

AAPC CPMA Certified Professional Medical Auditor: Your Ultimate Study Guide

If you're aiming for a career in *medical auditing*, obtaining the **Certified Professional Medical Auditor** (CPMA) designation can be your golden ticket. This certification not only boosts your credentials but also opens doors to various **medical auditing jobs**. However, preparing for the **AAPC CPMA certification** requires a well-structured study plan. For comprehensive resources, refer to [this guide](#).

Understanding the CPMA Exam

The CPMA exam focuses on auditing skills, clinical knowledge, and coding guidelines. To become a certified auditor, you need to pass this exam. It's essential to familiarize yourself with the exam format, types of questions, and the key areas covered.

Creating a Study Plan

A smart way to prepare for the CPMA exam is to create a study plan. Here are some steps to get you started:

- **Gather Resources:** Look for a reliable **CPMA exam study guide** that covers all the relevant topics.
- **Allocate Time:** Set aside consistent time each week dedicated to studying.
- **Practice Tests:** Taking practice exams can significantly help you feel more comfortable with the actual exam format.

Key Topics to Study

While preparing for your exam, focus on these key areas:

- Understanding coding systems and guidelines.
- The implications of various types of audits.
- The role of compliance in medical auditing.
- Common auditing examples and real-world scenarios.

Joining Study Groups

Learning from peers is an excellent way to deepen your understanding. Joining **medical coding**

and auditing forums or study groups can provide valuable insights. Discussing topics and sharing resources can enhance your knowledge and confidence.

Handling Exam Day

On the day of the CPMA exam, make sure you are well-rested and arrive early. Bring all necessary identification and materials as outlined in the exam instructions. Stay calm and focused; anxiety can hinder your performance.

Post Exam: Next Steps

After passing the exam, it's time to pursue **medical auditing jobs**. Update your resume with your new certification. Highlight your skills and any relevant experience you've gained during your studies or through practical exposure. For more exam prep resources, check [this link](#).

Conclusion

Becoming a **Certified Professional Medical Auditor** opens up numerous opportunities in the healthcare field. With the right study plan, resources, and mindset, you can conquer the CPMA exam and embark on a fulfilling career in medical auditing.

Good luck on your journey to certification!

Real Exam Questions 2025

Below given questions are for demo purposes only. **The full version** is up-to-date and contains actual questions and answers.

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AAPC-CPMA
Certified Professional Medical Auditor



Questions and Answers (PDF)

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Total Questions: 368

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Question: 1

Which statement is TRUE regarding 1995 and 1997 E/M Documentation Guidelines?

- A. The 1997 E/M Documentation Guidelines are more detailed using bullets and shading to determine levels of exams .
- B. The 1995 E/M Documentation Guidelines are never beneficial for specialists.
- C. The 1997 E/M Documentation Guidelines are beneficial for general practitioners.
- D. The 1997 E/M Documentation Guidelines are more detailed using bullets and shading to determine levels of exams.

Answer: D

Question: 2

Which statement is TRUE regarding the recommendations section of an audit report?

- A. The recommendations section should contain recommendations for resolving any detected errors.
- B. The recommendations section should include detail of each claim affected by the errors detected during the audit.
- C. If there are no binding rules for the post-payment risks detected, they should not be included in the recommendations.
- D. The order of the recommendations is irrelevant as long as they are all listed.

Answer: A

Question: 3

Which of the following scenarios will result in an audit finding?

- A. The lab results were not reviewed by the provider after the test were performed.
- B. A comprehensive metabolic panel performed on the date of a preventive exam
- C. Performing a laboratory test without the patients written consent
- D. Reporting codes 82435 and 82947 together on the same date of service

Answer: A

Question: 4

You Audit provider who is consistently reporting multiple units of CPT code 11042. What references can you use to show the provider multiple units of CPT code 11042 is not allowed and explain how it should be reported ?

- A. CPT codebook and MUE table.
- B. CPT codebook and NCCI edits
- C. MUE table only
- D. HCPCS codebook and NCCI edits

Answer: A

Question: 5

A provider receives multiple denials from Medicare on all claims submitted with 19307-LT 19307-RT, 19340-LT, 19340-RT. After completing a review of the records to verify the procedures were performed, what recommendation would you make to resold the denials?

- A. Resubmit the claims with a copy of the medical record to show the services were properly documented.
- B. Correct the modifiers and resubmit the claim. Medicare requires modifier 0 and one unit for bilateral procedures.
- C. Based on the code description the procedure cannot be performed bilaterally. Resubmit without LT and RT modifiers
- D. Correct the modifier and resubmit the claim. Medicare requires modifier 50 on bilateral procedures on one line item with one unit

Answer: B

Question: 6

In an audit report, which section would identify the specific binding standards or criteria that were applied during the course of the audit?

- A. Issue oriented findings
- B. Standards of review
- C. Discussion
- D. Summary

Answer: B

Question: 7

A provider consistently charges a higher level E/M service than is documented to help cover the cost of his declining practice. Would this be fraud or abuse Why?

- A. Abuse, charging one level higher on each visits does not show intent.
- B. Abuse; the provider's practice is common and therefore would not be considered fraudulent .
- C. Fraud; and over-coding of services would be considered fraudulent.
- D. Fraud; the provider intentionally over-coded to gain financially.

Answer: D

Question: 8

Which statement is TRUE regarding the written audit report?

- A. The recommendations can serve as a roadmap for achieving compliance.
- B. The audit report can be an effective educational tool.
- C. The report must be organized, succinct, and well written.
- D. All of the above.

Answer: D

Question: 9

According to the JC's Official "Do Not Use" List, what would be considered an abbreviation that should not be used a medial record and why?

- A. IU; because it can be mistaken for IV or the number 10
- B. HTN, because there should be more specification on the type of hypertension?
- C. PRN; because it may be misunderstood to be a privacy issue.
- D. IV; because it can be mistaken for IU

Answer: A

Question: 10

Which of the following would be an audit finding for psychiatric services?

- A. Reporting codes 90791 and 90785 on the same date of service.

- B. Reporting code 90832 only
- C. Reporting 90863 only
- D. Reporting codes 99214 and 90838 on the same date of service.

Answer: C

Question: 11

CMS has two sets of Evaluation and Management Documentations Guidelines , 1995 and 1997. Which set is used by physicians for office visits?

- A. 1995 E/M Documentation Guidelines
- B. 1997 E/M Documentation Guidelines
- C. The practice must choose either the 1995 or 1997 E/M Documentation Guidelines for the entire practice.
- D. The practice may use 1995 or 1997 E/M Documentation Guidelines for each visit; whichever is most advantageous for that visit.

Answer: D

Question: 12

Which of the following deficiencies are found after review of the documentation and the code submitted

- A. The provider is not indicated on the operative report, and the signature is missing
- B. The procedure codes are unbundled; only 29881-LT is reported for this case
- C. The diagnosis codes submitted do not support medical necessity
- D. There are no deficiencies

Answer: A

Question: 13

What form is used to authorize payment from the insurance carrier to go directly to the provider?

- A. Assignment of benefits
- B. Release of information
- C. Informed consent
- D. Patient registration form.

Answer: A