

Healthcare Compliance Practice Test (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. What must successor liability report when there are changes to locations or business units?**
 - A. Annual performance reviews**
 - B. Compliance training updates**
 - C. New business unit reports**
 - D. Financial statements**
- 2. What constitutes a conflict of interest in healthcare?**
 - A. A situation where personal interests align with professional duties**
 - B. A set of circumstances risking professional judgment due to secondary interests**
 - C. When a healthcare provider has financial stakes in multiple entities**
 - D. Any scenario where a decision must be made**
- 3. What should employees remember if they have questions during an investigation?**
 - A. To make their best guess**
 - B. To provide opinions based on rumors**
 - C. To stick to the facts and avoid speculation**
 - D. To remain silent until further notice**
- 4. What is the purpose of the healthcare fraud and abuse control program?**
 - A. To provide healthcare services to all Americans**
 - B. To coordinate enforcement activities related to healthcare fraud**
 - C. To monitor patient satisfaction levels**
 - D. To manage healthcare funding operations**
- 5. Which organization is primarily responsible for investigating healthcare fraud, waste, and abuse?**
 - A. The Federal Trade Commission (FTC)**
 - B. The Department of Justice (DOJ)**
 - C. The Office of Inspector General (OIG)**
 - D. The Centers for Medicare and Medicaid Services (CMS)**

- 6. What can be a consequence for a provider manipulating information on a medical claim?**
- A. Nothing, if the claim is paid**
 - B. Legal prosecution for healthcare fraud**
 - C. Increased patient trust**
 - D. Enhanced reputation in the community**
- 7. What is the role of Zone Program Integrity Contractors (ZPIC)?**
- A. To supervise patient care improvements**
 - B. To identify high-risk provider practices**
 - C. To educate patients about Medicare**
 - D. To process provider applications**
- 8. Under ADA, what is required for parking spaces accessible to the disabled?**
- A. All parking must be paved**
 - B. One of every six spaces must be made van accessible**
 - C. No accessible spaces are necessary for small businesses**
 - D. All businesses must have at least five accessible spaces**
- 9. What should employees be informed about when questioned regarding an investigation?**
- A. They have the right to decline to answer**
 - B. They must provide all requested information**
 - C. They have the right to request an attorney**
 - D. They can report the question to their supervisor**
- 10. What type of feedback can initiate a ZPIC audit?**
- A. Market research surveys**
 - B. Beneficiary complaints**
 - C. Provider self-assessments**
 - D. Internal performance reviews**

Answers

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

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Explanations

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1. What must successor liability report when there are changes to locations or business units?

- A. Annual performance reviews**
- B. Compliance training updates**
- C. New business unit reports**
- D. Financial statements**

Successor liability refers to the legal concept where a company that acquires another company inherits certain liabilities of the acquired company. When there are changes related to locations or business units, successor liability mandates the need for new business unit reports. These reports are critical because they provide a detailed account of the potential liabilities associated with newly acquired entities or changes to existing ones. New business unit reports offer insights into the operational, financial, and compliance aspects of the business units affected. They are essential for understanding how these changes might impact the overall compliance framework and obligations that the acquiring entity must adhere to. This helps in assessing any risks that could arise from the integration of the new business units and ensures that the acquiring organization remains compliant with relevant regulations. The other options, such as financial statements, compliance training updates, or annual performance reviews, do not specifically capture the legal responsibilities and the particular focus on liabilities that arise directly from changes in business structure, which is why they do not represent the requirements of successor liability as clearly as new business unit reports do.

2. What constitutes a conflict of interest in healthcare?

- A. A situation where personal interests align with professional duties**
- B. A set of circumstances risking professional judgment due to secondary interests**
- C. When a healthcare provider has financial stakes in multiple entities**
- D. Any scenario where a decision must be made**

In the context of healthcare, a conflict of interest arises when a healthcare professional's ability to make impartial decisions is compromised due to personal interests that diverge from their professional obligations. This scenario is best summarized by the idea that certain circumstances can jeopardize professional judgment when secondary interests are involved. When healthcare providers encounter situations where their personal gains—such as financial benefits, relationships, or other influences—might sway their decisions regarding patient care or treatment options, it creates a conflict of interest. This is particularly critical in healthcare, where the primary responsibility is to ensure the well-being of patients. Understanding the nuances of what constitutes a conflict of interest helps healthcare professionals recognize and manage these potentially problematic situations to maintain integrity and trust in patient care.

3. What should employees remember if they have questions during an investigation?

- A. To make their best guess**
- B. To provide opinions based on rumors**
- C. To stick to the facts and avoid speculation**
- D. To remain silent until further notice**

In any investigation, especially in the context of healthcare compliance, it is crucial for employees to stick to the facts and avoid speculation. This approach ensures that the information being provided is accurate and substantiated, which is essential for the integrity of the investigation. Focusing on factual information allows investigators to obtain clear and objective insights into the situation being examined. Speculation can lead to misunderstandings and the dissemination of misleading information, which can complicate the investigation and potentially result in inappropriate actions or conclusions. Similarly, sharing opinions based on rumors can undermine the reliability of the investigation and detract from a proper assessment of the relevant issues. By adhering strictly to factual information, employees contribute positively to the investigation process, enabling a more effective resolution that is based on verified data rather than subjective interpretations. This principle is a fundamental aspect of compliance and ethical conduct within the healthcare environment.

4. What is the purpose of the healthcare fraud and abuse control program?

- A. To provide healthcare services to all Americans**
- B. To coordinate enforcement activities related to healthcare fraud**
- C. To monitor patient satisfaction levels**
- D. To manage healthcare funding operations**

The healthcare fraud and abuse control program is specifically designed to coordinate enforcement activities related to healthcare fraud. Its primary purpose is to help prevent, detect, and prosecute fraudulent activities within the healthcare system. This program aims to safeguard both the integrity of the healthcare system and the funds allocated for healthcare services. By focusing on the enforcement of laws and regulations, it works to ensure that healthcare providers adhere to ethical practices and that patients receive the care they are entitled to without the burden of fraudulent billing or abuse. While providing healthcare services to all Americans, monitoring patient satisfaction, and managing healthcare funding operations are important aspects of the overall healthcare landscape, they do not specifically address the issue of fraud and abuse control within the sector. The primary focus of the program is on legal enforcement and compliance to protect the system and its beneficiaries against fraudulent actions.

5. Which organization is primarily responsible for investigating healthcare fraud, waste, and abuse?

- A. The Federal Trade Commission (FTC)**
- B. The Department of Justice (DOJ)**
- C. The Office of Inspector General (OIG)**
- D. The Centers for Medicare and Medicaid Services (CMS)**

The Office of Inspector General (OIG) is primarily responsible for investigating healthcare fraud, waste, and abuse. This organization plays a crucial role in safeguarding public health programs and ensuring the integrity of Federal health care benefit programs. The OIG conducts evaluations, audits, and investigations to identify and address issues related to fraud and abuse within healthcare services. The OIG is tasked specifically with enforcing compliance within healthcare entities, particularly those that participate in Medicare and Medicaid. Their authority allows them to monitor and evaluate the operations of these programs, identify areas of risk, and implement measures to prevent fraudulent activities. This focus on compliance and oversight is vital for maintaining the integrity of the healthcare system, protecting public funds, and ensuring that beneficiaries receive the services they are entitled to. Other agencies, such as the Department of Justice (DOJ) and the Centers for Medicare and Medicaid Services (CMS), also play important roles in the broader context of healthcare enforcement and regulation. The DOJ primarily handles prosecutions and legal actions against fraud once investigations have been conducted, while CMS oversees the administration of the Medicare and Medicaid programs but does not focus specifically on fraud investigations. The Federal Trade Commission (FTC) primarily deals with consumer protection and marketplace competition and is not directly involved in the oversight of healthcare.

6. What can be a consequence for a provider manipulating information on a medical claim?

- A. Nothing, if the claim is paid**
- B. Legal prosecution for healthcare fraud**
- C. Increased patient trust**
- D. Enhanced reputation in the community**

Manipulating information on a medical claim can lead to legal prosecution for healthcare fraud. This encompasses a range of illegal activities, including submitting false or misleading information on claims to receive payment that would not otherwise be warranted. The legal consequences can be severe, including criminal charges, hefty fines, and even imprisonment. Healthcare fraud undermines the integrity of the healthcare system, leading to increased costs for insurers and taxpayers, as well as potentially harming patients by compromising the quality of care. Regulatory bodies and law enforcement agencies actively pursue cases of fraud to maintain trust in the healthcare system and protect patient interests. As a result, the ramifications for providers found guilty of manipulating claims can be extensive and damaging, both to their careers and to the healthcare institution they represent.

7. What is the role of Zone Program Integrity Contractors (ZPIC)?

- A. To supervise patient care improvements**
- B. To identify high-risk provider practices**
- C. To educate patients about Medicare**
- D. To process provider applications**

The role of Zone Program Integrity Contractors (ZPIC) is primarily focused on identifying high-risk provider practices. ZPICs are tasked with ensuring the integrity of Medicare services by investigating questionable billing practices, fraud, and abuse in the system. This involves analyzing claims data, conducting audits, and reviewing interactions with providers to pinpoint suspicious activities that could indicate fraud or misuse of Medicare resources. By concentrating on high-risk areas, ZPICs help protect the Medicare program from improper payments and maintain compliance with federal regulations. The other options, while related to healthcare, do not accurately reflect the specific functions of ZPICs. For instance, supervising patient care improvements is more aligned with quality assurance programs rather than the legal and compliance-focused mission of ZPICs. Educating patients about Medicare is typically the role of outreach programs or advocacy organizations, not the contractors who primarily monitor provider practices. Processing provider applications is a responsibility generally associated with Medicare administrative contractors (MACs), which manage provider enrollments and claims processing rather than focusing on integrity and compliance investigations.

8. Under ADA, what is required for parking spaces accessible to the disabled?

- A. All parking must be paved**
- B. One of every six spaces must be made van accessible**
- C. No accessible spaces are necessary for small businesses**
- D. All businesses must have at least five accessible spaces**

The requirement that one of every six parking spaces must be made van accessible is based on guidelines established by the Americans with Disabilities Act (ADA). This regulation ensures that individuals with disabilities have equal access to facilities, including the ability to park in designated spaces that accommodate vans that may have wheelchairs or other adaptive technologies. Van-accessible spaces must meet specific dimensions and also include sign-age that indicates the space is reserved for van accessibility. This enhances mobility options for individuals requiring those accommodations, thus fostering inclusivity in public spaces. The other options do not accurately capture ADA requirements. For instance, while paving may be necessary for accessibility, it does not pertain directly to the number of accessible spaces mandated. Similarly, the notion that small businesses may not need accessible spaces contradicts ADA regulations, which apply broadly regardless of business size. Lastly, while at least accessible spaces are required, the provision of "at least five accessible spaces" is not a universal stipulation across all contexts and depends on the total number of spaces in the lot.

9. What should employees be informed about when questioned regarding an investigation?

- A. They have the right to decline to answer**
- B. They must provide all requested information**
- C. They have the right to request an attorney**
- D. They can report the question to their supervisor**

When employees are questioned regarding an investigation, it is crucial for them to understand that they have the right to request an attorney. This right is fundamental in ensuring that employees are aware of their legal protections during an investigative process. In situations where employees may be facing inquiries that could potentially implicate them in wrongdoing or lead to disciplinary action, having the option to consult with legal counsel can help safeguard their interests and ensure that they receive appropriate guidance on how to respond. This awareness empowers employees to protect their rights and understand the implications of the questions being asked of them, thereby fostering a more transparent and legally compliant investigation process. Acknowledging the need for legal representation can significantly influence how employees approach the questioning and the information they choose to disclose. Understanding this right is essential for maintaining compliance with regulations and protecting both the employees and the organization during investigations.

10. What type of feedback can initiate a ZPIC audit?

- A. Market research surveys**
- B. Beneficiary complaints**
- C. Provider self-assessments**
- D. Internal performance reviews**

Beneficiary complaints can indeed be a catalyst for a Zone Program Integrity Contractor (ZPIC) audit. These complaints often highlight potential issues such as fraud, abuse, or billing inaccuracies associated with healthcare services. When beneficiaries express concerns regarding their coverage, billing practices, or the quality of care they have received, these issues prompt further investigation to ensure compliance with healthcare regulations and standards. Audits initiated by ZPICs are designed to evaluate the legitimacy of claims and services provided, focusing on protecting Medicare funds and ensuring beneficiary rights are upheld. Therefore, when beneficiaries raise flags through complaints, this feedback provides regulatory bodies with a basis to scrutinize the practices of healthcare providers for compliance and integrity. Other options, while potentially informative, do not have the same direct impact in triggering audits. Market research surveys may gather general satisfaction information but are not usually linked directly to compliance issues. Provider self-assessments reflect an internal review process and may not include external feedback that points to compliance concerns. Internal performance reviews, similarly, focus on an organization's metrics and outcomes, leaving external beneficiary perspectives unaddressed. Thus, beneficiary complaints represent a critical external trigger for further compliance scrutiny in the healthcare system.

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://healthcarecompliance.examzify.com>

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