AAPC Certified Physician Practice Manager (CPPM) Practice Test (Sample)

Study Guide

Everything you need from our exam experts!

Sample study guide. For the full version with hundreds of questions, visit: https://aapccppm.examzify.com

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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 the acronym MS-DRG stand for?

A. Medicare Severity Diagnosis Related Group

B. Medicaid Standard Diagnosis Related Group

C. Medical Severity Diagnosis Report Group

D. Medicare Standard Diagnosis Reporting Group

2. What must be true for a physician to actively participate in incident-to services?

A. They must review all documentation before services

B. They must take part in the treatment

C. They must be physically present

D. They must bill separately for each service

3. Under accrual accounting, when are expenses recorded?

A. When cash is paid

B. When services are rendered

C. When they have been incurred

D. At the end of the fiscal year

4. What is the maximum imprisonment term for knowingly violating the Anti-Kickback Law?

A. Three years

B. Five years

C. Ten years

D. One year

5. Which of the following can HIPAA-covered entities and business associates disclose PHI for?

A. Marketing activities

B. Treatment and payment

C. Family notifications

D. Employee benefits

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6. What does the "CHECK" phase of PDCA compare outcomes to?

A. New benchmarks

B. Original benchmarks

C. Future projections

D. Stakeholder expectations

7. How many weeks of unpaid, job-protected leave can be granted under FMLA?

A. 4 weeks

B. 6 weeks

C. 12 weeks

D. 16 weeks

8. What is the primary focus of value-based purchasing in hospitals?

A. Reducing operational costs

B. Increasing the number of patients

C. Performance based on patient satisfaction, quality of care, and efficiency

D. Promoting financial incentives for staff

9. Accrual accounting is recognized when revenues are:

A. Earned

B. Requested

C. Collected

D. Reported

10. According to the Medical Group Management Association (MGMA), what percentage of denials are preventable?

A. 50%

B. 75%

C. 90%

D. 100%

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Answers

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

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Explanations

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1. What does the acronym MS-DRG stand for?

A. Medicare Severity Diagnosis Related Group

B. Medicaid Standard Diagnosis Related Group

C. Medical Severity Diagnosis Report Group

D. Medicare Standard Diagnosis Reporting Group

The acronym MS-DRG stands for Medicare Severity Diagnosis Related Group. This classification system is used by the Medicare program in the United States to determine payment for inpatient hospital services. It combines a patient's diagnoses and the severity of their condition to categorize them into specific groups, which then helps establish reimbursement rates. The inclusion of severity in the classification allows for more precise payment that can reflect the complexity of care needed by patients. This mechanism helps in ensuring that hospitals are compensated appropriately based on the level of services and resources utilized for patient care, thereby supporting both healthcare quality and financial sustainability within the Medicare system. Understanding MS-DRG is crucial for those involved in hospital administration, coding, and billing practices, as it directly impacts revenue management and compliance.

2. What must be true for a physician to actively participate in incident-to services?

A. They must review all documentation before services

B. They must take part in the treatment

C. They must be physically present

D. They must bill separately for each service

Active participation in incident-to services requires that the physician take part in the treatment of the patient. This means the physician has to be involved in the patient's care for the services provided by non-physician practitioners to qualify for Medicare's incident-to billing guidelines. When a physician actively participates in the treatment, it establishes a direct connection and ongoing relationship between the physician and patient. This is critical because incident-to services allow non-physician practitioners, like nurse practitioners or physician assistants, to bill under the physician's National Provider Identifier (NPI) when these conditions are met. However, the physician does not have to be physically present in the same location during the entire encounter, but they should have initiated care and must oversee the treatment. For billing to occur under the incident-to rule, it is essential that there is an initial evaluation and ongoing management of the patient by the physician, ensuring that the non-physician provider is working under the physician's direct supervision and according to the physician's plan of care. Therefore, the requirement for the physician to actively partake in the treatment is fundamental to comply with Medicare's incident-to guidelines.

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3. Under accrual accounting, when are expenses recorded?

A. When cash is paid

B. When services are rendered

C. When they have been incurred

D. At the end of the fiscal year

Under accrual accounting, expenses are recorded when they have been incurred, which aligns with the core principles of this accounting method. This approach emphasizes recognizing economic events as they occur, rather than when cash transactions take place. In practical terms, this means that if a business receives a service or product, it is necessary to record the expense at that time, even if payment is deferred to a later date. For example, if a healthcare practice receives medical supplies on credit, the expense would be recorded upon receipt of those supplies rather than when payment is made. This method provides a more accurate picture of the organization's financial status by matching expenses with the revenues they helped to generate within the same accounting period, thus offering better financial insights and allowing for more precise budgeting and forecasting. Cash accounting, on the other hand, records expenses only when cash is paid, which would not capture the economic reality of obligations as they are incurred. The other options, such as recording expenses when services are rendered or at the end of the fiscal year, do not encapsulate the ongoing obligation principle of accrual accounting. Therefore, recognizing expenses as they are incurred is fundamental to maintaining accurate financial records and ensuring compliance with generally accepted accounting principles (GAAP).

4. What is the maximum imprisonment term for knowingly violating the Anti-Kickback Law?

A. Three years

B. Five years

C. Ten years

D. One year

The maximum imprisonment term for knowingly violating the Anti-Kickback Law is indeed five years. This law is designed to prevent healthcare providers from engaging in illegal remuneration for services, which could lead to overutilization of services and increased healthcare costs. The law aims to ensure that decisions regarding patient care are made based on medical necessity rather than financial incentives. Violating the Anti-Kickback Law is considered a serious offense because it undermines the integrity of the healthcare system. The five-year imprisonment term reflects the severity of the violation and the potential harm it can cause. It underscores the importance of compliance with healthcare regulations and the ethical standards required in medical practice. Understanding the ramifications of such laws is crucial for those in healthcare administration, as it not only affects legal standing but also impacts the overall quality and trust in the healthcare services provided to the public.

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5. Which of the following can HIPAA-covered entities and business associates disclose PHI for?

A. Marketing activities

B. Treatment and payment

C. Family notifications

D. Employee benefits

The correct answer is based on the provisions established by the Health Insurance Portability and Accountability Act (HIPAA), which outlines the permissible uses and disclosures of Protected Health Information (PHI). Specifically, HIPAA allows covered entities and business associates to disclose PHI for treatment and payment purposes without the need for patient authorization. Disclosing PHI for treatment purposes includes sharing information with other healthcare providers for the coordination of care or consultation. For payment purposes, this includes activities related to billing, claims management, and other payment functionalities involved in healthcare operations. Thus, these activities are essential for the delivery of healthcare services and the financial operations of health providers. In contrast, while marketing, family notifications, and employee benefits might have situations where PHI can be shared, they often require specific authorizations or must meet more stringent criteria under HIPAA regulations. For instance, marketing activities typically require explicit consent from the patient unless they fall under certain exemptions. Family notifications may be permissible under specific circumstances, such as when the patient is incapacitated, but this is not universally applicable. Similarly, employee benefits would generally require additional measures to protect the confidentiality of PHI and often need informed consent from the individual. Therefore, treatment and payment stand out as inherently permissible uses of PHI

6. What does the "CHECK" phase of PDCA compare outcomes to?

A. New benchmarks

B. Original benchmarks

C. Future projections

D. Stakeholder expectations

The "CHECK" phase of the PDCA (Plan-Do-Check-Act) cycle is focused on evaluating and comparing the outcomes of the implemented changes against the original benchmarks that were established prior to the implementation of the plan. In this stage, the results of the actions taken are monitored and analyzed to determine whether the changes made have resulted in the expected improvements. This phase is essential for assessing whether goals were met and whether the records reflect the reality of the practice's performance. By comparing outcomes to the original benchmarks, the organization can identify gaps in performance, understand the impact of their actions, and make informed decisions on necessary adjustments. This systematic review against the original benchmarks ensures that any deviation from anticipated results can be understood and addressed, forming the basis for further cycles of improvement.

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7. How many weeks of unpaid, job-protected leave can be granted under FMLA?

A. 4 weeks

B. 6 weeks

C. 12 weeks

D. 16 weeks

Under the Family and Medical Leave Act (FMLA), eligible employees are entitled to a maximum of 12 weeks of unpaid, job-protected leave within a 12-month period. This leave can be utilized for various reasons, including the birth and care of a newborn, adoption of a child, care for an immediate family member with a serious health condition, or for the employee's own serious health condition that makes them unable to perform their job. The significance of this provision is that it ensures job security while allowing employees to address critical personal and family health issues without the risk of losing their employment. The duration of 12 weeks strikes a balance between providing sufficient time for recovery or care and maintaining operational continuity for employers. This framework helps support workforce stability and employee well-being, making it an essential component of workplace rights and protections in the United States.

8. What is the primary focus of value-based purchasing in hospitals?

A. Reducing operational costs

B. Increasing the number of patients

C. Performance based on patient satisfaction, quality of care, and efficiency

D. Promoting financial incentives for staff

The primary focus of value-based purchasing in hospitals is centered around performance metrics that include patient satisfaction, quality of care, and efficiency. This approach shifts the emphasis from merely providing services to ensuring that the services provided meet specific standards of excellence and deliver real value to patients. In a value-based purchasing model, hospitals are rewarded for the quality of care they deliver rather than the quantity of services provided. This means hospitals must prioritize not only clinical outcomes but also the patient experience, such as satisfaction and engagement levels. The overall goal is to create a healthcare system that holds providers accountable for the care they give by linking reimbursement to performance metrics. Enhancing patient satisfaction and optimizing the delivery of care is crucial since this framework encourages improvements in overall patient health, reduces hospital readmissions, and ultimately leads to a more efficient use of healthcare resources. Therefore, the focus on performance relating to these key factors significantly influences funding and operational strategies in healthcare institutions.

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9. Accrual accounting is recognized when revenues are:

A. Earned

B. Requested

C. Collected

D. Reported

Accrual accounting recognizes revenues when they are earned, regardless of when the cash is actually received. This concept is central to accrual accounting because it matches revenue with the expenses incurred to generate that revenue, providing a more accurate representation of a company's financial position during a specific time period. In this accounting method, the key focus is on the completion of the service or the delivery of goods, which signifies that the revenue has been earned. This method contrasts with cash accounting, where revenue is recorded only when cash is received, potentially leading to discrepancies in financial reporting if the timing of cash flows does not align with the actual performance and delivery of services. The other options pertain to different aspects of revenues or requests for payment rather than the actual recognition of earned income. For instance, revenue is not recognized when merely requested or collected; those actions may occur at different times and do not reflect the true status of revenue earned under accrual accounting.

10. According to the Medical Group Management Association (MGMA), what percentage of denials are preventable?

A. 50%

B. 75%

C. 90%

D. 100%

The assertion that 90% of denials are preventable aligns with findings that indicate a significant majority of denied claims arise from avoidable errors and oversights in the medical billing and coding process. The MGMA emphasizes the crucial nature of proper claim management and underscores that many claims are denied due to reasons such as incomplete information, incorrect coding, or failure to follow up on prior authorizations. By implementing better practices and training, healthcare organizations can drastically reduce the incidence of such denials. This highlights the importance of maintaining meticulous documentation, ensuring accurate coding, and following up diligently with payers to ensure that claims are processed smoothly. Understanding this statistic is vital for practices aiming to improve their revenue cycle management, as it points to the need for enhanced training and procedural safeguards to minimize preventable errors. Emphasizing a proactive approach to claim management can ultimately lead to improved cash flow and operational efficiency within physician practices.

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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://aapccppm.examzify.com

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

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