AAPC

CPMA®

Certified Professional Medical Auditor

STUDY GUIDE

2026

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Clinical Examples Used in this Book

AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides, exams, and workbooks are actual, redacted office visit and procedure notes donated by AAPC members.

To preserve the real world quality of these notes for educational purposes, we have not re-written or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially they are as one would find them in a coding setting.

2233 South Presidents Dr. Suite F, Salt Lake City, UT 84120
800-626-2633, Fax 801-236-2258, www.aapc.com
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Introduction

AAPC would like to introduce the *Medical Auditing Training: CPMA®* for 2025. This material was developed to help coders, auditors, and other medical professionals expand their knowledge base and prepare for the Certified Professional Medical Auditor (CPMA®) examination.

AAPC has prepared a program of study that is aimed at providing the most up-to-date information relating to documentation guidelines, compliance guidelines, coding and reimbursement concepts, and medical record auditing and reporting.

The Business of Medicine

The business of medicine is highly complex, ever changing, and tightly regulated. Healthcare providers are subject to a myriad of guidelines and requirements, as implemented by insurers and government agencies. These rules cover a wide range of issues, from how providers must handle medical records to the documented diagnoses or clinical indications a patient must demonstrate if an insurer is to pay for a procedure.

Until the 1940s, healthcare insurance was not commonplace for Americans. During World War II, the Stabilization Act (1942) placed wage and price controls on employers. Congress limited the wages that could be offered but allowed the adoption of employee insurance plans. The 1954 Internal Revenue Code exempted employer contributions to employee health plans from employee taxable income, making health insurance even more appealing.

President Lyndon B. Johnson signed Medicare into law on July 30, 1965, under title XVIII of the Social Security Act. Beneficiaries were able to sign up for the program on July 1, 1966. U.S. citizens were automatically enrolled in Part A Medicare (which covers hospital stays) at age 65 and had an option to enroll in Part B Medicare, which covers physician services.

The Nixon Administration proposed the Health Maintenance Organization Act of 1973 (P. L. 93–222) to help to control healthcare costs. It authorized $375 million to assist in establishing and expanding health maintenance organizations (HMOs). The act also overrode state laws that prohibited the establishment of prepaid health plans and required employers with 25 or more employees to offer an HMO option if they furnished healthcare coverage to employees.

Preferred Provider Organizations (PPOs) emerged next. A PPO fits within the framework of managed care health insurance. PPOs create a network of doctors, hospitals, and other healthcare providers, and negotiate predetermined fees with a given carrier. PPOs offer members more options, in that members do not have to maintain a primary care physician. A PPO does not require referrals.

The addition of these and other novel health plans has led to a high level of complexity. Hospitals, clinics, and private physician practices must contend with many issues to stay in business. This has led to a greater number of medical professionals with the skill sets necessary to keep the business side of medicine running smoothly.

Healthcare regulations are not always definitive, and may vary by payer, geographic area, and the setting in which patient care is provided. To be effective, the auditor must distinguish and comprehend the precise regulatory requirements that apply in a particular circumstance. Audit findings and recommendations must be supported by applicable, verifiable guidelines, which should be clearly enumerated and explained for the provider.

The Importance of Audits in a Practice

Medical auditing is critical to a compliant and profitable physician practice. Medical audits can provide a mechanism for:

- Reviewing quality of care provided to patients
- Educating providers on documentation guidelines
- Ensuring all services are supported and all appropriate revenue is captured
- Defending against external audits, malpractice litigation, and health plan requests and denials

According to the United States Department of Health and Human Services (HHS), from 2018-2020 for every dollar spent on healthcare-related fraud and abuse investigations, the government recovered $4.30. In fiscal year 2020, the federal government recovered $1.8 billion as a result of healthcare fraud settlements and judgments. Whether in response to recovery audit contractor (RAC) audits, private payer denials, or just for peace of mind, more physicians are performing (or planning) regular self-audits. The risks associated with noncompliance are simply too great. Certified Professional Medical Auditors (CPMA®) display proven knowledge of coding,

5. As an auditor, you are reviewing medical records printed from an electronic health record (EHR). What risk should you be aware of in the use of EHRs?

   A. Delay between the patient visit and when the information is placed in the chart.
   B. Copying or cloning.
   C. Illegibility.
   D. Failing to make corrections and giving an explanation of a delayed entry.

6. Which form is signed by the patient to verify that the patient understands procedures, outcomes, and options of the treatment?

   A. Assignments of Benefits
   B. Release of Information
   C. Confirmation of Receipt of Privacy Note
   D. Informed Consent

7. Why is the CERT program beneficial to auditors?

   A. The CERT program provides percentages of errors by provider on claims processed. This gives an auditor a chance to review that service for the provider and provide education on documentation.
   B. The CERT program allows providers to identify errors in their documentation before being audited.
   C. The CERT program identifies errors causing improper payments by the Medicare program. The errors found can identify areas for providers to improve documentation.
   D. The CERT program provides error rates upon provider request for auditors to complete a focused audit.

8. SOAP is a common format used to document in the medical record. In this acronym, what does the A represent?

   A. Assessment
   B. Analysis
   C. Appraisal
   D. Assistance

9. When must authentication of a report by a physician or another practitioner take place?

   A. Prior to transcription
   B. When report is being dictated
   C. As soon as the patient has left the exam room
   D. After the document has been transcribed and reviewed

10. Providers and suppliers that have been approved by a national accreditation organization may be exempt from which of the following?

    A. Federal surveys to determine compliance with Medicare conditions
    B. Routine state survey agencies to determine compliance with Medicare conditions
    C. OIG investigations
    D. Audits

Chapter 3

Coding and Reimbursement

Introduction

Accurate reimbursement begins with accurate coding, and rules that vary by payer. In this chapter, we will discuss CPT® guidelines and payer policies.

CPT® Coding Concepts

The CPT® code book contains instructions, coding guidelines, parenthetical notes, and symbols to provide guidance for proper coding. Not all payers follow CPT® coding guidelines. An auditor must be able to apply payer variations to the CPT® guidelines during an audit and must communicate the differences in a way that will make sense to the provider.

CPT® Conventions and Iconography

An established set of conventions and symbols are used throughout the CPT® code book. We will focus on the icons most helpful in the audit process.

+ Add-on Codes (Appendix D in the CPT® code book)—some of the procedures listed in CPT® are carried out in addition to the primary procedure. Add-on codes are never reported alone, and always accompany specific primary procedure codes. There is a parenthetical note following the add-on code to indicate the associated primary code(s).

EXAMPLE

+31627 with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s])

(31627 includes 3D reconstruction. Do not report 31627 in conjunction with 76376, 76377)

(Use 31627 in conjunction with 31615, 31622-31626, 31628-31631, 31635, 31636, 31638-31643)

When the list of associated add-on codes is too extensive, there will not be a list of applicable primary codes in a parenthetical note following the add-on code.

All add-on codes are exempt from the multiple procedure concept (see the modifier 51 definition in CPT® Appendix A). The multiple surgical procedure reduction is applied when multiple procedures are performed during the same operative session. The highest valued code is paid at 100 percent, the second highest valued code is paid at 50 percent, and each additional procedure is paid at 25 percent. If a claim exceeds five line items, payers may evaluate for special pricing. The fee schedule for add-on codes already accounts for the reduction, and the payment is made at 100 percent.

The Medicare National Physician Fee Schedule (MPFS) Relative Value File is useful to determine if procedures are subject to the multiple procedure payment reduction. If there is a 0 in the Multiple Procedure column, the procedure is not subjected to the multiple procedure payment reduction. If there is a 2 in the multiple procedure column, the procedure is subjected to the multiple procedure payment reduction. To access the Medicare National Physician Fee Schedule Relative Value File, go to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html. The file contains information (for example, global days, RVUs, assist surgeon appropriate, etc.) all auditors use during the audit process.

EXAMPLE

A provider performs a bronchoscopy with computer-assisted, image-guided navigation. The correct codes are 31622 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed, diagnostic with cell washing, when performed (separate procedure) and + 31627 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed, with computer-assisted, image guided navigation (List separately in addition to code for primary procedure). The 2023 non-facility Medicare national payment amount for 31627 is $ 1,103.71, and $250.43 for 31622. The total reimbursement expected is $1,354.14. Do not reduce the fee for the add-on code because the Multiple Procedure Indicator for 31627 is 0.

- A bullet symbol located to the left of a code indicates new procedures and services added to the CPT® code book. When auditing, use the correct codes for the date of service audited. For example, you may perform an audit in March 2022 for dates of service from October 2021. In this case, use the codes from 2021 that were valid when the procedure was performed.

DOCUMENTATION DISSECTION – ANESTHESIA

Patient: H Caldwell **Date of Service:** 2/21/XX

Facility: General Hospital

Outpatient surgery

Surgeon: M. Specials, MD

Anesthesiologist: L Miller, MD [1]

Preoperative Diagnosis: Prostatic Hypertrophy

Postoperative Diagnosis: Prostatic Hypertrophy [2]

Procedure: Cystoscopy
Transurethral resection of prostate [3]

Anesthesia: General

Anesthesia Start: 7:05 [4]

Anesthesia End: 9:19 [5]

ASA Physical Status: 2 [6]

L Miller, MD inserted an arterial line in the left radial artery. [7]

Electronically Signed: L. Miller, MD

The correct codes and modifiers for this case are 00914-AA-P2, 36620

[1] Case personally performed by the anesthesiologist

[2] Diagnosis

[3] Procedure used to determine the correct anesthesia code

[4] Start time

[5] Stop time

[6] Physical Status modifier P2

[7] Additional reportable procedure performed by the anesthesiologist

EXAMPLE

Report the CPT® codes for the professional services for these services.

Diagnosis: Non-Hodgkin lymphoma, malignant follicular lymphoma.

Medication	Ordered	Administered	Route	Date	Start Time	End Time
Dexamethasone Sodium phosphate	10 mg	10 mg	IVPB	5/11/20XX	12:30 p.m.	12:53 p.m.
Notes: Administered in the same bag as palonosetron						

Medication	Ordered	Administered	Route	Date	Start Time	End Time
Palonosetron	0.25 mg	0.25 mg	IVPB	5/11/20XX	12:30 p.m.	12:53 p.m.
Notes: Administered in the same bag as palonosetron						

Medication	Ordered	Administered	Route	Date	Start Time	End Time
Doxorubicin	72 mg	72 mg	IVP	5/11/20XX	12:55 p.m.	12:55 p.m.
Notes: 8 mg Doxorubicin was wasted						

Medication	Ordered	Administered	Route	Date	Start Time	End Time
Vincristine	2 mg	2 mg	IVP	5/11/20XX	12:53 p.m.	12:58 p.m.
Cyclophosphamide	1073 mg	1073 mg	IV	5/11/2016	1:05 p.m.	2:00 p.m.
Notes:						

Medication	Ordered	Administered	Route	Date	Start Time	End Time
Diphenhydramine	50 mg	25 mg	IV	5/11/20XX	9:30 a.m.	9:56 a.m.
Notes: 25 mg Diphenhydramine was wasted						

Codes reported:

CPT®: 96413, 96411 x 2, 96367 x2

Rationale: According to CPT® guidelines, when administering multiple infusions, injections, or combinations, only one initial service code is reported unless protocol requires that two separate IV sites must be used. The initial code that best describes the key or primary reason for the encounter should always be reported irrespective of the order in which the infusions are administered.

The administration of the saline is not reported. According to CPT® guidelines, the fluid used to administer the drug(s) is considered incidental hydration and is not separately reported.

Intravenous or intra-arterial push is defined as an injection in which the healthcare professional administering the substance is continuously present to administer the injection and observe the patient, or an infusion of 15 minutes or less.

The patient is administered cyclophosphamine for 55 minutes, which is reported 96413. Vincristine is administered as a push, which is reported 96411. Doxorubicin is also administered as a push and is reported 96411. For the 26-minute administration of

5. What is the E/M code for the case below using AMA CPT® guidelines for Office or Other Outpatient E/M Services:

   CHIEF COMPLAINT: Left tibia fracture.

   HISTORY OF PRESENT ILLNESS: Patient is a 13-year-old male we first saw on 05/09/XX. He was noted to have been injured when he jumped while running down a hill. He sustained a Salter-Harris II fracture of the distal tibia. He is currently non-weight bearing in a short-leg cast. He has been compliant with his activity modifications.

   PHYSICAL EXAMINATION: He is intact to sensation. His capillary refill of the toes remains stable. There is no skin breakdown at the proximal or distal aspect of the cast. The cast is intact.

   ANCILLARY STUDIES: Radiographs of the left ankle show good alignment and positioning of the fracture. Growth plate is stable.

   IMPRESSION:

   Left distal tibia fracture.

   PLAN: He will continue with the use of his cast, maintain non-weight bearing status. Return for reassessment in two weeks. Cast care instructions are once again being reviewed. Continue with Ibuprofen.

   A. 99212
   B. 99213
   C. 99214
   D. 99215

6. A patient receives monitored anesthesia care for an endoscopy of ileal conduit and exchange of left nephroureteral catheter. The anesthesia provider prepares the patient for anesthesia at 12:18. The surgery begins at and ends at 12:33. The anesthesia provider ends care for the patient at 13:31. What is the total anesthesia time?

   A. 15 minutes
   B. 58 minutes
   C. 60 minutes
   D. 73 minutes

7. Using the section of the Medicare National Physician Fee Schedule Relative Value File provided below, determine which procedure the global surgical concept does not apply to.

HCPCS	DESCRIPTION	PCTC IND	GLOB DAYS	PRE OP	INTRA OP	POST OP	MULT PROC	BILAT SURG	ASST SURG	CO-SURG	TEAM SURG
11646	Exc f/e/e/n/l mal+mrg >4 cm	0	010	0.10	0.80	0.10	2	0	1	0	0
1170F	Fxnl status assessed	9	XXX	0.00	0.00	0.00	9	9	9	9	9
11730	Removal of nail plate	0	000	0.00	0.00	0.00	2	0	1	0	0
11732	Remove nail plate add-on	0	ZZZ	0.00	0.00	0.00	0	0	1	0	0

   A. 11646
   B. 1170F
   C. 11730
   D. 11732

Scope of the Audit

The scope of an audit determines the range of the activities and the period (months or years) of records subjected to examination. The Institute of Internal Auditors defines the objective and the scope, as follows:

> *Audit objectives represent the high-level goals and anticipated accomplishments of the review and address controls and risks associated with the client's activity. The audit's scope defines the parameters to be used toward achieving those objectives.*

The scope also defines what will *not* be a part of the audit. This is important so that the outcomes do not reflect misleading information. Always state a clear purpose (objective) for an audit and indicate the scope of what will be included.

The following are suggested questions to consider narrowing the scope:

- Will the audit be limited to government payers only?
- If no, will self-pay also be included in the scope?
- Will the audit be limited to E/M codes only?
- Will the audit include surgical procedures?
- For E/M codes, will both established and new patient visits be included?
- Will the audit include outpatient and inpatient records?
- Are all providers (MD, DO, NP, and PA) to be included in the audit?

EXAMPLE

Consider a new provider in a clinic at a teaching hospital. The audit scope would be limited to that new provider, and the time could be the first day the provider began seeing patients, up to the date that the decision was made to perform the audit. The audit could be limited to government payers, due to the Physicians at Teaching Hospitals (PATH) guidelines. The scope of services would include all items billed during the audit time frame, due to the unique nature of PATH guidelines.

Determining Which Services to Audit

The next step is to make selections, based on the time period established in the scope. The selection is made from a larger sample. The sample is usually created from a report generated within the billing system for retrospective audits. The sample for prospective audits is all the claims that are being held, pending the audit findings.

EXAMPLE

Consider the example that was used above concerning the new provider in the clinic.

The objective would be to determine if the new provider was documenting and billing accurately and was complaint with Physicians at Teaching Hospitals (PATH) guidelines. The scope was outlined above. The report would be generated with the following parameters:

- One provider
- Medicare and Medicaid services only (PATH guidelines are written and enforced by CMS)
- All CPT®/HCPCS Level II codes billed
- Dates of service from first day to present day

This could produce a very large report. The final selection would come from this report or sample.

With prospective, retrospective, and focused reviews, different selections criteria can be used.

- Random selection (any type, level of service, visit, or procedure)
- Controlled (a specific level of service or type of service)
- High volume services
- High-risk services
- Frequent denials
- Past errors

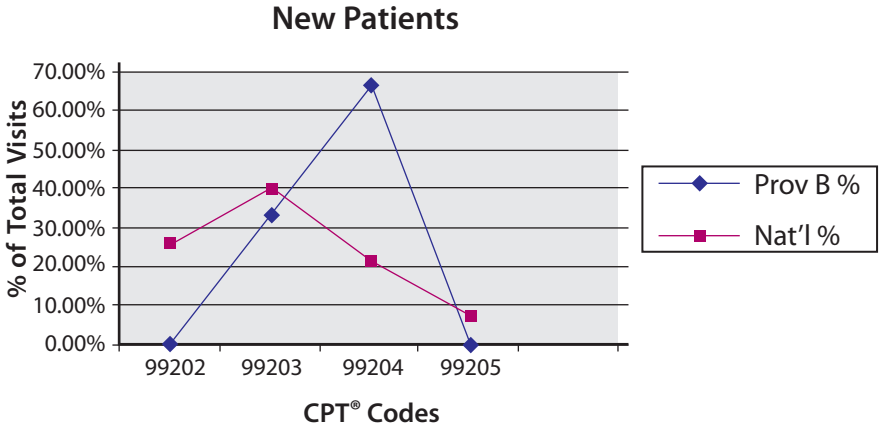
Determining the Number of Records to Audit

Next, determine how many records or claims will be selected for the audit. Later, we will discuss what constitutes a valid statistical sample.

The final audit selection should include a certain percentage of patient encounters to ensure a representative sample. Auditing too few records may distort results, while auditing too many records normally is not any more effective. The compliance officer, office manager, and/or practitioner should help determine the appropriate number of medical records to review. A good selection size is 10-15 charts, per provider. Concentrate on visits that took place during a specific period, so that trends can be observed.

The OIG recommends five to 10 random charts per physician, when conducting an annual compliance audit. Again, the input from management and the provider is very important. If both E/M and surgical services are to be audited, it may be that 10 from each category would be a part of the final selection. The goal is to ensure that the objective can be met with the selection that is made.

9. Based on the bell curve below, which E/M level(s) should be audited?



A. 99204

B. 99202, 99204

C. 99202, 99204, 99205

D. 99202, 99203, 99204, 99205

10. What statistical tool is used by OIG's Office of Audit Services and available to providers?

A. Microsoft Excel

B. HEAT

C. RAT-STATS

D. Quicken

Chapter 5

Risk Analysis and Communication

Introduction

To justify an allegation of error, auditors are limited to the application of controlling standards. If a controlling standard does not exist for the service that is being evaluated, do not declare error, but use persuasive standards (with appropriate citations and qualifications) to identify potential post-payment risk. Understanding how to find and differentiate between controlling and persuasive criteria is a core skill for any auditor.

Validation of Audit Results

The most important step in any compliance audit is validation of the rules particular to the services being audited and the payer that the services are being billed to. The accuracy of an audit result must be validated through appropriate risk analysis, which should occur at the beginning of the audit. When an audit reveals an error or non-conformance, the specific reason for the non-conformance must be identified with citations to the applicable policy provision or binding rule. Discussing audit findings with a provider allows the auditor to provide a risk analysis, identify specific risk, and recommend corrective action with supporting documentation.

It can be difficult to identify a clear error if coding and reimbursement policies are ambiguous. In such cases, the auditor should focus on the potential risks associated with the method of reporting an issue. The auditor should address the likelihood the payer will declare the codes and modifiers used to be erroneous, the reasons why, and the corrective action recommended (to include an alternative method of reporting) to mitigate that risk. A complete review of any persuasive standards relied upon will help to support the recommended course of action. Where a clear and unambiguous binding standard exists as a basis for declaring an error, cite the appropriate.

Resources and Tools

To communicate a clear recommendation for mandated or suggested corrective action, the successful auditor must identify the resources and tools used to conduct the audit. Where no binding standard exists, any persuasive resource used to identify potential risk must be identified.

Contract-Based Commercial Insurance Plans

Most common commercial insurance plans are contract based; that is, benefits arise primarily under a contract between the insurance company and the subscriber/patient. Where the healthcare provider is in network, the provider agrees to abide by certain rules in a separate contract. In these situations, the auditor must review the contract to determine the rules the provider is bound to follow. Specifically:

(i) Is the provider obligated to conform to the insurance company's published medical policies? If so, does non-conformance entitle the payer to recoup the money, or is the only sanction potential termination of the provider's network status? In such a case, is the provider offered a chance at implementing corrective action? How these questions are answered will significantly affect the audit result, in terms of whether an auditor can declare error or can simply declare potential risk.

EXAMPLE OF CONTRACT LANGUAGE

Group and Participating Group Physicians agree to accept and comply with Policies of which Group knows or reasonably should have known (for example, Clinical Policy Bulletins or other Policies made available to Group and Participating Group Physicians generally, including, but not limited to those set forth in Section 4.1.3). Company may at any time modify Policies. Company will provide ninety (90) days prior notice by letter, newsletter, electronic mail, or other media, of Material Changes. Failure by Group to object in writing to any Material Change within thirty (30) days following receipt thereof constitutes Group's acceptance of such Material Change. In the event that Group reasonably believes that a Material Change is likely to have a material adverse financial impact upon Group, Group agrees to notify Company, specifying the specific bases demonstrating a likely material adverse financial impact, and the Parties will negotiate in good faith an appropriate amendment, if any, to this Agreement. If the parties are unable to negotiate any such amendment and Group provides notice of termination of this Agreement not more than fifteen (15) calendar days after receipt of a Material Change, then this Agreement shall terminate coincident with the effective date of the Material Change. Group and Participating Group Physicians agree that noncompliance with any requirements of this Section 5.1 or any Policies will relieve Company and Members from any financial liability for the applicable portion of the Physician Services.

Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable
11402	17104		19960101	20061231	1
11402	17250		19960101	19970101	1
11402	19120		19960101	*	1
12032	11040		19990401	*	1
12032	11041		19990401	20101231	1
12032	11042		19990401	20101231	1
12032	11043		19990401	*	1
12032	11104		20190101	*	1
12032	11900		19960101	*	1
12032	11901		19960101	*	1
12032	12031		19960101	*	1
12032	12042		19960101	*	0
12032	12052		19960101	*	1
12032	12053		19960101	*	1

35. Review the operative report and NCCI edits provided. What is the audit finding?

A. Code 11104 is not reported separately as it is considered inclusive to 12032 and 11402

B. Code 12032 is not reported separately as repairs are inclusive to the excision

C. Modifier 59 is added to 11104 instead of modifier 51

D. The codes reported are correct

36. What additional audit finding can be reported?

A. The surgeon's signature is missing

B. The diagnosis code is incorrect

C. The patient's status following the surgery is missing

D. There are no additional audit findings

CASE 4

A 71-year-old patient is undergoing monitored anesthesia care for eye surgery. Dr. J. Smith is medically directing this case and two other concurrent cases, all of which have CRNAs.

Patient: W. Williams Date of Service: 05/31/XX

Postoperative Diagnosis: Diabetic cataract, O.S.

Operation: Extracapsular cataract removal with insertion of intraocular lens, left eye.

Anesthesia: Monitored anesthesia care.

Anesthesia Provided by: Jane Doe, CRNA with medical direction by John Smith, anesthesiologist

Chapter 1 Questions

1. **Answer:** B. Misusing codes on a claim

   Rationale: CMS defines abuse as an action that results in unnecessary costs to a federal healthcare program, either directly or indirectly. Misrepresenting the diagnosis to justify payment, billing for services at a higher level than provided or necessary, and altering claim forms to receive a higher payment are examples of fraud, not abuse.

   CMS examples of abuse:

   - Misusing codes on a claim
   - Charging excessively for services or supplies
   - Billing for services that were not medically necessary
   - Failure to maintain adequate medical or financial records
   - Improper billing practices
   - Billing Medicare patients a higher fee schedule than non-Medicare patient

2. **Answer:** C. No, the tests must be reasonable and necessary to diagnose or treat a patient's medical condition.

   Rationale: Reasonable and Necessary Services: The OIG states that physicians should be able to order any tests, including screening test, they believe are appropriate for the treatment of their patients, but practices should be aware that Medicare will only pay for services that meet the Medicare definition of reasonable and necessary.

3. **Answer:** C. Proper claims filing

   Rationale: Two laws, the Civil Monetary Penalty Law and the False Claims Act, are related to proper claims filing. Mere mistakes, which can be remedied by returning overpayments, does not result in violations of these laws.

4. **Answer:** A. False Claims Act (FCA)

   Rationale: Relative to healthcare services, examples of fraud or misconduct subject to the False Claims Act include:

   - Falsifying a medical chart notation
   - Submitting claims for services not performed, not requested, or unnecessary
   - Submitting claims for expired drugs
   - Upcoding and/or unbundling services
   - Submitting claims for physician services performed by a non-physician provider (NPP) without regard to incident-to guidelines

CASE 10

PATIENT: J. Nichols

DATE: 4/13/20XX

REFERRING PHYSICIAN: Stephen Klein, M.D.

CHIEF COMPLAINT: Chronic UTIs [1]

HISTORY OF PRESENT ILLNESS: Ms. Pinkston is a 29-year-old young lady referred to us [2] by Dr. Klein for evaluation of the above and advice on treatment. [3] She states that she underwent a C-section in 20XX. This was complicated by a reaction to the epidural as well as a post-op hematoma. It has resulted in decreased sensation of her bladder filling. She has mild urge incontinence and urgency, which was preceded by a stress incontinence that she has not been treated for. This has also resulted in a urinary tract infection about once a month. She seemed to be doing timed voiding on her own to decrease the amount of urine and to have fewer accidents. She says she has good stream when she voids. She feels like she does not completely empty. She has had no dysuria, frequency, or hematuria but does have nocturia three times a night. Thus Dr. Klein referred her to us for evaluation of the infections and urinary incontinence. She has no history of stones, sexually transmitted disease, or family history of any urologic problems.

PAST MEDICAL HISTORY: Significant for depression

PAST SURGICAL HISTORY: Tonsillectomy, adenoidectomy, C-section and myringotomy tubes

MEDICATIONS: Zoloft

ALLERGIES: STADOL, MORPHINE, LATEX, RELPAX

SOCIAL HISTORY: She is married and is a medical assistant at Max's Dermatology. She does not smoke. Drinks occasionally. No history of alcohol abuse. Exercises regularly

FAMILY HISTORY: Significant for hypertension.

REVIEW OF SYSTEMS: Please refer to the chart unless otherwise stated.

PHYSICAL EXAM: Constitutional: Well-nourished, well-developed white female
Eyes: PERRL ENT: Tympanic membranes and external canal normal. No abnormality of sinuses or nasal airways. Normal oropharynx. Neck: Supple, no masses. Respiratory: Clear to auscultation. Cardiovascular: Regular rate and rhythm. Gastrointestinal: Abdomen is mildly obese, benign. No hepatosplenomegaly. No CVA tenderness, back without deformity. Skin: Warm/Dry Extremities: Full ROM. Normal gait and station. No edema. Genitourinary: Genitalia normal to inspection. Normal cervix. No masses or discharge.

LABS: Urinalysis ordered. [4]

ASSESSMENT/PLAN: We will have her obtain a MESA symptom score, voiding diary, and a local cystourethroscopy. [5]

Electronically signed by: Dan Brown, M.D., F.A.C.S. [6]

Board Certified Urologist

4/13/20XX

Stephen Klein, M.D.

4444 SW ABC Trail

Colorado Springs, CO 29192

Dear Dr. Klein: [7]

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