AAPC CERTIFIED PROFESSIONAL MEDICAL AUDITOR (CPMA) PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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.

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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!

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Questions

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1. What does informed consent typically include regarding alternative treatments?

A. Only the alternatives prescribed by the physician

B. A detailed explanation of options

C. Comparative costs of treatments

D. Only alternatives that the patient suggests

2. Which coding system is used for chemotherapy and therapeutic drug supplies?

A. ICD-10

B. HCPCS Level II

C. CPT

D. DRG

3. In radiology auditing, what must be verified along with the order for the test?

A. Medical necessity

B. Complete documentation

C. Payment acceptance

D. Imaging guidance

4. How many sampling units are selected for review in a Discovery Sample under a CIA?

A. 25

B. 50

C. 75

D. 100

5. In the context of trigger point injections, which code should be reported for fluoroscopic guidance?

A. 76942

B. 20552

C. 77002

D. 20553

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6. Which symbol in the CPT indicates a code that may not require separate billing for associated moderate sedation?

A. Triangle

B. Bulls-eye

C. Forbidden

D. Bullet

7. What will a provider receive if an improper payment is identified by a Recovery Auditor?

A. A payment adjustment notification

B. A decision and rationale review letter

C. A claim denial notice

D. A request for additional documentation

8. In the context of health auditing, what does the abbreviation CERT stand for?

A. Clinical Error Review Team

B. Comprehensive Error Rate Testing

C. Certified Evaluation and Review Tool

D. Comprehensive Evaluation Review Techniques

9. What is the minimum frequency for conducting an internal audit?

A. Monthly

B. Quarterly

C. Annually

D. Biannually

10. According to the OIG CIA agreement, what is the minimum frequency for an IRO to perform an audit?

A. Monthly

B. Quarterly

C. Annually

D. Bi-annually

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Answers

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

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Explanations

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1. What does informed consent typically include regarding alternative treatments?

A. Only the alternatives prescribed by the physician

B. A detailed explanation of options

C. Comparative costs of treatments

D. Only alternatives that the patient suggests

The correct answer encompasses the comprehensive nature of informed consent, which is an essential component of patient autonomy and shared decision-making in healthcare. Informed consent is not just about obtaining permission for a treatment; it involves providing patients with relevant information that helps them understand their healthcare options thoroughly. A detailed explanation of options in informed consent includes presenting the proposed treatment, but importantly, it also covers alternative therapies that the patient may consider. This means that the physician should communicate not only what is recommended but also other viable treatments available, including those that may not be favored but are still suitable for the patient. This level of detail ensures that patients can weigh the benefits and risks of each option, empowering them to make informed decisions regarding their care. Understanding this principle is crucial for ethical medical practice, as it reinforces the patient's right to autonomy and informed participation in their healthcare journey. This approach aligns with best practices in patient communication and helps build trust in the healthcare provider-patient relationship.

2. Which coding system is used for chemotherapy and therapeutic drug supplies?

A. ICD-10

B. HCPCS Level II

C. CPT

D. DRG

The coding system used for chemotherapy and therapeutic drug supplies is HCPCS Level II. This system is specifically designed to represent products, supplies, and services that are not covered by CPT codes, including drugs not typically administered in a physician's office. HCPCS Level II codes are used to identify various items such as durable medical equipment (DME), prosthetics, and non-oral medications, which includes chemotherapy drugs. ICD-10 coding, in contrast, is focused on diagnosis codes and is used to indicate the reasons for patient encounters and the conditions being treated. CPT codes primarily represent medical procedures, professional services, and diagnostic tests performed by healthcare providers, but they do not encompass the actual pharmaceutical products used for treatment. DRG codes are related to hospital payment systems and classify inpatient services based on the diagnosis and treatment performed; they do not pertain largely to outpatient drug administration. Thus, HCPCS Level II is critical for accurately coding and billing for chemotherapy and therapeutic drug supplies, ensuring appropriate reimbursement and compliance in medical billing practices.

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3. In radiology auditing, what must be verified along with the order for the test?

A. Medical necessity

B. Complete documentation

C. Payment acceptance

D. Imaging guidance

In radiology auditing, verifying medical necessity along with the order for the test is crucial. Medical necessity ensures that the procedure being ordered is appropriate for the patient's condition and aligns with established guidelines or criteria. It is essential for compliance with insurance requirements, as most payers will only cover procedures that can be demonstrated to be medically necessary. Auditors must review the documentation to confirm that the radiological service being ordered is justified by the patient's diagnosis or symptoms. If medical necessity is not established, the facility or provider risks claim denials, which can significantly impact revenue and compliance with regulatory standards. Establishing medical necessity protects both the patient and the healthcare provider by ensuring that tests ordered are appropriate and warranted based on clinical evidence. While complete documentation is important, it would normally be part of the broader context of ensuring medical necessity, as documentation must support the claims made for the necessity of the test. Payment acceptance and imaging guidance, while relevant in their contexts, do not directly pertain to the verification tied specifically to the order of the test itself in the auditing process.

4. How many sampling units are selected for review in a Discovery Sample under a CIA?

A. 25

B. 50

C. 75

D. 100

In the context of a Corporate Integrity Agreement (CIA), a Discovery Sample is typically utilized to evaluate the effectiveness of a compliance program and to identify any potential issues. A Discovery Sample is designed to assess a random selection of claims to determine the overall rate of compliance and any patterns of error that might exist. For the selection of sampling units, a Discovery Sample typically consists of 50 units. This number is often established as a standard guideline within the auditing community to ensure a statistically significant analysis without being overly burdensome on the entities under review. The use of 50 sampling units allows auditors to obtain reliable insights into the compliance and accuracy of billing practices while maintaining a manageable sample size for review. This standard helps ensure that the findings are robust and can accurately reflect overall compliance, which is important for both the auditor's conclusions and the organization's efforts to improve its practices. Thus, the rationale for selecting 50 sampling units in a Discovery Sample under a CIA aligns with best practices in the field of medical auditing.

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5. In the context of trigger point injections, which code should be reported for fluoroscopic guidance?

A. 76942

B. 20552

C. 77002

D. 20553

The appropriate code to report for fluoroscopic guidance during trigger point injections is 77002. This code is specifically assigned for fluoroscopic guidance for needle placement, which is essential in ensuring precise administration of the injection into the trigger points identified in the patient. The use of fluoroscopic imaging allows for better visualization of the anatomy, helping to avoid complications and improve the effectiveness of the injection. Understanding the context of the procedure is important; trigger point injections are often performed to relieve pain caused by muscle knots, and using imaging guidance can enhance the accuracy of the injection. While other codes mentioned relate to the procedure of injection itself or other forms of imaging, 77002 uniquely identifies the requirement for fluoroscopic guidance, which is central to this specific aspect of the procedure.

6. Which symbol in the CPT indicates a code that may not require separate billing for associated moderate sedation?

A. Triangle

B. Bulls-eye

C. Forbidden

D. Bullet

In the Current Procedural Terminology (CPT) coding system, the bullseye symbol represents codes that may not require separate billing for associated moderate sedation when the sedation is provided as part of the procedure. The presence of the bullseye symbol alongside the code indicates that the moderate sedation is considered included in the primary procedure and does not warrant separate coding or billing. This concept emphasizes the importance of thoroughly understanding the coding guidelines to avoid unnecessary billing errors. When moderate sedation is performed in conjunction with specific procedures marked by the bullseye, it streamlines the billing process, as the sedation is automatically factored into the payment for the primary service. Understanding these symbols and their implications is crucial for accurate medical coding and compliance, ensuring that practitioners and facilities receive appropriate reimbursement without over- or under-coding services.

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7. What will a provider receive if an improper payment is identified by a Recovery Auditor?

A. A payment adjustment notification

B. A decision and rationale review letter

C. A claim denial notice

D. A request for additional documentation

When a Recovery Auditor identifies an improper payment, the provider will receive a decision and rationale review letter. This letter outlines the auditor's findings, detailing the reasons for the identified improper payment. It serves as a formal communication to the provider, explaining the basis for the recovery action and providing insights into the auditing process. This letter is important because it not only informs the provider of the issue but also allows them an opportunity to review the findings and, if necessary, respond to the audit results. By providing the decision along with the rationale, the auditor fosters transparency in the auditing process and ensures that providers understand the criteria used to assess the payment accuracy. This process is distinct from other potential communications that might be sent in different scenarios, such as notices of payment adjustments or claim denials, which serve different purposes and do not typically provide the comprehensive rationale that is offered in a decision and rationale review letter.

8. In the context of health auditing, what does the abbreviation CERT stand for?

A. Clinical Error Review Team

B. Comprehensive Error Rate Testing

C. Certified Evaluation and Review Tool

D. Comprehensive Evaluation Review Techniques

The abbreviation CERT stands for Comprehensive Error Rate Testing, which is a program initiated by the Centers for Medicare & Medicaid Services (CMS). This program is designed to measure the level of improper payments in various healthcare claims submitted to Medicare. By evaluating these claims, CERT assists in identifying and reducing billing errors, ensuring compliance with Medicare's policies. Understanding this term is crucial in the field of medical auditing because it emphasizes the importance of monitoring the accuracy of claims and the financial integrity of healthcare systems. The CERT program collects data through medical record reviews and analyzes it to determine error rates, thereby providing insight into areas where additional training or oversight may be needed. This focus on quality and accuracy aligns with the goals of medical auditing, which seeks to improve patient care while safeguarding financial resources. The other options provided do not accurately capture the primary function or established meaning of the CERT abbreviation in health auditing, making Comprehensive Error Rate Testing the correct choice.

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9. What is the minimum frequency for conducting an internal audit?

A. Monthly

B. Quarterly

C. Annually

D. Biannually

The minimum frequency for conducting an internal audit is annually. An annual internal audit is crucial for healthcare organizations as it allows them to assess their compliance with regulations, quality of care, and operational efficiencies. Conducting these audits regularly ensures that any discrepancies or areas needing improvement can be identified and addressed in a timely manner. By performing audits on an annual basis, organizations are able to maintain compliance with industry standards and government regulations, preventing potential penalties and fostering an environment of continuous improvement. In addition, annual audits can help to establish a systematic approach to identifying weaknesses in coding, billing practices, and documentation, which enhances the overall integrity of the healthcare organization. While more frequent audits (such as quarterly or monthly) can be beneficial for specific circumstances or to address immediate issues, they are not required by standard practices for general compliance. Therefore, conducting internal audits at least annually establishes a foundational framework for ongoing monitoring and quality assurance.

10. According to the OIG CIA agreement, what is the minimum frequency for an IRO to perform an audit?

A. Monthly

B. Quarterly

C. Annually

D. Bi-annually

The correct answer, which indicates that an Independent Review Organization (IRO) must perform an audit at least annually according to the Office of Inspector General (OIG) Corporate Integrity Agreement (CIA), is grounded in the requirement set by the OIG to ensure compliance and oversight in healthcare settings. An annual audit allows for the effective evaluation of compliance with applicable laws, regulations, and policies. This timeframe strikes a balance between frequent oversight and the practicality of conducting comprehensive audits, as more frequent audits could impose significant administrative burdens on both the healthcare organization and the IRO. Additionally, the annual requirement encourages a continuous improvement approach, where issues can be identified and remedied in a timely manner without overwhelming resources. The findings from these audits can then be used to enhance compliance efforts, training, and policies throughout the year. While other frequencies such as monthly, quarterly, or bi-annually may provide more regular checks, the OIG specifically stipulates an annual audit as a minimum standard that aligns with regulatory expectations. This annual requirement ensures that there is a structured and systematic approach to compliance monitoring in a healthcare environment.

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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://aapccertifiedpromedicalauditor.examzify.com

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

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