

Certification Council for Medical Audit Specialists



Candidate Handbook

Candidate Handbook

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Certification Council for Medical Audit Specialists

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Certification Council for Medical Audit Specialists

Introduction

American Association of Medical Audit Specialists (AAMAS)

The Certification Council of the American Association of Medical Audit Specialists is the sole credentialing authority for Certified Medical Audit Specialists (CMAS). AAMAS is comprised of professionals from various medical care reimbursement backgrounds. The professional member disciplines represented within AAMAS include but are not limited to hospital bill auditors, compliance auditors, medical fraud and abuse auditors, independent review consultants, pre-certification, utilization review, case management, risk management, medical records review, quality assurance, and representation through various health plans. (Indemnity, HMO, PPO, POS, TPA, etc.). As such AAMAS is the parent organization of The Certification Council for Medical Audit Specialists.

Mission Statement

AAMAS is an organization dedicated to the advancement of professional standards and ethical practices of the medical audit specialists. AAMAS is committed to providing leadership in education, certification and communication and will promote membership awareness of legislative issues within the healthcare reimbursement environment.

Vision Statement

AAMAS aspires to be the nationally recognized leader in the practice of medical audit and its impact on health care reimbursement.

Certification Council for Medical Audit Specialists

The Certification Council for Medical Audit Specialists is responsible for all aspects of the certification process. The Council is dedicated to maintaining the standards set forth by AAMAS. The Certification Council officers, members and consultants maintain and update the testing context as laws and regulations change; screen candidates; conduct surveys for appropriateness of testing material; and maintain the registry of exam participants.

Nondiscrimination Policy

The American Association of Medical Audit Specialists and the Certification Council for Medical Audit Specialists do not discriminate among candidates on the basis of age, gender, race, color, religion, national origin, disability, marital status, or sexual preference.

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Certification Council for Medical Audit Specialists

Earning CMAS Credentials

As you are preparing for your examination, it is important to understand the reasoning behind professional certification. Through professional certification, legitimacy is bestowed upon a body of work and a separate and unique entity becomes established. In addition, a profession is able to establish a code of conduct, standards, and expectations for behavior. Through our professional association, we are proud to promote excellence and visibility by providing you the ability to earn the designation of Certified Medical Audit Specialist (CMAS). Its designation demonstrates an acquired body of knowledge and expertise in the field of medical audit.

We believe that certification of medical auditors as specialists will provide a standard set of expectations for employers and provide a mechanism for the establishment of formal medical audit programs. Although medical auditors are found in multiple health care settings such as hospitals, physician practices, insurance companies, private and commercial audit companies, consulting firms, government contracted agencies, and the US government itself, they all share common skills.

Building upon the basic skill and history of hospital bill audit, the profession of medical auditing has expanded to meet the growing role of the medical auditors. Medical auditors have become an invaluable member of the institutional finance team. Recognizing its role expansion and growing expectations, this examination touches upon multiple areas of health care reimbursement and finance issues, as well as the unique aspect of clinical medicine. Medical auditors are challenged by governmental compliance issues, managed care complexities, and contractual reimbursement arrangements, as well as by bridging the chasm between the health care financial world and the clinical operational setting.

By utilizing a fact based well-defined approach, the conduct of medical audit communication between entities will be enhanced. The ability of the auditors to move between different audit settings will be promoted through the use of standards, rules, guidelines, and expectations rather than opinion and self proclaimed policy.

An individual awarded the CMAS credential agrees to conduct himself/herself in an ethical and professional manner. This includes demonstrating behavior that is indicative of professional integrity. By accepting the certification requirements, the candidate agrees to uphold the values and ethics of the AAMAS as an organization, and to follow the AAMAS standards and bylaws, including the guidelines outlined in the National Health Care Billing Audit Guidelines approved by the AAMAS general membership.

Earning the credential of Certified Medical Audit Specialist (CMAS) grants the medical auditor the use of the CMAS credential in all professional communications such as on letterheads, stationary, business cards, official letters, directory listings and other areas where his/her professional signature is required.

Candidate Handbook

This Candidate Handbook was developed to assist in preparing for the CMAS certification examination. It is the intention of this handbook to be just that – a candidate handbook. By virtue of your admittance to the CMAS certification examination, you are already expected to possess minimum knowledge to pass and to research areas of skill in which you feel you need to concentrate.

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CMAS Certification

Eligibility Requirements

To be eligible to take the CMAS certification examination, an applicant must be a current member of AAMAS, plus have two (2) years of authenticated health care audit experience (minimum of 20 hrs/week) Educational requirements -- a minimum of 60 college semester units **or** a licensed health care professional (a diploma in nursing meets the educational requirement). Also required is one college level or Council approved course in Accounting, Finance, or Statistics.

The CMAS certification examination is given at the AAMAS national conference. Arrangements may be made for the examination to be administered at additional sites. Details for onsite testing are available from members of the Certification Council.

Documentation of Eligibility

The certification examination application form must be postmarked sixty (60) days prior to the scheduled exam date to avoid a late fee. There will be a \$50.00 late charge for applications received between 30 and 59 days before the scheduled exam date. Absolutely no applications will be accepted less than 30 days before the scheduled exam date To be considered a fully qualified candidate, the application packet must contain the official CMAS application form, an up-to-date resume, proof of having taken an approved accounting, finance, or statistics course or successfully completed the course offered by AAMAS and the examination fee.

Confirmation of Eligibility

A confirmation letter of eligibility will be sent to an applicant after qualifications and auditing experience has been verified.

Application Process

Application Form

The CMAS certification application form can be found at the AAMAS website <http://www.aamas.org> under the certification application section. A copy of the application form is also located at the end of this candidate handbook.

Examination Fee

Application Fee: \$350.00.
Fee is payable to: AAMAS
AAMAS Tax ID 650573775

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Certification Council for Medical Audit Specialists

Mailing address
AAMAS Certification Council
10200 W 44th Ave, Suite 304
Wheat Ridge, CO 80033

Credit card payments are accepted. Space for credit card information is located at the bottom of the CMAS certification application form.

Examination Procedures

Reporting for the Examination

Candidates are required to report **ON TIME** for the scheduled examination. After the doors have been closed, late arrivals will not be admitted to the examination room. The AAMAS certification examination will be administered in a 4-hour continuous block. Examination candidates will not be allowed to leave a proctor's presence during the testing period. If a candidate has special needs and feels that he/she cannot participate in this type of format please contact the Certification Council through the web site.

Identification Verification

Candidates arriving at the examination *must present* to the proctor:

- The original Confirmation letter of Eligibility;
- Two (2) separate forms of valid ID, one of which **MUST** be a photo and signature-bearing
 - Identification card (e.g., valid driver's license) with the name that appears on their confirmation letter.

Candidates who appear without identification will **NOT** be permitted to take the examination and will be required to reapply. These candidates will receive a refund of their application fee *minus* a \$50.00 administration fee.

Security

The Certification Council ensures that the certification examination follows strict security standards designed to assure all candidates are provided the same opportunity to demonstrate their knowledge, skill, and abilities in the medical audit community. Council members will strictly monitor the testing environment.

Use of Calculators

A quiet non-programmable, solar powered or battery operated calculator without printing capabilities may be used during the examination. Proctors will inspect ALL calculators. Calculators not conforming to this requirement will not be permitted.

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Writing Instruments

Candidates are required to bring a black non-smearing ink pen for use on the answer sheet.

Other Examination Rules

- No electronic devices are allowed in the examination room. This includes cell phones, beepers and other signaling devices that could create a distraction to examination candidates.
- No eating, drinking or smoking is permitted in the examination room. Water will be provided.
- Reference books, notes or other study materials may not be brought into the examination room.
- One scratch paper will be provided. Proctors will ensure this is returned at the end of the exam.
- Proctors will be available to answer questions candidates may have during the examination. Please raise your hand to obtain this assistance.

Post Examination Procedures

Scoring

To achieve certification, candidates must obtain a passing score. The Modified Angoff method is used to determine the passing score.

Pass and Fail Notification

The notification and certificates will be sent out within eight (8) weeks. Candidates who do not pass the exam will be allowed to re-test one time for a fee of \$150.00.

Appeals

Candidates, who feel their examination score was in error, may appeal their score. The appeal must be in writing detailing the error. The appeal must be submitted to the Certification Council within 30 calendar days of receiving their score.

Denials

If the applicant is deemed ineligible for certification, or if the documentation submitted does not meet the requirements listed, the candidate will be notified in writing listing the specific reason(s) for the denial. Candidates may appeal in writing to the Certification Council within 30 calendar days of receiving their letter. Denials may be based on:

- Failure to fulfill membership requirements
- Failure to fulfill experience and education requirements
- Obtaining or attempting to obtain certification or recertification by fraud or deception

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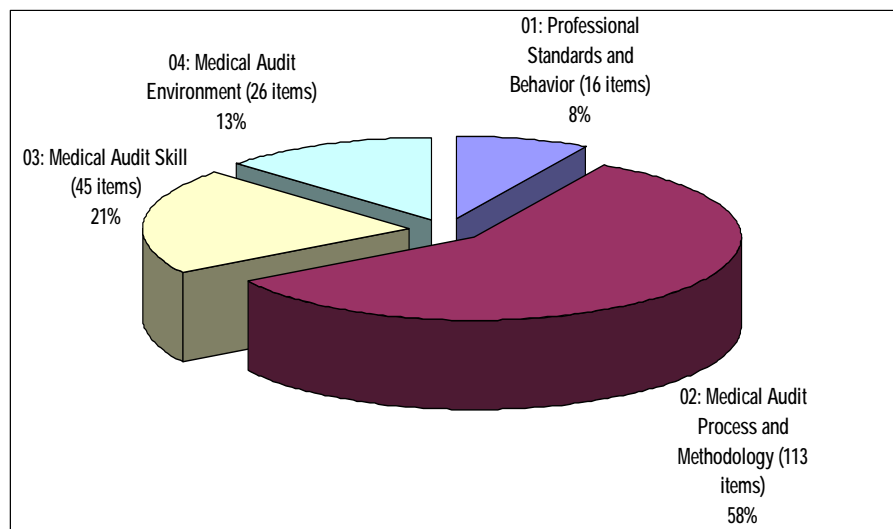


Certification Council for Medical Audit Specialists

Core Curriculum Domains

The Certified Medical Audit Specialist certification examination is based on four main core curriculum domains. Each domain is supported by task-specific categories and sub-categories representing the scope and job responsibilities of medical auditors nationally.

AAMAS conducted two national Job Task Analysis surveys in 2004 and 2006¹ completed by medical auditors from all types of disciplines. Job Task Analysis (JTA), also referred to as Job Delineation Study, is a systematic process designed to identify the skills, knowledge and abilities required in the performance of a task or tasks within an occupation or profession. For medical auditors, the JTA survey confirmed the various skills, knowledge and abilities that define the scope of medical audit practice. The results of the JTA survey serve as the blueprint in the design, evaluation and content validation of the CMAS certification examination, and became the test specification basis for the items constructed for the CMAS examination. The JTA survey results (knowledge, skills and abilities) were psychometrically and statistically validated according to the “frequency and criticality” responses provided by medical auditor survey participants. Finally, these results serve as the empirical content specification linked to the development of the CMAS certification examination.



Core Curriculum Domain

CMAS Test Specification Report

¹ The 2006 AAMAS Job Task Analysis Project was conducted by the Center on Education and Training for Employment Ohio State University (CETE-OSU). Led by Dr. James T. Austin, PhD, Senior Research Specialist in collaboration with Marilyn Balcita, RN CPUR CMAS CICA, AAMAS Advisor.

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Note: The AAMAS Job Task Analysis reports may be found on the AAMAS website at www.aamas.org

I. Core Domain 01: Professional Standards and Audit Behavior (8%)

- Participate in goal setting, strategic planning, and mission/vision development activities
- Integrate code/standards of conduct policies in performance of medical audit activity
- Establish/monitor appropriate patient access and confidentiality policies
- Establish/participate in enforcing expectations and systems of accountability
- Apply principles of objectivity in performance of medical audit activity
- Develop/monitor effectiveness of internal control policies
- Apply principles of independence in performance of medical audit activity

II. Core Domain 02: Medical Audit Process and Methodology (58%)

A. Investigate and Verify Charges Against Medical Record Documentation

- Inpatient Hospital
- Outpatient Hospital
- Physician
- Ambulatory Centers
- SNF/LTC/Rehab

B. Audit Process, Work Flow, and Audit Findings

- Plan/discuss pre-audit process
- Line by line bill audit
- Validate eligibility/benefits
- Apply third party payment rules
- Review/audit accuracy of UB-04
- Assign/validate ICD-9-CM codes
- Assign/validate MS DRG codes
- Assign/validate E and M codes
- Apply official coding rules
- Assign/validate revenue codes
- Audit billing/claims systems for accuracy and timeliness
- Conduct focused and target audits
- Write audit report using standard format
- Develop pre-audit procedures and tools
- Use statistically generated audit samples
- Post audit conference and discussion
- Conduct exit interview
- Review/audit accuracy of CMS 1500
- Assign/validate CPT codes
- Assign/validate APC codes
- Apply Correct Coding Initiative rules
- Assign/validate Physician Fee Schedule
- Assign/validate HCPCS II

C. Other Relevant Medical Audit Responsibilities

- Update/review/maintain charge description master (CDM)
- Provide clinical interpretation and guidance to fellow auditors and staff
- Recommend/approve/monitor use of external auditors or subcontractors
- Apply medical necessity rules in audit activity
- Apply utilization review criteria and protocols in medical audit activity
- Apply coding rules in medical audit activity
- Apply regulatory and legislative policies in medical audit activity
- Report identified and potential quality and risk management issues
- Participate/conduct interrater reliability (IRR) and validation exercises
- Develop/update data base for tracking and trending medical audit findings
- Prepare/submit cost benefit and financial impact analysis reports

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D. Quality Improvement Activities, Education and Training

- Develop/update/maintain/disseminate training manuals and educational materials
- Participate in education and training of staff
- Develop Quality Assurance/Improvement policies and procedures
- Monitor productivity levels of staff
- Recommend process improvement solutions

E. Compliance and Special Investigations

- Develop risk assessment surveys
- Conduct due diligence and compliance audits using set rules, policies and procedures
- Prepare audit workpapers and report findings
- Develop compliance programs
- Investigate compliance reports and issues
- Recommend/monitor disciplinary and corrective action plans
- Collaborate/cooperate with external and regulatory auditors
- Monitor/apply Office of Inspector General and General Services Administration sanction list
- Interpret/apply/disseminate laws, accreditation, licensure and certification mandates

F. Contracts and Negotiations

- Review/write contracts
- Negotiate with external auditors
- Negotiate with payors

G. Denial and Appeals Management

- Track and review denied claims
- Write appeal letters
- Participate in denial and appeal discussion and follow-ups
- Conduct adjustments and payments
- Recommend business process rules

H. Health Information Management (Medical Records)

- Abstract/collect records for department indices/databases/registries
- Collect data for internal/external use (Quality Assurance, Utilization Management, Risk Management and other related studies)
- Perform quantitative and qualitative analysis
- Calculate and interpret healthcare statistics
- Monitor and enforce JCAHO standards on Health Information Management
- Evaluate software and coding systems
- Maintain record storage and filing systems
- Monitor credentialing programs

I. Informatics and Technology

- Email, word processing, spreadsheets and databases
- Graphics, flow chart, and presentation tools
- Statistical applications
- Project Management tools
- Other commercial billing and auditing systems, homegrown systems, coding systems and antifraud software

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III. Core Domain 03: Audit Skill (21%)

A. *Interaction and Communication*

- Physicians
- Nurses and other clinical practitioners
- Senior management team
- Legal Counsel/Attorneys
- External auditors
- Regulatory auditors

B. *Specific Knowledge and Skill Set*

- Accounting/Finance
- Problem Solving
- Statistics
- Quantitative and Qualitative Analysis
- Nursing Process
- Clinical Judgment
- Project Management
- Programming and Configuration
- Health Information Mgt. Principles
- Proposal Writing
- Research
- Negotiating

C. *Leadership and Management*

- Prepare/submit budget
- Hire/recommend/terminate staff
- Develop productivity, quality control, and process improvement measures
- Conduct performance appraisals
- Develop departmental policies and procedures
- Develop strategic plans, goals and objectives for unit/dept assigned
- Participate in internal/external work groups/committees
- Supervise billers/patient accounting or claims personnel
- Supervise coding, Medical Transcription or Health Information Management personnel
- Supervise nursing or clinical staff

IV. Core Domain 04: Medical Audit Environment (13%)

Application of Laws, Guidance, Standards, Guidelines and Other Accrediting Body Requirements

- National Healthcare Billing Audit Guidelines
- Federal and State mandated laws
- Office of Inspector General Compliance Guidance
- General Accepted Accounting Principles
- Medicare/Medicaid Policies
- National and Local Coverage Determination
- National Committee for Quality Assurance
- Health Insurance Portability And Accountability Act of 1996
- Medicare Integrity Program
- US Sentencing Rules
- Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)
- Interpretative Guidelines, UM criteria, standards and protocols
- HEDIS and Quality Measures
- Sarbanes-Oxley Act
- General Health Insurance reimbursement methodologies
- Employee Retirement Income Security Act (ERISA)

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Sample Questions

1. National Hospital Billing Audit Guidelines require that:
 - A. Auditors must be certified.
 - B. Hospitals must charge audit fees in excess of \$75.
 - C. Auditors must conduct themselves in an acceptable professional manner, adhere to ethical standards, keep confidentiality requirements, and be objective
 - D. Audits must always be conducted on-site

2. Which statement constitutes the *vision* of AAMAS:
 - A. Is an organization dedicated to the advancement of the professional standard and ethical practices of the Certified Medical Audit Specialist
 - B. Is the voice of the medical audit community
 - C. Promotes a unifying influence in the field of medical audit, and operates on a for profit basis
 - D. Believes that all persons and entities involved with health care have an ethical responsibility to contain cost without sacrificing access to quality affordable health care

3. Principal inpatient diagnosis is defined as:
 - A. The diagnoses that the utilization nurses write in their concurrent review sheet.
 - B. The diagnosis that has been optimized by the DRG grouper
 - C. The condition which utilized the most resources while inpatient.
 - D. The condition established after study to occasion the admission of the patient to the hospital

4. In accounting terminology, the term “credit” means:
 - A. A positive cash balance
 - B. A positive financial position
 - C. The left side of the ledger
 - D. The right side of the ledger

5. Statistics are important in medical audit primarily because:
 - A. They identify trends/problem areas in hospital operations, and help identify contract opportunities for both payers and providers
 - B. They always make the audit report appear credible
 - C. They demonstrate the use of a statistician in the final medical audit analysis.
 - D. The use of statistical process control in the performance of an audit provides an opportunity to increase the audit fee

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6. In a final medical audit report, the purpose of the executive summary is:
- A. To serve as a synopsis on the important points of the audit
 - B. To pinpoint areas of vulnerability and identify personnel responsible for such
 - C. To demonstrate how good an auditor you are
 - D. To attract the attention of top level and senior staff for an additional compensation
7. The part of Medicare that covers hospice care, home health care, skilled nursing facilities, and inpatient hospital stays is known as:
- A. Medicare Part A
 - B. Medicare Part B
 - C. Medicaid
 - D. Medicare Part D
8. A regulation to guarantee patients new rights and protections against the misuse or disclosure of their health records is called:
- A. Emergency Medical Treatment and Active Labor Act
 - B. Advisory Council on Social Security
 - C. Health Insurance Portability & Accountability Act of 1996
 - D. Electronic Healthcare Network Accreditation Commission
9. G.A.A.S. is the acronym for:
- A. Generally accepted accounting standards
 - B. Generally accepted auditing standards
 - C. Generalized audit analysis statistics
 - D. Gifted audit analytic students
10. Revenue codes are codes that identify the specific type of service being billed by line item (e.g., room and board, IV therapy/supplies, ancillary service). Revenue codes are billed using which form:
- A. UB-04
 - B. Advanced Beneficiary Notice (ABN)
 - C. CMS-1500
 - D. Certificate of Medical Necessity (CMN)

Answer Key

- 1. c 6.a
- 2. b 7.a
- 3. d 8.c
- 4. d 9.b
- 5. a 10.a

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Certification Council for Medical Audit Specialists

CMAS Certification Application Form

Name _____ Phone (H) _____
 Address _____ City _____ State _____
 Zip _____ Email Address _____
 Employer _____
 Phone (W) _____ Job Title: _____
 # of years employed as a Medical Auditor: _____ Highest Education Level: _____
 School(s) Attended: _____ Degree(s) Awarded: _____
 Professional Licensure #: _____ Type: _____
 State of Issue: _____ Expiration: _____

1. AAMAS Membership is required.

2. Indicate required college or Certification Council approved course and enclose proof of completion

Accounting____ Finance____ Statistics____

3. Resume is required

****Name on the Certificate will appear as below****

Printed Name _____ Signature _____

Date Submitted: _____

Application Fee: \$350.00 Fee is payable to: AAMAS (AAMAS Tax ID: 650573775) *\$50 is non-refundable

Mailing Address: AAMAS-Certification Council
10200 W 44th Avenue, Suite 304
Wheat Ridge, CO 80033

To Pay By Credit Card:

Name as it appears on Credit Card: _____

Type of Card: _____ Credit Card #: _____

Expiration Date: _____

Billing Address (if different from above) _____

Signature of Card Holder _____

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