AAPC CERTIFIED PROFESSIONAL COMPLIANCE OFFICER (CPCO) CERTIFICATION PRACTICE EXAM (SAMPLE)

STUDY GUIDE

SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR THE FULL VERSION STUDY GUIDE

https://aapccpco.examzify.com

Table of Contents

Introduction

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

This guide was designed to help you do exactly that.

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

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

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

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

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

Let's begin.

How to Use This Guide

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

1. Start with a Diagnostic Review

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

2. Study in Short, Focused Sessions

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

3. Learn from the Explanations

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

4. Track Your Progress

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

5. Simulate the Real Exam

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

6. Repeat and Review

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

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

Questions

1. **If a compliance officer has questions regarding discrimination in healthcare programs, which office should they contact?**
   - A. Office for Civil Rights (OCR)
   - B. Office of Inspector General (OIG)
   - C. Department of Health and Human Services (HHS)
   - D. Centers for Disease Control and Prevention (CDC)

2. **What does FPS stand for in the context of fraud prevention in healthcare?**
   - A. Fraud Prevention Strategy
   - B. Fraud Prevention System
   - C. Fraud Protection Services
   - D. Fraud Processing System

3. **What aspect of an internal investigation must be carefully worded and tied back to regulatory standards?**
   - A. Interview scripts
   - B. Audit protocol
   - C. Reporting forms
   - D. Compliance plans

4. **What is the aim of technical safeguards in HIPAA compliance?**
   - A. To oversee workforce conduct
   - B. To ensure physical security of facilities
   - C. To protect ePHI through technological measures
   - D. To provide training on HIPAA regulations

5. **What was the compliance deadline for all covered entities under the HIPAA Omnibus Rules?**
   - A. January 1, 2015
   - B. September 22, 2014
   - C. June 30, 2014
   - D. December 31, 2014

6. Which of the following statements is correct about documentation reviews during an internal investigation?

A. They can only include financial records

B. They may include emails, mobile phone calendars, and notes

C. They are limited to electronic documents

D. They require a minimum of two witnesses

7. If a practice uses an outsourced compliance officer, what does the OIG recommend?

A. Conducting annual audits

B. Designating a liaison from the practice

C. Eliminating the internal compliance officer

D. Increasing insurance coverage

8. In the case of incident-to billing, what must be true for the requirements to be met regarding provider availability?

A. The provider must be in the office

B. The provider must be available by email

C. The provider may only be reached by pager

D. All staff must report to the provider

9. Which office is primarily responsible for investigating health care fraud, waste, and abuse?

A. CMS

B. Office of Inspector General (OIG)

C. Department of Justice

D. Health and Human Services (HHS)

10. Are OIG guidelines for compliance programs mandated for third-party health care companies?

A. No, they are optional

B. Yes, but the implementation date hasn't been provided yet

C. Yes, with immediate effect

D. No, only for public companies

Answers

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

Explanations

1. If a compliance officer has questions regarding discrimination in healthcare programs, which office should they contact?

A. Office for Civil Rights (OCR)

B. Office of Inspector General (OIG)

C. Department of Health and Human Services (HHS)

D. Centers for Disease Control and Prevention (CDC)

The correct choice is the Office for Civil Rights (OCR) because this office is specifically responsible for enforcing federal civil rights laws that prohibit discrimination in healthcare settings. These laws ensure that individuals receive fair treatment regardless of race, color, national origin, disability, age, or sex, specifically in programs and activities that receive federal funding. When a compliance officer has concerns related to discrimination or the application of these civil rights laws in healthcare, the OCR is the go-to agency for guidance and assistance. They provide resources, training, and oversight to ensure compliance with these important regulations. Other options, while relevant to healthcare in various capacities, do not focus specifically on discrimination issues. The Office of Inspector General (OIG) deals primarily with combating fraud, waste, and abuse in federal healthcare programs. The Department of Health and Human Services (HHS) oversees national health policies but is broader in scope and does not directly address discrimination concerns. The Centers for Disease Control and Prevention (CDC) focuses mainly on public health issues and disease prevention, rather than civil rights enforcement.

2. What does FPS stand for in the context of fraud prevention in healthcare?

A. Fraud Prevention Strategy

B. Fraud Prevention System

C. Fraud Protection Services

D. Fraud Processing System

In the context of fraud prevention in healthcare, FPS stands for Fraud Prevention System. This term denotes a comprehensive framework or set of tools and processes used to identify, prevent, and address fraudulent activities within healthcare settings. A Fraud Prevention System typically encompasses various technological and procedural components designed to detect suspicious activities, verify the authenticity of claims, and ensure compliance with regulations. A Fraud Prevention System is crucial because it helps healthcare organizations protect themselves against financial loss, maintain integrity in billing and coding practices, and uphold patient trust. By utilizing advanced data analytics and monitoring techniques, a Fraud Prevention System can enhance the detection of irregularities and streamline reporting practices, ensuring quick intervention when potential fraud is identified. Each of the other choices represents plausible concepts related to fraud but does not align as precisely with the established terminology in healthcare fraud prevention as "Fraud Prevention System" does.

3. What aspect of an internal investigation must be carefully worded and tied back to regulatory standards?

A. Interview scripts

B. Audit protocol

C. Reporting forms

D. Compliance plans

The aspect of an internal investigation that must be carefully worded and tied back to regulatory standards is the audit protocol. Audit protocols guide how an internal audit is conducted and outline the procedures and standards that need to be followed to ensure compliance with relevant regulations. These protocols must align with regulatory requirements to ensure that the findings are valid and that the organization can demonstrate adherence to applicable laws and standards. Properly articulating audit protocols supports the consistent application of compliance measures and ensures that any findings can withstand scrutiny during regulatory reviews or external audits. It's crucial for these protocols to incorporate specific references to regulatory standards, as they serve as a framework for assessing the organization's compliance status and the effectiveness of its policies and procedures. Careful wording in audit protocols helps avoid ambiguity and misinterpretation during the investigation process, reinforcing the integrity and reliability of the compliance program. By establishing clear, standard procedures tied to regulatory expectations, an organization can better protect itself from compliance failures and potential penalties.

4. What is the aim of technical safeguards in HIPAA compliance?

A. To oversee workforce conduct

B. To ensure physical security of facilities

C. To protect ePHI through technological measures

D. To provide training on HIPAA regulations

The aim of technical safeguards in HIPAA compliance is to protect electronic protected health information (ePHI) through technological measures. This involves implementing various technologies and protocols designed to ensure the confidentiality, integrity, and availability of ePHI. Such safeguards include access controls like unique user identification, encryption of data, and audit controls that track access and usage of ePHI. By utilizing these technical measures, organizations can minimize the risk of unauthorized access and potential data breaches, thereby aligning with the overarching goal of HIPAA to safeguard patient information. While overseeing workforce conduct, ensuring physical security of facilities, and providing training on HIPAA regulations are all important components of a comprehensive compliance program, they fall under other categories of safeguards rather than technical safeguards specifically. Technical safeguards operate on the electronic level and focus exclusively on the protection of information as it is stored, transmitted, or processed using technology.

5. What was the compliance deadline for all covered entities under the HIPAA Omnibus Rules?

A. January 1, 2015

B. September 22, 2014

C. June 30, 2014

D. December 31, 2014

The compliance deadline for all covered entities under the HIPAA Omnibus Rules was September 22, 2014. This date marked the end of the grace period that allowed covered entities and their business associates to implement necessary changes mandated by the Omnibus Rule, which updated existing standards for HIPAA compliance. The updates included new privacy protections for patients and clarified the responsibilities of business associates regarding Protected Health Information (PHI). Covered entities had to ensure that their policies, procedures, and practices were in alignment with the new regulations by this deadline to maintain compliance and avoid potential penalties. The changes were critical, as they strengthened patients' privacy rights and expanded the scope of liability to business associates, reinforcing that they too must comply with HIPAA regulations.

6. Which of the following statements is correct about documentation reviews during an internal investigation?

A. They can only include financial records

B. They may include emails, mobile phone calendars, and notes

C. They are limited to electronic documents

D. They require a minimum of two witnesses

The statement that documentation reviews during an internal investigation may include emails, mobile phone calendars, and notes is correct because a comprehensive internal investigation should encompass a wide range of documentation to thoroughly assess facts and circumstances. This broad scope helps to ensure that all relevant information is considered, including communication records, scheduling details, and informal notes that may provide context or insights into the issue being investigated. Incorporating these various forms of documentation contributes to a more complete understanding of the situation at hand, enabling investigators to make informed decisions based on a detailed examination of all relevant materials. By looking beyond just financial records or strictly electronic documents, the investigation can capture nuances that might otherwise be overlooked, enhancing the integrity and outcome of the review process.

7. If a practice uses an outsourced compliance officer, what does the OIG recommend?

A. Conducting annual audits

B. Designating a liaison from the practice

C. Eliminating the internal compliance officer

D. Increasing insurance coverage

Designating a liaison from the practice when using an outsourced compliance officer is recommended by the OIG to ensure effective communication and oversight between the practice and the external compliance service. This liaison plays a crucial role in maintaining a direct line of contact, facilitating the flow of information, and ensuring that the compliance initiatives align with the specific needs and operations of the practice. Having an internal liaison helps to integrate the compliance processes into the daily operations, making it easier to address compliance issues and implement appropriate measures. This approach optimizes the relationship with the outsourced officer, ensuring that compliance strategies are not only implemented but also tailored to address the unique risks and challenges faced by the practice. The other options do not align with the OIG's recommendations in the context of utilizing an outsourced compliance officer. Conducting annual audits is a good practice but does not directly relate to the effective management of an outsourced compliance function. Eliminating the internal compliance officer may create gaps in oversight, leading to potential compliance risks. Increasing insurance coverage, while important in risk management, does not address the strategic necessity of maintaining ongoing compliance oversight and governance in conjunction with outsourced services.

8. In the case of incident-to billing, what must be true for the requirements to be met regarding provider availability?

A. The provider must be in the office

B. The provider must be available by email

C. The provider may only be reached by pager

D. All staff must report to the provider

In the context of incident-to billing, the requirement for provider availability emphasizes that the supervising provider must be present in the office while the services are being performed by a non-physician practitioner or auxiliary staff member. This is critical because incident-to billing allows the practice to bill for services rendered by non-physician providers under the supervising physician's National Provider Identifier (NPI), which enables the practice to receive higher reimbursement rates associated with physician services. The requirement for the provider to be physically present in the office ensures that there is direct supervision, reinforcing the appropriateness of the service rendered and that the supervising physician can intervene if necessary. This supervision is a safeguard designed to maintain the quality of care and ensure compliance with regulations. Other options, such as availability by email or pager, do not fulfill the strict criteria set forth for incident-to billing since these forms of communication do not equate to physical presence. The same goes for the requirement that all staff must report to the provider; while communication is vital, it does not imply that the provider is directly supervising the care being provided at the time of service. Thus, the most accurate depiction of the requirement for provider availability is that the provider must be in the office.

9. Which office is primarily responsible for investigating health care fraud, waste, and abuse?

A. CMS

B. Office of Inspector General (OIG)

C. Department of Justice

D. Health and Human Services (HHS)

The Office of Inspector General (OIG) is primarily responsible for investigating health care fraud, waste, and abuse. The OIG operates under the Department of Health and Human Services (HHS) and is dedicated to protecting the integrity of federal health care programs, such as Medicare and Medicaid. It investigates issues like fraud and abuse within these programs and works to protect both the beneficiaries and the taxpayers. Furthermore, the OIG conducts audits, evaluations, and investigations, providing oversight and enforcing compliance in health care facilities. This role is distinct from other agencies; for example, while the Centers for Medicare & Medicaid Services (CMS) plays a significant role in administering those programs and ensuring compliance with regulations, its focus is more on the operational aspects rather than investigating fraud directly. Similarly, the Department of Justice (DOJ) handles prosecution of criminal cases related to health care fraud but does not conduct the initial investigations, which falls under the jurisdiction of the OIG. While the HHS encompasses a broader range of health services and programs, the OIG specifically focuses on preventing and addressing fraud, waste, and abuse within these areas. Thus, the OIG's unique mission and authority make it the primary agency for investigating these issues.

10. Are OIG guidelines for compliance programs mandated for third-party health care companies?

A. No, they are optional

B. Yes, but the implementation date hasn't been provided yet

C. Yes, with immediate effect

D. No, only for public companies

The correct response emphasizes that while the Office of Inspector General (OIG) has established guidelines for compliance programs, these guidelines are not mandated for third-party health care companies. The guidelines offer a framework and best practices intended to enhance compliance and integrity in health care operations, particularly valuable for organizations seeking to avoid fraud and ensure ethical conduct. However, adherence to these guidelines remains voluntary and is not enforceable by law for third-party contractors. The option indicating that yes, the guidelines are mandated but without an implementation date, suggests a misunderstanding of their nature. The OIG's recommendations are advisory rather than compulsory, meaning organizations can benefit from the guidance without the obligation to comply under a strict timeline. This enhances the understanding that while the aim is to promote improved compliance practices, the actual requirement to follow these guidelines does not extend to third-party companies with the force of law. In contrast, the other options mischaracterize the nature of the guidelines, either suggesting they are compulsory in some form or limited to specific types of organizations. The reality is that compliance with OIG guidelines is advisable and advantageous, but ultimately a choice for third-party health care entities.

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://aapccpco.examzify.com

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