CPMA ANALYSIS AND COMMUNICATIONS PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR THE FULL VERSION STUDY GUIDE

https://cpmaanalysiscomms.examzify.com

Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.

ALL RIGHTS RESERVED.

No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.

Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.

SAMPLE

Table of Contents

Copyright 1

Table of Contents 2

Introduction 3

How to Use This Guide 4

Questions 5

Answers 9

Explanations 11

Next Steps 17

SAMPLE

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.

SAMPLE

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!

SAMPLE

Questions

SAMPLE

1. What are auto and workers' compensation plans considered to be?

A. They must always comply with HIPAA standards.

B. They are exempt from HIPAA entirely.

C. State regulated commercial insurance plans are not required to comply with HIPAA standards.

D. Medicaid plans are subject to HIPAA only in part.

2. Which option is NOT a component of an audit report?

A. Background

B. Financial statements

C. Summary of audit findings

D. Report attachments

3. Which of the following is a possible objective of an audit?

A. Assess compliance with pending changes in payer documentation standards.

B. Increase revenue by optimizing billing rules.

C. Assess patient satisfaction with services.

D. Evaluate staff workload efficiency.

4. What type of information can be found in the provider's contract with the insurance carrier?

A. The provider's obligation to follow the insurance company's medical policies.

B. Utilization patterns of the provider compared to all other providers of the same specialty in that region.

C. What the insurance benefits are for each patient insured by that carrier.

D. Potential risks to specific providers.

5. Which statement is TRUE regarding the discussion portion of the audit report?

A. In case there is no binding rule to declare an error, it is appropriate to identify any concerns regarding the potential for post-payment risk.

B. When there is no binding rule, the potential post-payment risk should not be reported.

C. The recommendations for each claim should be addressed in the discussion.

D. The discussion portion should contain a brief overview of issue-oriented risk areas that were identified.

SAMPLE

6. Issues should be presented in a logical sequence.

A. In a logical sequence.

B. In random order.

C. In descending order of importance.

D. In order of discovery date.

7. In cases where an overpayment occurs without evidence of fraudulent conduct, what action should the entity take to avoid liability under the False Claims Act?

A. File a civil complaint with the inspector general.

B. Do nothing until an audit is completed.

C. Voluntarily identify, disclose and refund overpayments.

D. Pursue recovery only from the payer.

8. Why is expertise necessary to properly identify the relevant statutory and regulatory provisions, and any potential conflict with secondary guidance materials?

A. To ensure the audit is completed quickly.

B. To minimize the cost of the audit.

C. Because erroneous declaration of error could create reverse False Claims Act liability for the auditee.

D. To maximize reimbursements.

9. Which option represents information that may be found in a contract between a provider and a commercial insurance plan that is pertinent to an auditor?

A. Whether the provider is required to report the nurse to doctor ratio for the clinic.

B. Whether the provider is obligated to conform to the insurance company's published medical policies.

C. Whether the provider is required to disclose when new employees are hired.

D. Whether the provider is required to perform annual audits of their coding.

SAMPLE

10. The IRO's report is typically submitted to which recipients along with the annual report?

A. The OIG

B. The compliance officer

C. The auditee's legal counsel

D. The entity and the compliance officer

SAMPLE

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. What are auto and workers' compensation plans considered to be?

A. They must always comply with HIPAA standards.

B. They are exempt from HIPAA entirely.

C. State regulated commercial insurance plans are not required to comply with HIPAA standards.

D. Medicaid plans are subject to HIPAA only in part.

Understanding how HIPAA applies to different kinds of health plans helps here. Auto and workers' compensation plans are excluded from the HIPAA Privacy Rule because they're governed primarily by state laws and exist to address injury claims, not to be standard health plans that pay for medical care across the board. Because of that state-regulated, purpose-specific framework, these plans do not have to follow HIPAA privacy and security standards. Medicaid, by contrast, is generally covered by HIPAA, so it is subject to those protections.

2. Which option is NOT a component of an audit report?

A. Background

B. Financial statements

C. Summary of audit findings

D. Report attachments

The idea being tested is what actually forms part of an audit report versus what is being audited. An audit report is the auditor's formal communication about the financial statements, including context, the scope of the audit, the basis for the opinion, and the auditor's conclusion. The financial statements themselves are the documents that are audited, not elements that belong to the audit report. So listing the financial statements as a component would be incorrect because they are the subject of the audit, not the component of the report. Other items—background, a summary of audit findings, and attachments to the report—can appear in or accompany the audit report to provide context, highlight key issues, or append supplementary information. Thus, the financial statements are not part of the audit report, making that option the best answer.

3. Which of the following is a possible objective of an audit?

A. Assess compliance with pending changes in payer documentation standards.

B. Increase revenue by optimizing billing rules.

C. Assess patient satisfaction with services.

D. Evaluate staff workload efficiency.

Audits focus on whether the billing process and supporting documentation meet payer requirements and regulatory standards. Assessing compliance with pending changes in payer documentation standards targets exactly that: verifying that current documentation and claims align with updated payer rules so potential denials are avoided and compliance is maintained. The other options describe aims like boosting revenue, measuring patient satisfaction, or evaluating staffing efficiency—valuable in their own right but not the primary aim of an audit, which is to verify conformity to rules and accuracy of documentation and claims.

SAMPLE

4. What type of information can be found in the provider's contract with the insurance carrier?

A. The provider's obligation to follow the insurance company's medical policies.

B. Utilization patterns of the provider compared to all other providers of the same specialty in that region.

C. What the insurance benefits are for each patient insured by that carrier.

D. Potential risks to specific providers.

The essential idea is what a provider contract with a payer typically requires the provider to do. In these agreements, one of the main obligations is to follow the insurer's medical policies and guidelines for determining medical necessity and appropriate utilization. This aligns the services billed with the payer's standards and helps guide coverage decisions, audits, and reimbursements. That's why the statement about adhering to the insurance company's medical policies is the best fit for what such a contract contains. Details about utilization patterns compared with other providers, patient-level benefit descriptions, or risks to individual providers aren't what the contract primarily lays out. Utilization comparisons are more about market or quality analysis, patient benefits are defined in the policy or plan documents and not the contract itself, and risk disclosures to specific providers aren't the core contractual content.

5. Which statement is TRUE regarding the discussion portion of the audit report?

A. In case there is no binding rule to declare an error, it is appropriate to identify any concerns regarding the potential for post-payment risk.

B. When there is no binding rule, the potential post-payment risk should not be reported.

C. The recommendations for each claim should be addressed in the discussion.

D. The discussion portion should contain a brief overview of issue-oriented risk areas that were identified.

The discussion portion is about communicating risk and uncertainties when there isn't a clear rule that would make a formal error declaration. When no binding rule exists to declare an error, it's appropriate to identify concerns regarding potential post-payment risk. This approach keeps the report informative by highlighting where payments could be at risk, where controls may be weak, and what the financial impact might be, without asserting a finding that isn't anchored in a defined standard. If you don't report these risk concerns, stakeholders would lack crucial insight into possible overpayments or mispayments. Recommendations for every claim aren't typically required to appear in the discussion, and a discussion that only offers a brief overview of risk areas might miss important specific risk signals. Focusing on identifying potential post-payment risk when rules are absent provides actionable awareness and guides subsequent remediation.

SAMPLE

6. Issues should be presented in a logical sequence.

A. In a logical sequence.

B. In random order.

C. In descending order of importance.

D. In order of discovery date.

Presenting issues in a logical sequence helps the audience follow the argument as it unfolds. When you arrange points in a clear progression—starting with context, then stating the issue, backing it with facts, showing implications, presenting options, and finishing with a recommendation—you create a natural path the listener can anticipate and understand. Each point builds on the previous one, so the relationships and cause-and-effect are obvious instead of hidden. If the issues were in random order, the flow would feel chaotic and the audience would have to constantly reconstruct connections, making it harder to grasp why each point matters. Ordering by descending importance inserts subjectivity into the structure; what's deemed "most important" can bias perception and distort how the audience weighs other items. Ordering by discovery date treats chronology as the organizing principle, which can obscure the logical relationships between issues and mislead about what matters for the decision at hand. In communications practice, a logical sequence strengthens clarity, retention, and persuasiveness, guiding decision-makers smoothly from understanding to action.

7. In cases where an overpayment occurs without evidence of fraudulent conduct, what action should the entity take to avoid liability under the False Claims Act?

A. File a civil complaint with the inspector general.

B. Do nothing until an audit is completed.

C. Voluntarily identify, disclose and refund overpayments.

D. Pursue recovery only from the payer.

Acting quickly to identify and rectify overpayments is critical. When there's an overpayment with no fraudulent intent, voluntarily spotting it, disclosing it to the funding agency, and refunding or crediting the amount demonstrates proactive compliance and a commitment to correcting errors. This approach is viewed favorably under the False Claims Act because it shows the entity did not attempt to profit from the overpayment and took steps to prevent harm, which can reduce potential liability or penalties. Waiting for an audit or doing nothing signals inattention to compliance and can heighten exposure to liability. Filing a complaint with an inspector general is not a corrective action the entity takes to address the overpayment itself, and pursuing recovery only from the payer doesn't address the improper disbursement and can complicate the corrective process.

SAMPLE

8. Why is expertise necessary to properly identify the relevant statutory and regulatory provisions, and any potential conflict with secondary guidance materials?

A. To ensure the audit is completed quickly.

B. To minimize the cost of the audit.

C. Because erroneous declaration of error could create reverse False Claims Act liability for the auditee.

D. To maximize reimbursements.

Understanding which statutes and regulations apply and how they interact with guidance materials is essential because these rules define what counts as a true or false claim and what must be reported or corrected. Statutes and regulations set the binding standards for compliance, while secondary guidance materials can help interpret those standards but may not be legally binding or perfectly aligned with the statutes. An expert can navigate any conflicts between binding rules and guidance, determine which provisions actually apply to a given situation, and assess how those provisions interact with the guidance. This is crucial because an erroneous declaration of an error can trigger liability under the reverse False Claims Act for the auditee. If the wrong legal standards are applied or if a misinterpretation leads to improper reporting or misstatement of payments, the auditee may be held liable for falsely avoiding repayment or improperly obtaining a payment. Expertise helps ensure accurate identification of the applicable law, appropriate handling of errors, and avoidance of actions that could expose the entity to this significant legal risk. While factors like speed, cost, or trying to maximize reimbursements might come into play in practice, they do not address the fundamental need to base actions on correct, binding legal requirements and to recognize conflicts with guidance to prevent legal liability.

9. Which option represents information that may be found in a contract between a provider and a commercial insurance plan that is pertinent to an auditor?

A. Whether the provider is required to report the nurse to doctor ratio for the clinic.

B. Whether the provider is obligated to conform to the insurance company's published medical policies.

C. Whether the provider is required to disclose when new employees are hired.

D. Whether the provider is required to perform annual audits of their coding.

The core idea is that a contract between a provider and an insurer sets expectations for how care will be evaluated for coverage. Auditors rely on a standard that shows what counts as medically necessary and covered. When the contract requires the provider to conform to the insurer's published medical policies, it gives the auditor a clear, objective yardstick to verify that claims and clinical decisions align with the plan's rules. This alignment helps determine whether services billed were appropriate for reimbursement and supports audit findings. Other options mix in operational or HR details that don't directly govern reimbursement decisions or what an auditor checks against the insurer's policies. For example, reporting staffing ratios, disclosing new hires, or internal coding audits may occur in various contexts, but they don't establish the insurer's coverage criteria or medical necessity standards that auditors routinely verify.

SAMPLE

10. The IRO's report is typically submitted to which recipients along with the annual report?

A. The OIG

B. The compliance officer

C. The auditee's legal counsel

D. The entity and the compliance officer

Recipients for the IRO report alongside the annual report are the entity itself and the compliance officer. This setup ensures internal governance and action: the organization receives the findings so leadership can authorize corrective actions, and the compliance officer can oversee the program, track remediation, and report on progress. External bodies like the OIG aren't the typical audience for routine internal reports, unless policy or law requires disclosure, and involving the auditee's legal counsel isn't standard for the annual report, though counsel may be consulted in cases with legal implications.

SAMPLE

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://cpmaanalysiscomms.examzify.com

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

SAMPLE