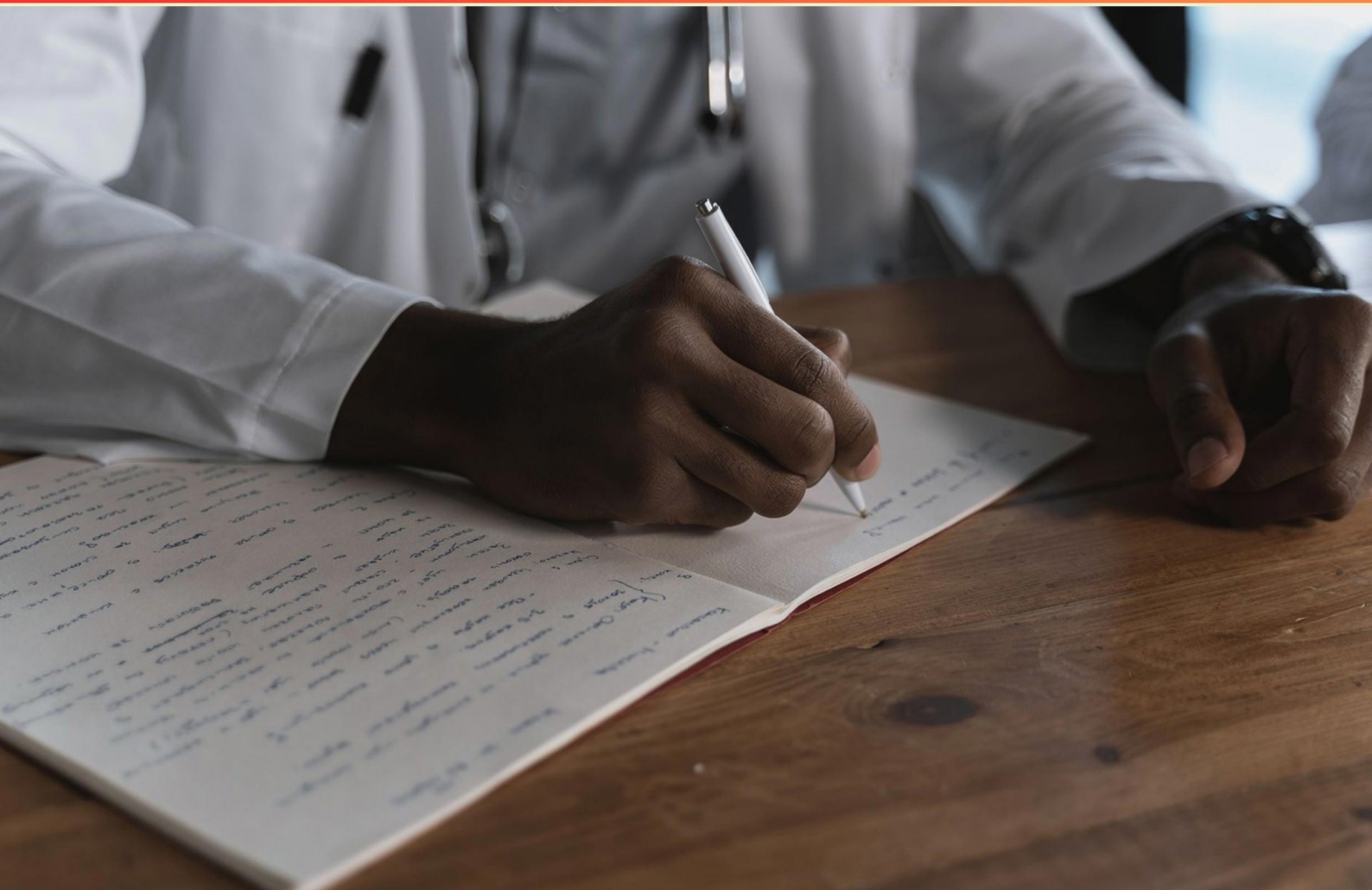


AAPC CERTIFIED PROFESSIONAL MEDICAL AUDITOR (CPMA) PRACTICE EXAM (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

**VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE**

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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.

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!

Questions

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- 1. What is RAT-STATS used for by an auditor?**
 - A. Generating qualitative reports
 - B. Software used in performing statistical random samples and evaluating results
 - C. Creating financial forecasts
 - D. Analyzing patient satisfaction surveys
- 2. Under which statute is the SDRP appropriate for detected violations?**
 - A. Medicare Law
 - B. Anti-Kickback Statute
 - C. Stark Self-Referral Law
 - D. HIPAA Regulations
- 3. Informed consent must include information about which component?**
 - A. Only patient's medical history
 - B. The nature and purpose of a proposed treatment
 - C. General hospital policies
 - D. Patient's financial obligation
- 4. Where can the status indicators for surgical procedures be found?**
 - A. In the Annual CPT Code Update
 - B. On the National Physician Fee Schedule Relative Value File
 - C. In the Medicare General Information Guidelines
 - D. In each patient's medical record
- 5. Which hematologic/lymphatic symptom is significant to note?**
 - A. Excessive worrying
 - B. Unusual bleeding
 - C. Decreased output
 - D. Abdominal pain
- 6. How many units are assigned to the +99100 qualifying circumstance code?**
 - A. 2 units
 - B. 3 units
 - C. 1 unit
 - D. 5 units

- 7. What is required for a covered entity to justify the use of the entire medical record?**
- A. A broad signature from the patient
 - B. A non-specific request from HHS
 - C. A specific justification stating it is the minimum needed
 - D. A full review from legal counsel
- 8. What does pharmacologic management entail?**
- A. Reviewing side effects and ongoing monitoring
 - B. Only prescribing new medications
 - C. Physical examination and lifestyle assessment
 - D. Patient history and diagnostic testing
- 9. How often must CIAs require the entity to report on compliance?**
- A. Monthly.
 - B. Quarterly.
 - C. Annually.
 - D. Bi-annually.
- 10. If a provider cannot obtain a history from the patient, what must they document?**
- A. The patient's known allergies
 - B. The patient's condition that prevented obtaining history
 - C. The reason why the provider is unable to treat the patient
 - D. The last time the patient was seen

Answers

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

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Explanations

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1. What is RAT-STATS used for by an auditor?

- A. Generating qualitative reports
- B. Software used in performing statistical random samples and evaluating results**
- C. Creating financial forecasts
- D. Analyzing patient satisfaction surveys

RAT-STATS is specifically designed as a statistical software tool utilized by auditors to perform statistical random sampling and to evaluate results effectively. This capability allows auditors to analyze a subset of data that represents the whole, which is essential in determining patterns, discrepancies, or compliance levels without the need to examine every single record. By generating statistically valid samples, RAT-STATS enhances the efficiency of audits and increases the reliability of the findings, as it uses statistical methodologies to ensure that the samples drawn are representative of the larger population. This focus on statistical evaluation distinguishes RAT-STATS from the other options listed. Unlike qualitative reports or financial forecasts which may involve more subjective measures or projections based on trends, RAT-STATS is grounded in quantitative analysis. Additionally, while patient satisfaction surveys are important for healthcare quality assessment, they typically do not fall under the primary usage of RAT-STATS, which is centered on statistical sampling and analysis rather than direct survey analysis.

2. Under which statute is the SDRP appropriate for detected violations?

- A. Medicare Law
- B. Anti-Kickback Statute
- C. Stark Self-Referral Law**
- D. HIPAA Regulations

The correct answer identifies the Stark Self-Referral Law as the statute under which the Self-Disclosure Protocol (SDRP) is appropriate for detected violations. The Stark Law prohibits physicians from referring Medicare patients for certain health services to entities with which they have a financial relationship, unless an exception applies. The SDRP is a formal protocol established by the Centers for Medicare & Medicaid Services (CMS) for providers who want to voluntarily disclose actual or potential violations of the Stark Law. By utilizing this protocol, healthcare providers can disclose any concerns they have regarding noncompliance with the Stark Law. The SDRP encourages transparency and compliance within healthcare operations, supporting providers who proactively address potential issues. While the other statutes listed are crucial in their own right, they do not specifically include a self-disclosure process analogous to the SDRP for Stark Law violations. The Medicare Law encompasses a broad range of regulations, the Anti-Kickback Statute specifically addresses financial incentives for referrals, and HIPAA Regulations focus mainly on the privacy and security of health information. Therefore, the SDRP is uniquely aligned with the Stark Self-Referral Law to facilitate the resolution of compliance issues related to physician referrals.

3. Informed consent must include information about which component?

- A. Only patient's medical history
- B. The nature and purpose of a proposed treatment**
- C. General hospital policies
- D. Patient's financial obligation

Informed consent is a fundamental aspect of patient care and medical ethics, and it specifically requires that patients receive crucial information about the nature and purpose of any proposed treatment. This includes explaining the procedures, potential risks and benefits, expected outcomes, and any alternative treatments that may be available. Providing this information ensures that patients can make informed decisions about their healthcare, which is essential for respecting their autonomy and right to participate in their treatment choices. By focusing on the nature and purpose of the proposed treatment, healthcare providers aid patients in understanding what to expect, thus fostering trust and collaboration in the healthcare relationship. While elements like medical history, hospital policies, and financial obligations may be relevant to the overall context of care, they do not fulfill the primary requirement of informed consent, which is fundamentally about making sure the patient is adequately informed about the treatment itself before proceeding.

4. Where can the status indicators for surgical procedures be found?

- A. In the Annual CPT Code Update
- B. On the National Physician Fee Schedule Relative Value File**
- C. In the Medicare General Information Guidelines
- D. In each patient's medical record

The status indicators for surgical procedures are located on the National Physician Fee Schedule (NPFS) Relative Value File. This is because the NPFS includes important information related to reimbursement for services, including the status indicators that reflect whether a surgical procedure is covered, its payment level, and any associated conditions or codes. The status indicators help clarify whether the procedures are subject to certain rules, such as whether they are performed in an outpatient setting or in a hospital. The Annual CPT Code Update primarily addresses updates and changes to the Current Procedural Terminology codes themselves but does not specify reimbursement details or status indicators. The Medicare General Information Guidelines provide overviews and basic rules for Medicare claims but do not contain the detailed payment-related information found in the NPFS. While each patient's medical record includes crucial information about individual services rendered, it does not provide generalized coding status indicators that apply to procedures across the board. Thus, the National Physician Fee Schedule Relative Value File is the correct source for accessing status indicators related to surgical procedures.

5. Which hematologic/lymphatic symptom is significant to note?

- A. Excessive worrying
- B. Unusual bleeding**
- C. Decreased output
- D. Abdominal pain

Noting unusual bleeding as a significant hematologic/lymphatic symptom is crucial because it can be an indication of various serious underlying conditions. This symptom may suggest a platelet disorder, clotting factor deficiencies, or an issue with the blood vessels themselves. Its presence can alert healthcare providers to potential conditions such as leukemia, thrombocytopenia, or hemophilia, which require prompt diagnostic evaluation and intervention to prevent complications. On the other hand, while excessive worrying is a concern in a psychological context, it does not relate directly to hematologic or lymphatic health. Decreased output could refer to various bodily functions but is vague regarding its relevance to the hematologic/lymphatic system. Abdominal pain, while significant in many medical scenarios, is not as specific to hematologic/lymphatic disorders as unusual bleeding, making it a less prominent symptom to prioritize in this context.

6. How many units are assigned to the +99100 qualifying circumstance code?

- A. 2 units
- B. 3 units
- C. 1 unit**
- D. 5 units

The correct answer is that the +99100 qualifying circumstance code is assigned 1 unit. This code is used to indicate that a service was performed in a context that warrants additional consideration due to an unusual circumstance. The designation of 1 unit reflects its intended usage, emphasizing that it adds a value to the primary service but does not represent a standard or fixed number of additional units like some other codes. When medical coders or auditors review the use of this code, they recognize that it signifies enhanced complexity or special situations that may necessitate more resources, but it is specifically quantified as one unit. This means it does not multiply the value significantly compared to other codes that might add multiple units for different aspects of care or conditions. Understanding how many units to assign accurately reflects the nature of the qualifying circumstance and aids in proper billing and reimbursement processes.

7. What is required for a covered entity to justify the use of the entire medical record?

- A. A broad signature from the patient
- B. A non-specific request from HHS
- C. A specific justification stating it is the minimum needed**
- D. A full review from legal counsel

To justify the use of the entire medical record as a covered entity, it is essential to have a specific justification stating that the information being accessed is the minimum necessary to accomplish the intended purpose. This aligns with the HIPAA Privacy Rule, which dictates that covered entities must make reasonable efforts to limit the use and disclosure of protected health information to the minimum necessary to achieve the desired result. By providing a specific justification that focuses on the minimum necessary standard, the covered entity demonstrates compliance with regulatory requirements while protecting patient privacy. This approach emphasizes the importance of assessing the scope of information required for a particular task, thus ensuring that only relevant data is used, which is a critical aspect of ethical medical record management and patient confidentiality.

8. What does pharmacologic management entail?

- A. Reviewing side effects and ongoing monitoring
- B. Only prescribing new medications
- C. Physical examination and lifestyle assessment
- D. Patient history and diagnostic testing

Pharmacologic management involves the comprehensive oversight of a patient's medication regimen, which includes reviewing side effects and ongoing monitoring. This aspect of care ensures that medications are effectively addressing the patient's condition while minimizing adverse reactions and complications. It encompasses evaluating the efficacy of prescribed medications, adjusting dosages as necessary, managing any side effects, and regularly checking in on how the patient is responding to their treatment plan. In contrast, simply prescribing new medications does not encompass the full scope of pharmacologic management. It is critical that healthcare providers engage in continuous monitoring and review rather than just initiating drugs. Physical examinations and lifestyle assessments are important aspects of overall patient care, but they are not specific to pharmacologic management. Similarly, gathering patient history and conducting diagnostic testing are essential parts of the diagnostic process but do not capture the essence of managing drug therapy effectively. Thus, ongoing assessment and monitoring are crucial elements that define pharmacologic management.

9. How often must CIAs require the entity to report on compliance?

- A. Monthly.
- B. Quarterly.
- C. Annually.
- D. Bi-annually.

The requirement for Continuous Improvement Agreements (CIAs) to have entities report on compliance annually aligns with the best practices for oversight and monitoring of compliance programs. This timeframe is considered sufficient to ensure that the entity is actively evaluating its compliance measures and can incorporate feedback into its practices. Annual reporting allows for a comprehensive review of the compliance activities over a longer duration, which can capture the effects of any implemented changes, identify potential trends in compliance issues, and ensure that the organization is consistently adhering to the regulatory standards established in the CIA. While more frequent reporting, such as monthly or quarterly, may provide more immediate insights into compliance, it can lead to significant administrative burdens and may overwhelm an organization with paperwork rather than fostering a culture of compliance. An annual review strikes a balance between thoroughness and practicality, enabling entities to make meaningful assessments and improvements to their compliance programs on a reasonable schedule.

10. If a provider cannot obtain a history from the patient, what must they document?

- A. The patient's known allergies
- B. The patient's condition that prevented obtaining history**
- C. The reason why the provider is unable to treat the patient
- D. The last time the patient was seen

When a provider is unable to obtain a history from the patient, it is critical to document the patient's condition that prevented the provider from gathering this information. This documentation is essential because it provides context for the situation, demonstrating the reasons behind the challenges in obtaining a comprehensive medical history. This practice aligns with the principles of medical documentation, which emphasize the importance of clarity and continuity in patient care. Recording the specific condition that hindered the collection of history helps ensure that care decisions are made with an accurate understanding of the patient's situation. It also aids in compliance with healthcare regulations and standards, ensuring that the provider's actions are well-documented and justifiable, especially in instances where future treatment or interventions may be necessary. By documenting the patient's condition, the provider establishes a clear narrative of the circumstances affecting patient care, which could be crucial for follow-up visits or for other medical professionals who might take over the treatment of that patient.

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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