AAPC

AAPC-CPMA
Certified Professional Medical Auditor

Questions And Answers PDF Format:

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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 mt 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

Question: 14

What is informed consent?

A. A way to indicate that a discussion between the patient and the provider took place about a patient's condition and the treatment options available, to allow the patient an opportunity to ask question and make an informed choice on his or her plan of treatment .
B. An agreement to allow the provider to inform other patients about a specific patients condition.
C. A way for the provider to indicate that he or she has communicated his or her wishes to the patient on a specific treatment plan, and that it is the only option a patient has.
D. Communication between the physician's office staff and the patient relating to the patient's rights of privacy.

Answer: A

Question: 15

What is the maximum penalty the OIG may seek for fraudulent claims?

A. 10,000 per item or service.
B. 15,000 per item or service.
C. 10,000 per item or service plus three times the amount of over-payments.
D. 15,000 per item or service plus three ties the amount of over-payments.

Answer: C

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