

# AAPC Certified Professional Compliance Officer (CPCO) Certification Practice Exam (Sample)

## Study Guide



**Everything you need from our exam experts!**

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# Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

**Remember:** successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

# How to Use This Guide

**This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:**

## **1. Start with a Diagnostic Review**

**Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.**

## **2. Study in Short, Focused Sessions**

**Break your study time into manageable blocks (e.g. 30 - 45 minutes). Review a handful of questions, reflect on the explanations.**

## **3. Learn from the Explanations**

**After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.**

## **4. Track Your Progress**

**Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.**

## **5. Simulate the Real Exam**

**Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.**

## **6. Repeat and Review**

**Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.**

**There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!**

## Questions

- 1. In the context of healthcare, what does the term "Disclosure" refer to?**
  - A. Data sharing within an organization**
  - B. The release or transfer of information to an outside entity**
  - C. Internal communication of patient information**
  - D. Public access to health records**
- 2. What is the primary function of the Office of Audit Services within the OIG?**
  - A. To enforce compliance laws**
  - B. To conduct audits to prevent fraud**
  - C. To manage financial transactions**
  - D. To process healthcare claims**
- 3. Which organization provides advisory opinions on the anti-kickback law?**
  - A. CMS**
  - B. HHS**
  - C. OIG**
  - D. FDA**
- 4. If the main entrance cannot be made handicap accessible, what should be done?**
  - A. People should be detoured to another entrance**
  - B. There is no need to provide an alternative**
  - C. All visitation should be canceled**
  - D. Only employees can use the main entrance**
- 5. In what year did OSHA publish the Bloodborne Pathogens standard?**
  - A. 1989**
  - B. 1991**
  - C. 1994**
  - D. 1995**

- 6. How many months of health coverage does COBRA provide after employment ends?**
- A. 12 months**
  - B. 18 months**
  - C. 24 months**
  - D. 30 months**
- 7. What is the primary purpose of a Corporate Integrity Agreement?**
- A. To establish financial penalties**
  - B. To ensure compliance with laws**
  - C. To provide legal counsel**
  - D. To facilitate training programs**
- 8. What primary function is associated with the OIG in relation to Medicare programs?**
- A. Resource allocation**
  - B. Fraud prevention**
  - C. Public relations**
  - D. Policy development**
- 9. How does CMS categorize improper payments?**
- A. Based on patient satisfaction**
  - B. According to billing summaries**
  - C. As insufficient documentation, no documentation, or medical necessity**
  - D. By creating comprehensive audit reports**
- 10. What accurately describes Zone Program Integrity Contractors (ZPICs)?**
- A. Federal employees overseeing audits**
  - B. Private entities hired by CMS**
  - C. State agencies managing Medicare claims**
  - D. Nonprofit organizations supporting healthcare reform**



## **Answers**

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

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## **Explanations**

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**1. In the context of healthcare, what does the term "Disclosure" refer to?**

- A. Data sharing within an organization**
- B. The release or transfer of information to an outside entity**
- C. Internal communication of patient information**
- D. Public access to health records**

The term "Disclosure" in the healthcare context specifically refers to the release or transfer of information to an outside entity. This can include sharing patient data with third parties such as insurers, other healthcare providers, or legal entities. The concept of disclosure is critical as it pertains to patient privacy and confidentiality under regulations such as HIPAA (Health Insurance Portability and Accountability Act), which governs the circumstances under which a healthcare provider may disclose protected health information (PHI) without patient consent. This definition emphasizes the importance of understanding the boundaries of patient information sharing and maintaining compliance with regulatory standards. Safeguarding patient data while appropriately disclosing pertinent information to enable care coordination or legal processes is a key responsibility of healthcare professionals. This careful balance between protecting patient privacy and ensuring necessary information flow is vital for both ethical and legal compliance in healthcare settings. The other options, while related to information management within healthcare, do not capture the specific nature of externally directed data sharing that "Disclosure" entails.

**2. What is the primary function of the Office of Audit Services within the OIG?**

- A. To enforce compliance laws**
- B. To conduct audits to prevent fraud**
- C. To manage financial transactions**
- D. To process healthcare claims**

The primary function of the Office of Audit Services within the Office of Inspector General (OIG) is to conduct audits aimed at preventing fraud. This office plays a pivotal role in overseeing various healthcare programs and ensuring that federal funds are used efficiently, effectively, and in accordance with legal requirements. By conducting thorough audits, the Office of Audit Services can identify potential areas of fraud, waste, and abuse within healthcare systems. This proactive approach not only helps to secure the integrity of federal healthcare programs but also assists in promoting compliance among healthcare providers. While enforcing compliance laws, managing financial transactions, and processing healthcare claims are important functions within the healthcare system, they do not specifically capture the essence of the OIG's audit services. The focus is primarily on audit activities that analyze processes and expenditures, assess risks, and develop recommendations to enhance operational effectiveness and compliance, making the chosen answer the most accurate reflection of the office's primary responsibilities.

**3. Which organization provides advisory opinions on the anti-kickback law?**

- A. CMS**
- B. HHS**
- C. OIG**
- D. FDA**

The correct answer is the Office of Inspector General (OIG), as this organization is responsible for providing advisory opinions regarding the anti-kickback statute. The OIG issues these opinions to help clarify the legal implications surrounding specific financial arrangements in healthcare, particularly those that may involve potential violations of the anti-kickback law. These opinions are instrumental for healthcare providers and organizations in ensuring compliance with federal regulations. The OIG's focus on the anti-kickback statute stems from its role in protecting government healthcare programs from fraud and abuse. By providing guidance and clarity through advisory opinions, the OIG helps entities make informed decisions related to their business practices, reducing the risk of engaging in arrangements that could be deemed illegal or unethical. In contrast, other organizations like CMS, HHS, and the FDA, while integral to the healthcare system, do not specifically provide advisory opinions on the anti-kickback law. CMS primarily oversees Medicare and Medicaid programs, HHS is involved in broader public health and welfare issues, and the FDA regulates food and drug safety. Thus, their functions differ from the specific mandate of the OIG concerning compliance with the anti-kickback statute.

**4. If the main entrance cannot be made handicap accessible, what should be done?**

- A. People should be detoured to another entrance**
- B. There is no need to provide an alternative**
- C. All visitation should be canceled**
- D. Only employees can use the main entrance**

Detouring individuals to another entrance is the most effective solution when the main entrance cannot be made handicap accessible. This approach ensures that individuals with disabilities can still access the building and receive the services they need. It reflects a commitment to inclusivity and compliance with regulations such as the Americans with Disabilities Act (ADA), which mandates that public spaces be accessible to everyone. Providing an alternative entrance acknowledges the importance of accommodating all visitors, and it allows the organization to maintain its operations while addressing accessibility concerns. This route not only prioritizes the safety and accessibility for those with mobility issues but also demonstrates a proactive stance in creating an equitable environment.

**5. In what year did OSHA publish the Bloodborne Pathogens standard?**

**A. 1989**

**B. 1991**

**C. 1994**

**D. 1995**

The Occupational Safety and Health Administration (OSHA) published the Bloodborne Pathogens standard in 1991. This landmark regulation was designed to protect workers who are exposed to blood and other potentially infectious materials. The standard established a set of requirements intended to minimize the risk of transmission of diseases such as HIV and Hepatitis B in healthcare and other settings where such exposures could occur. The 1991 implementation of this standard marked a significant advancement in workplace safety regulations, emphasizing the need for organizations to develop and follow exposure control plans, provide training, and ensure the proper use of personal protective equipment (PPE). This reflects OSHA's commitment to safety and health in the workplace, particularly concerning biological risks. Understanding the correct date is crucial for compliance professionals, as it lays the foundation for how bloodborne pathogens are managed and how workplace safety regulations have evolved over time.

**6. How many months of health coverage does COBRA provide after employment ends?**

**A. 12 months**

**B. 18 months**

**C. 24 months**

**D. 30 months**

COBRA, the Consolidated Omnibus Budget Reconciliation Act, generally allows eligible employees and their dependents to continue health insurance coverage for up to 18 months after employment ends or after certain qualifying events, such as a reduction in work hours. This period can be extended in certain special circumstances, such as disability, but the standard duration for most qualifying events is 18 months. Understanding the duration provided by COBRA is essential for compliance officers as they navigate the complexities of employee benefits and ensure that former employees are informed of their rights regarding health coverage continuation. This knowledge is crucial for maintaining compliance with federal regulations and supporting workforce well-being.

**7. What is the primary purpose of a Corporate Integrity Agreement?**

- A. To establish financial penalties**
- B. To ensure compliance with laws**
- C. To provide legal counsel**
- D. To facilitate training programs**

The primary purpose of a Corporate Integrity Agreement (CIA) is to ensure compliance with laws and regulations. A CIA is typically established as part of a settlement with governmental organizations when a healthcare entity has been accused of wrongdoing, such as healthcare fraud or abuse. Through this agreement, the organization commits to improving and maintaining compliance programs and adhering to specific legal and ethical standards. Incorporating compliance measures not only serves as a corrective action but also as a proactive approach to prevent future violations. This often involves implementing training programs, conducting regular audits, and ensuring transparent reporting practices, all aimed at fostering a culture of compliance within the organization. Thus, the essence of a CIA is rooted in ensuring that the organization understands and fulfills its legal obligations, thereby mitigating risks associated with non-compliance.

**8. What primary function is associated with the OIG in relation to Medicare programs?**

- A. Resource allocation**
- B. Fraud prevention**
- C. Public relations**
- D. Policy development**

The primary function associated with the Office of Inspector General (OIG) in relation to Medicare programs is fraud prevention. The OIG is responsible for ensuring the integrity of Medicare and Medicaid programs by investigating and reducing fraud, waste, and abuse. This includes auditing and monitoring compliance with federal laws and regulations to protect the programs from improper billing practices and other fraudulent activities. The focus on fraud prevention is critical as it helps safeguard taxpayer dollars and ensures that beneficiaries receive the care they need without being defrauded. Through various initiatives, including investigations, performance evaluations, and the promotion of best practices, the OIG plays a vital role in maintaining the trust and efficiency of these healthcare programs. While resource allocation, public relations, and policy development are all significant functions within the broader healthcare landscape, they do not primarily capture the direct role of the OIG concerning Medicare programs, which is fundamentally aimed at preventing fraudulent activities.

## 9. How does CMS categorize improper payments?

- A. Based on patient satisfaction
- B. According to billing summaries
- C. As insufficient documentation, no documentation, or medical necessity**
- D. By creating comprehensive audit reports

The correct answer identifies how the Centers for Medicare & Medicaid Services (CMS) classifies improper payments based on specific criteria. Improper payments are primarily categorized as instances of insufficient documentation, no documentation, or issues related to medical necessity. This categorization is critical because it helps determine the underlying reasons why payments may not comply with regulations or guidelines. Insufficient documentation refers to situations where the medical records do not provide enough evidence to support the services billed. No documentation indicates that there is a lack of any records at all to justify the claim. Medical necessity refers to whether the services provided were necessary for the patient's diagnosis or treatment; if a service is found to be unwarranted based on clinical guidelines, it can also be deemed an improper payment. Understanding this categorization is essential for compliance officers and healthcare providers, as it helps them identify areas for improvement in their documentation practices and billing processes, ultimately reducing the risk of future improper payments and potential audits by CMS.

## 10. What accurately describes Zone Program Integrity Contractors (ZPICs)?

- A. Federal employees overseeing audits
- B. Private entities hired by CMS**
- C. State agencies managing Medicare claims
- D. Nonprofit organizations supporting healthcare reform

Zone Program Integrity Contractors (ZPICs) are private entities that have been contracted by the Centers for Medicare & Medicaid Services (CMS) to perform various tasks aimed at ensuring the integrity of Medicare claims. Their primary responsibilities include conducting audits and investigations to detect and prevent fraudulent activities, waste, and abuse in the Medicare program. ZPICs play a crucial role in safeguarding Medicare funds and ensuring compliance with applicable laws and regulations. This distinction highlights that ZPICs are not federal employees, nor are they state agencies. While they do contribute to the oversight of Medicare services, their work is performed as independent contractors rather than as state or federal entities. This separation underscores the role of private contractors in enhancing the efficiency and effectiveness of Medicare oversight while allowing for specialized expertise in program integrity.



## 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](mailto:hello@examzify.com).**

**Or visit your dedicated course page for more study tools and resources:**

**<https://aapccpco.examzify.com>**

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