efforts, help design the framework and facilitate the process.

B - Internal Audit's contribution is a valuable resource, not an unfair advantage.

C - Front line leaders are responsible for day-to-day risk management. While Internal Audit can add value, they should not own the process as they are responsible for evaluating an organization's risk management processes.

D - Internal Audit can leverage and share its expertise in risk management, educate on ERM and facilitate discussions with common language, templates, tools, and frameworks.

BOK Category: 4D2: Core Business Functions: Administrative Functions:
Cognitive Level: Application

37.) A healthcare organization wants to strengthen its culture of safety. What is one of the most effective ways for this organization to measure and evaluate its culture and commitment to patient safety?

a. Conduct surveys
b. Review placement in national rankings of hospitals
c. Review volumes of letters and emails received from patients
d. Assess employee retention

Correct Answer: A

Rationale:

A - One of the most effective ways for an organization to evaluate and measure the culture and commitment to patient safety is to conduct surveys. Surveys can help management identify strengths, trends and provide benchmark data.

B - These rankings are an external assessment of many factors beyond its culture of safety including staff and patient satisfaction, innovation, etc. and are not the most effective method for measurement.

C - The volume of patient comments may not directly demonstrate an organization's commitment to a culture of safety and is not the most effective method for measurement.

D - Employee retention may not directly demonstrate an organization's commitment to a culture of safety and is not the most effective method for measurement.

BOK Category: 4D4: Core Business Functions: Administrative Functions: Patient Safety
Cognitive Level: Analysis

38.) The Internal Auditor is conducting fieldwork for a Locum Tenens Audit. During an interview with key leaders, management informs the Internal Auditor that they do not have Locum Tenens and that all physicians are credentialed through the credentialing process. What should the Internal Auditor do next?

a. Obtain and review the Locum Tenens policy
b. Obtain and review the Credentialing policies and procedures
c. Obtain a data pull of billed claims that contain the Locum Tenens modifier
d. Verify the physicians are credentialed on claims with the Locum Tenens modifier

Correct Answer: C

Rationale:

A - The Locum Tenens policy would be obtained in the background part of the audit process.

B - The Credentialing policies and procedures would be obtained in the background part of the audit process.

C - This will determine if the organization billed for Locum Tenens. A true Locum Tenens would not be credentialed and would be billed with a modifier Q5 or Q6.

D – This option could only be completed after Option C.

BOK Category: Business Aspects of Care Setting: Core Care Settings: Physician Practices
Cognitive Level: Analysis

39.) The Internal Auditor identified issues during a Physician Contract Compliance Audit. The auditor is ranking the risk level for each of the findings. Which issue has the highest risk level?

a. An agreement was not in place for a surgeon providing specialty call coverage.
b. The President of Medical Staff services has not been paid for the previous calendar year.
c. One physician had two separate contracts and received compensation for 13.5 hours of work in one day.
d. Contracted physicians for OB-GYN calculated their service hourly instead of the contracted daily rate.

Correct Answer: A

Rationale:

A - **The lack of an agreement is high risk because there is a potential for a Stark violation and the proper screening/evaluation of the physician's services and compensation may not have occurred.**

B - A delay of payment to the President of Medical Staff is not high risk but may indicate poor monitoring of contracted required payments.

C - A physician can incur excess hours if on-call and providing direct patient services during a 24-hour period.

D - The calculation methodology needs to agree with the contract but is not the highest risk.

BOK Category: 1A1: Business Aspects of Care Setting: Core Care Settings: Physician Practices
Cognitive Level: Analysis

40.) During fieldwork, the Internal Auditor is conducting a walkthrough at a medical office building to identify areas of risk. Which of the following indicates the highest regulatory risk?

a. The medical office building is named for a major donor.
b. One of the medical office suites has signage outside their door with the full hospital name, indicating the suite is a department of the hospital.
c. Monitoring by security personnel of physical access to doors is only handled on an "as needed" or requested basis.
d. A standardized electronic security access control program has not been implemented.

Correct Answer: B

Rationale:

A - Major donors often have medical office buildings named in their honor.

B - The signage indicates a provider-based location. Provider-based departments have significant regulatory requirements such as notices of co-insurance, signage, billing, and education.

C - While physical security is becoming more of a concern, the monitoring level is not a high regulatory risk.

D - The lack of a standardized electronic security access program is not as high of a risk as Provider-Based clinic risks.

BOK Category: 1B6: Business Aspects of Care Setting: Other Care Settings: Medical Office Buildings
Cognitive Level: Analysis

41.) Mary has been a patient of Dr. Smith for years but noticed that her out-of-pocket cost increased 150%. Who should Mary contact to obtain the rationale for the increase?

a. Employer
b. Health Plan
c. Referring Clinician
d. Healthcare Financial Management Association

Correct Answer: B

Rationale:

A - An employer can play an important role in shaping community health care systems through their direct efforts to institute system change, their negotiations with health plans, and their decisions concerning the structure of health benefits for their employees.

B - The key role of a health plan is to provide coverage for medical care to its members.

C - A referring clinician means a healthcare professional who is not employed by a private hospital operator but has the right to refer patients for treatment

D - The Healthcare Financial Management Association is a professional membership organization that helps healthcare finance management executives and professionals navigate the complexities of the healthcare industry.

BOK Category: 2A1: Revenue Cycle: Health Insurance Provider Revenue Cycle Elements: Enrollment and Eligibility
Cognitive Level: Application

42.) After a patient has completed their visit, what revenue cycle phase includes accurately documenting medical services and communicating them to the billing office to increase recovered revenue, secure revenue integrity, and compliment the revenue cycle?

a. Charge Capture
b. Credentialing providers and enrolling them in payer networks
c. Coordination of Care
d. Third-Party follow-up

Correct Answer: A

Rationale:

A - **Charge capture is a process used by doctors and other health care providers to get paid for their services. In its simplest form, charge capture is the process whereby doctors record information on their services, which is then sent out to different payers and insurance companies for reimbursement**

B - Credentialing is the process of verifying the professional qualifications of medical providers and is required by most medical facilities and services, including hospitals and health insurance companies.

C - Care Coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.

D - Third-Party follow-up is when a person or entity contracts with either the plan or the third-party administrator to provide payment for claims of healthcare items or services for plan participants.

BOK Category: 2A4: Revenue Cycle: Health Insurance Provider Revenue Cycle Elements: Claims Processing
Cognitive Level: Application

43.) An auditor needs to obtain information on their organization's processes for requesting participation in a payor network, completing credentialing requirements, submitting documents to the payer, and signing a contract. Which revenue cycle area should they contact?

a. Denials Management
b. Managed Care
c. Payer Enrollment
d. Charge Capture

Correct Answer: C

Rationale:

A - This function is responsible for reviewing and resolving denied claims.

B - Managed Care is the function responsible for loading and updating managed care contractual terms.

C **- Payor enrollment is the process of a provider joining a health insurance plan's network. The process includes requesting participation in a payer network, completing credentialing requirements, submitting documents to the payer, and signing a contract.**

D - Charge capture is a process used by doctors and other health care providers to get paid for their services. In its simplest form, charge capture is the process whereby doctors record information on their services, which is then sent out to different payers and insurance companies for reimbursement.

BOK Category: 2A1: Revenue Cycle: Health Insurance Provider Revenue Cycle Elements: Enrollment and Eligibility
Cognitive Level: Application

44.) A member of the hospital's Account Receivable team is responsible for analyzing the payment received from the insurance payor to determine if there was an error causing the payment to be delayed. What is the process called if an error is reported and the claim gets directed to the clearinghouse for charge review and follow-up so the claim can be sent back to the payor for correction?

a. Medical Coding
b. Claim/Remittance Processing
c. Insurance Follow-up
d. Patient Collections

Correct Answer: B

Rationale:

A - Medical coding is to assign medical coders to medical transcriptions.

B – **Claim/Remittance processing is one of the key steps in the medical billing process. It determines the amount of reimbursement that the healthcare provider will receive after the insurance company clears the claim charges.**

C - Insurance follow-up is to determine which benefits are covered, submit patient claims, and follow-up on those submissions.

D - Patient Collections is a process which involves monitoring accounts that are outstanding and pursuing payment of those balances from patients.

BOK Category: 2A4: Revenue Cycle: Health Insurance Provider Revenue Cycle Elements: Claims Processing
Cognitive Level: Application

45.) Revenue cycle key performance indicators (KPIs) provide the foundation for standardization and benchmarking. The Initial denial rate as a percentage of claim volume is a trending indicator of the total population of initial denials at the claim level. What are the components for Initial denial rate as a percentage of claim dollars formula?

a. Initial denials overturned and paid (gross charges for overturned and paid claims) divided by total initial denial dollars paid and adjusted (gross charges)
b. Total inpatient denials overturned, paid, and converted to observation status divided by total inpatient denials overturned paid and adjusted
c. Total initial denial claims gross charges divided by total claims submitted gross charges.
d. Total initial denial claims divided by total claims submitted.

Correct Answer: C

Rationale:

A - This formula is a performance and trending indicator of denial appeal success focus on gross charges.

B - This formula is a performance and trending indicator of denial appeal success focus on converted to observation.

C **- This formula is a trending indicator of the total population of initial denials at the claim level with a focus on claim dollars. It provides overall trend on rates of occurrence for both volume and dollars, highlighting potential process, system, or data issues.**

D - This formula is a trending indicator of total population of initial denials at the claim level focused on claim volume.

BOK Category: 2A5: Revenue Cycle: Health Insurance Provider Revenue Cycle Elements: Claims Appeals
Cognitive Level: Analysis

46.) An Internal Auditor is reviewing the controls related to goods and devices in the acute care hospital operating room. Which finding should be classified as a high risk due to regulatory compliance?

a. Vendors did not always provide the same quality goods to the hospital.
b. Controls related to vendor contracts need improvement to address the scenario where the contract expires and is still being negotiated.

c. Controls are not in place to identify overcharges from vendors, including investigating spikes in the price paid.
d. The returned medical device process is not functioning effectively and requires enhancement.

Correct Answer: D

Rationale:

A - The quality of goods presents a quality or safety risk, but it does not have billing and regulatory impact.

B - The hospital may pay higher prices than necessary in this scenario, but it does not affect billing and regulations.

C - The hospital may pay higher prices than necessary in this scenario, but it does not affect billing and regulations.

D - **Devices removed and returned to the vendor under recall or warranty have billing implications that can result in fines and penalties. As an example, the Office of Inspector General (OIG) identified cardiac devices as a focus area over several years in the OIG Work Plan.**

BOK Category: 1A2: Business Aspects of Care Setting: Core Care Settings: Acute Care Hospitals
Cognitive Level: Analysis

47.) An auditor is conducting a charge capture audit in an Orthopedic clinic. In order for the auditor to determine if there are any patients with missing charges, the auditor must review which of the following:

a. The encounter forms and medical record
b. The proof of payment and cash receipts
c. The report of arrived patients and encounter forms (charges)
d. The schedule and encounter forms (charges)

Correct Answer: C

Rationale:

A - This only tells the auditor if notes and other information was recorded and reflected on encounter

B - This review only reflects receipts for payments collected.

C - The arrived patients will let the auditor know how many patients were seen in clinic and should have encounter forms or charges reflected.

D - This only reflects scheduled appointments and may not take into account any cancelled appointments.

BOK Category 2C5: Revenue Cycle: Healthcare Provider Revenue Cycle Elements: Charge Capturing
Cognitive Level: Analysis

48.) A patient enrolled in a liver research study had a CT scan of the liver. The patient did not have an emergency visit. The charges were billed to a payor and not the research sponsor. What is the best documentation for the auditor to review to determine whether the charges should have been billed to the research sponsor?

a. The physician order for the CT scan
b. The research study protocol coverage analysis
c. The medical record documentation
d. The billing claim submitted to the payor

Correct Answer: B

Rationale:

A - While the physician order is necessary for scheduling the CT, it may not indicate that the test is for research purposes only.

B - The research study protocol coverage analysis provides the procedures that are specific for the research study. When medical services are only rendered for specific purposes of the research study, the charges should be billed to the research sponsor in accordance with the coverage analysis.

C - The medical record may or may not provide additional information for identifying the CT scan as a research specific test.

D - The billing claim will provide the charges and may have the modifier for clinical research but could be appropriately billed to payor if it is considered as a standard of care and not just for research purposes.

BOK Category: 2B6: Revenue Cycle: Healthcare Provider Reimbursement: Research Sponsors
Cognitive Level: Application

49.) A patient called the scheduling department to schedule a dermatology procedure their physician ordered. What must the clinic do before the day of the appointment to ensure the patient can have the procedure?

a. Collect the copayment before the scheduled procedure.
b. Verify the patient has insurance benefits.
c. Obtain the patient consent.
d. Obtain authorization from the payor for the procedure.

Correct Answer: D

Rationale:

A - Depending on the clinic policies and practices, the co-payment may not need to be paid before the day of procedure.

B - Verifying the patient has insurance benefits is a good first step but unless approved they should not proceed with the procedure.

C - Patient consents are normally done when the patient arrives for the appointment.

D - The clinic must obtain authorization from the patient's insurance before proceeding with the procedure. The procedure will need to be approved so the clinic can bill and receive payment.

BOK Category: 2C3: Revenue Cycle: Healthcare Provider Revenue Cycle Elements: Registration/Patient Access
Cognitive Level: Application

50.) An auditor is performing a review of their hospital billing processes. What would the auditor review to determine root causes for delays in billing?

a. Do a comparison of charge dates and date of service.
b. Review claims with modifiers.
c. Run a report to look for duplicate charges.
d. Look at patients discharged but not final billed report.

Correct Answer: D

Rationale:
A - This would be used to determine if there are charges posting for the right date of service.
B - This would be used to identify whether there is appropriate coding including the modifier as an element.
C - This would be used to determine if overbilling is occurring.

D - Often times, billing claims are held up because of lack of coding and charges and would be reported on a discharged not final billed (DNFB) report.

BOK Category: 2C8: Revenue Cycle: Healthcare Provider Revenue Cycle Elements: Billing
Cognitive Level: Application

51.) What element is critical to code by professional and hospital coders regardless of the visit type?

a. Procedure code
b. Patient age
c. Diagnosis code
d. Modifier

Correct Answer: C

Rationale:

A - This is referred to as CPT code which is used to identify medical services and procedures performed during visit.

B - Not a code but considered demographics.

C - The diagnosis code otherwise referred to as ICD-10 is a morbidity classification for classifying diagnosis and reason for visits in all health care settings.

D - Used to further identify special procedures or multiple procedures.

BOK Category: 2C7: Revenue Cycle: Healthcare Provider Revenue Cycle Elements: Coding
Cognitive Level: Analysis

52.) Dr. Jones is a cardiologist who performs pacemaker insertions and has requested that the hospital order the medical devices from Cardinal Company. The surgery manager asks the Compliance Officer to review Dr. Jones' request to ensure a compliant process is set up for which regulatory requirement?

a. EMTALA
b. CARES Act
c. Physician Payment Sunshine Act
d. HITECH Act

Correct Answer: C

Rationale:

A - EMTALA is a federal law that requires hospitals to provide stabilization treatment for anyone who comes into the emergency department.

B - The CARES Act provides economic assistance for workers, families, small business, and industries.

C - The Compliance Officer must find out if the company has disclosed to the Centers for Medicare and Medicaid Services (CMS) any payments or other transfers of value made to the cardiologist or the teaching hospital to ensure there is no violation of the Physician Payment Sunshine Act.

D - The HITECH Act sets standards for information security.

BOK Category: 3B7: Regulatory Environment: Regulations: Physician Payment Sunshine Act
Cognitive Level: Application

53.) The hospital emergency department would like Internal Audit to complete an EMTALA audit. What is one important piece of the regulation that the Internal Auditor should look for evidence of?

a. Information regarding patients' ability to pay for services was not obtained prior to patients receiving medical screening exams.
b. The emergency department staff recorded patient wait times.
c. Patients were not transferred to another facility after they were stabilized.
d. The Hospital By-Laws include EMTALA processes.

Correct Answer: A

Rationale:

A - This is an important piece for EMTALA as many violations are given out for this. Internal Audit should review the regulation was followed.

B - This is not a regulatory requirement; however, wait times are beneficial for operational benchmarks.

C - A transfer after the patient is stabilized is permitted under EMTALA.

D - While this is good practice to include in the by-laws, it would not be a specific regulation of EMTALA.

BOK Category: 3B8: Regulatory Environment: Regulations: EMTALA
Cognitive Level: Analysis

54.) The Internal Auditor is wrapping up an audit of Virtual Medicine/Telehealth. A meeting to review key findings is scheduled with the Finance Manager. Which key finding would have the most impact on lost revenue?

a. Coding and billing for Virtual Medicine/Telehealth may not comply with federal requirements.
b. Changes in federal and state laws and regulations may impact where this service can be used.
c. Patient end user devices may not be able to access the internet.

d. Access to Virtual Medicine/Telehealth applications may not align with credentialing and privileging processes.

Correct Answer: A

Rationale:

A - Inaccurate coding and billing and/or non-compliance can result in denials having the most impact on lost revenue.

B - The risk in non-compliance of federal and state laws would be reputational damage; however, if not monitored and addressed timely it can also contribute to loss of revenue.

C - This could prevent the use of Virtual Medicine/Telehealth.

D - This could prevent the use of this service and negatively impact the quality of care.

BOK Category: 1B7: Business Aspects of Care Setting: Other Care Settings: Virtual Medicine
Cognitive Level: Application
