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Medical Assisting Today

The Magazine for Professional Medical Assistants

Eyes on the Money

Non-Physician Practitioners Offer Practice Benefits but Require Attention to Billing

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Say Yes to Service

In late 2014, I was approached by a longtime friend, mentor, and the 2015 AAMA President who asked me to consider running for the Board of Trustees (BOT). The invitation took me by surprise. Although I felt I was a capable leader at the local chapter and state society levels, I wondered whether the national organization really needed someone like me—an everyday medical assistant working in the "trenches." What could I bring to the BOT?

Eleven years later, I am so glad I said yes. Taking that step helped me grow as an individual and as a leader. It taught me to work with many different types of people, to listen and think before responding, and to recognize the value of everyday medical assistants' voices and experiences to our profession.

In this issue, you will meet the candidates for officer and trustee positions. I encourage everyone to read about them, attend the two virtual Meet the Candidates events, and join the in-person event in Reno, Nevada, following the morning session of the House of Delegates. More information will be shared with all delegates and alternate delegates regarding these virtual events. As you learn more about these leaders, I hope you will also begin to imagine where your own service could take you. Maybe I will see your name in a future edition of *Medical Assisting Today*.

If you are not quite ready to pursue a position on the BOT, there are still many meaningful ways to get involved. I encourage you to review the *Volunteer Leadership Position Descriptions* to learn about the committees, strategy teams, and task forces where your talents and perspective are needed. Serving for one complete year can also help you build the qualifications to serve on the BOT in the future. There is a place for you—you only need to discover where your passion lies. But the BOT committees are not the only places where volunteers are needed. The Continuing Education Board (CEB) welcomes members to serve on its task forces and on the CEB itself. If certification is where your interest lies, consider becoming a member of the Certifying Board or its Task Force for Test Construction.

The AAMA offers many areas of service, and our organization grows stronger when members step forward to serve alongside national leaders. Your experience, ideas, and willingness to help can make a real difference. Won't you consider becoming involved and helping our organization continue to grow? I encourage you to visit the "Volunteer Resources" page on the AAMA website and explore the "Leader's Center." Complete both pages of the volunteer application and send it, along with your résumé and statement, to the AAMA by August 1, 2026. I look forward to seeing you on a committee in the coming year—and I hope to see you in Reno!

Virginia Thomas, CMA(AAMA)

Virginia Thomas, CMA (AAMA)
2024–2026 President

AAMA® Mission

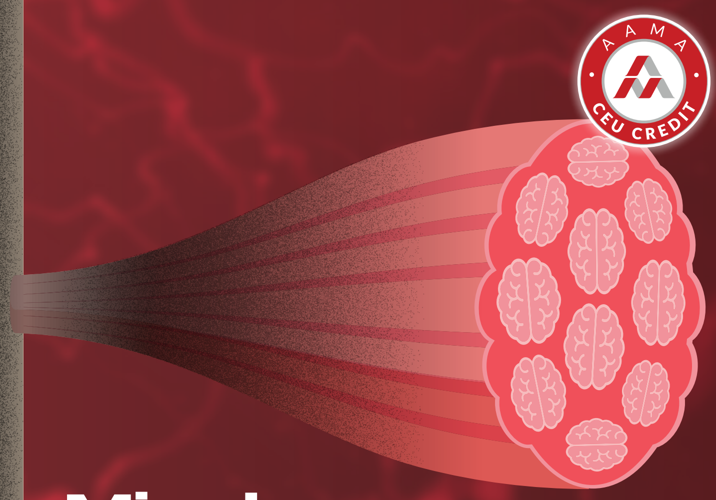
The mission of the AAMA is to empower medical assistants by advancing education, certification, advocacy, and scope-of-practice protection.

CMA (AAMA)® Certification

The CMA (AAMA) is awarded to candidates who pass the CMA (AAMA) Certification Exam. PSI Services LLC constructs and administers the exam. The CMA (AAMA) credential must be recertified every 60 months by the continuing education or exam method.

Eyes on the Money

Mind over Muscle



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Candidates for the AAMA Board of Trustees

Vice President

Jane Seelig, CMA-A (AAMA)

We need to promote the CMA (AAMA) value outside of our organization, while the AAMA continues to represent and meet the needs of our profession as well as finding ways to attract and retain credentialed members.

Vital Stats
Member: 1979; Certified: 1981

National Volunteer Teams

Chaired: 2011 Annual Conference Education; 2008 Annual HOD Tellers; 2014 Annual HOD Credentials; 2019 Annual HOD Reference; Awards; Bylaws and Resolutions; Documents; Leadership Development; Marketing

Served: Speaker of the House; Vice Speaker of the House; Trustee; Annual Conference; Career Professional Development; Conference CE Sessions; Endowment; Maxine Williams Scholarship; Membership Development; Nominating; Public Affairs; Strategic Issues Planning

Vice Speaker of the House

Cameron Smith, BS, CMA (AAMA), CPC, HITCM-PP, PBT(ASCP)

Medical assisting is more than a career—it's the backbone of patient care in America. We are on the front lines every day, and you deserve a trustee who understands the demands of the profession, respects the dedication required, and fights for the resources needed to succeed. Let's win together.

Vital Stats
Member: 2015; Certified: 2016

National Volunteer Teams

Chaired: Bylaws and Resolutions; Editorial Advisory; Engagement and Outreach

Served: Awards; Educators Collaborative; Marketing; Membership Development; Partnership; Test Construction

AAMA Awards: AAMA Rising Star Award (2023)

Secretary

Shirley Sawyer, CMA (AAMA)

We need to continue mentoring members to help them grow within the organization. Actively promote the organization in alignment with our mission and vision statements and communicate core values. Focus on increasing membership by listening to what our members are saying and responding to their needs.

Vital Stats
Member: 1991; Certified: 1995

National Volunteer Teams

Chaired: Continuing Education Board; Career Professional Development; Conference CE Sessions; Editorial Advisory; Leadership Development; Partnership

Served: Advisory Service; Annual Conference; Assessment-Based Certificate; Awards; Bylaws and Resolutions; Career Professional Development; Documents; Educators Collaborative; HOD Minutes; Maxine Williams Scholarship; Membership Development and Marketing; Nominating; Practice Managers; Reference

AAMA Awards of Distinction: Leadership and Mentoring (2018)

Trustee

Erica Arends, CMA (AAMA)

Medical assistants are the heart of rural health care. My vision for the continued success of the AAMA is to build partnerships, find new pathways, and mentor students and non-traditional members to include all medical assistants. I hope to do this while keeping true to the AAMA values and mission.

Vital Stats
Member: 2009; Certified: 2011

National Volunteer Teams

Served: Editorial Advisory; Leadership Development; Practice Managers; Reference

Rachel Ozburn, CMA (AAMA)

My vision is to strengthen the American Association of Medical Assistants by increasing membership, supporting state growth, and advancing the recognition of the CMA (AAMA). Through *advocacy, leadership, and unity, we will empower medical assistants and elevate the profession nationwide.*

Vital Stats
Member: 2008; Certified: 2011

National Volunteer Teams

Served: Conference CE Sessions; Test Construction

Terri Slinker, CMA (AAMA)

Run for the Roses:

Championing CMAs (AAMA)

- *Advocating for recognition, respect, and advancement within the health care team*
- *Supporting initiatives that elevate our profession nationwide*

Focused on the Finish Line

- *Promoting certification and continuing education*
- *Encouraging leadership development for all members*

A Team Player

- *Listening to members*
- *Building collaboration through networking*

Vital Stats
Member: 1984; Certified: 1984

National Volunteer Teams

Chaired: Annual Conference; Practice Managers

Served: Continuing Education Board; Assessment-Based Certificate; Bylaws and Resolutions ✦

Call for Community Corner Profiles

This issue of *Medical Assisting Today* is the first to feature a Community Corner article (page 30). To continue highlighting the AAMA's amazing communities at the state and chapter levels in this new way, we need your submissions! Sign up via the AAMA website:

BOT Qualifications

Thinking of running for the AAMA Board of Trustees? Check the *AAMA Bylaws* on our website (on the "Leader's Center" webpage) to make sure you meet the requirements for nominations. Nominees have already been announced, but candidates may put forth nominations from the floor at the AAMA Annual Conference. ✦

Your Deadline to Make a Difference

Reminder: AAMA Volunteer Leadership Applications are due by **August 1**.

You can find the application on the "Volunteer Opportunities" webpage, accessible via the "Join the AAMA" dropdown menu. Or simply search for "AAMA Volunteer Leadership Application" in the search bar. ✦

Eyes on Earnings

Watch for the annual AAMA Compensation and Benefits Survey, coming to your email inbox this summer. Your responses help create an accurate report! ✦

How to Display Your Credential—The Right Way!

If you've earned the CMA (AAMA) credential and have maintained the credential's currency, you should be including the credential "CMA (AAMA)" after your name. Don't forget to include "(AAMA)" to reflect the credential accurately!

Correct: Jane Doe, CMA (AAMA)

Incorrect: Jane Doe, CMA

When writing a complete sentence, use commas around "CMA (AAMA)."

Correct: The illustrious Jane Doe, CMA (AAMA), will be our guest speaker. ✦

Save the AAMA's Texting Line to Your Contacts

Make sure the cell phone number on your AAMA profile is correct so you receive reminders and tips about CMA (AAMA)® recertification as well as membership news. Allow the AAMA to track your deadlines and keep you updated on when you must take action to maintain your credential.

Save these numbers to your phone!

- **Membership:** 888/505-1489
- **Certification:** 833/986-3121

Note: These are not customer service lines. Please call 312/899-1500 or 800/228-2262 to speak with an AAMA representative. ✦

Outcomes Measures for the Accreditation of Education Programs and the Significance of NCCA Accreditation of Certification Programs in the Occupation/Profession

Donald A. Balasa, JD, MBA, ICE-CCP
AAMA CEO and Legal Counsel

There continues to be an increasing emphasis on requiring academic programs that are preparing students for an occupation/profession to demonstrate by student outcomes measures the effectiveness of their education. For occupations that are not licensed, the performance by students on national certification exams is often required by accrediting bodies that accredit occupational education programs.

However, a fundamental misunderstanding about using the results of certification exams for student outcomes measures has become the conventional wisdom in certain accreditation schools of thought. The purpose of this article is to examine what I consider this fundamental understanding and offer some clarifications and refinements in the appropriate use of certification exam results as a student outcomes measure.

The Accreditation of Certification Programs/Exams

Occupational certification programs and their exams may most frequently be accredited under two accreditation standards. One standard is the National Commission for Certifying Agencies (NCCA) *Standards for the Accreditation of Certification Programs*[1] (NCCA *Standards*). The other standard is ISO/IEC 17024:2026: *Conformity Assessment—General Requirements for Bodies Operating Certification of Persons*[2] (*ISO 17024*). ("ISO" is the abbreviation for "International Organization for Standardization.")

The accreditation of certification programs and their exams is different from (1) the institutional accreditation of schools and (2) the programmatic accreditation of programs of study for occupations/professions within schools.

In this paper I will be focusing mostly on accreditation under the NCCA *Standards*.

NCCA Accreditation

The NCCA describes its accreditation in its current *Standards*:

> Accreditation is both a process and a status. The NCCA's accreditation process uses peer review to evaluate a certification program's compliance with these standards, recognizes programs that demonstrate compliance, and serves as a resource on certification quality. NCCA *Standards* address the structure and governance of the certifying agency; the characteristics of the certification program; the information required to be available to applicants, certificants, and the public; and the recertification initiatives of the certifying agency. The NCCA's *Standards for the Accreditation of Certification Programs* used as a foundation the *Standards for Educational and Psychological Testing*, promulgated by the American Psychological Association … [and other testing and measurement bodies].
>
> As a status, NCCA accreditation recognizes and provides public notification that the certification program is committed to self-study and external review by one's peers, meets *Standards*, and seeks continuous improvement to maintain the quality of examination and certification of its constituent professionals. Upon achieving accreditation, the certification program must embrace transparency and accountability to its stakeholders, certificants, and the public through communications that are publicly available and readily accessible.[1]

A Certification Program Purpose

The NCCA *Standards* contain the following:

> **Standard 1: Purpose**
>
> The purpose of the certification program must be to recognize each individual who meets established criteria. These criteria must uphold standards for practice in a profession, occupation, role, or specialty area.
>
> …
>
> *Commentary:*
>
> 1. Certification is a type of credential that can be offered for a specific profession, occupation, role, or specialty area across multiple disciplines. Programs should specify the *target population(s)* for certification, including the *level of experience for the targeted practitioner* and the purpose of the certification program.[1] [Emphasis added.]

The above excerpt would seem to indicate that a certification program that is seeking NCCA accreditation may target a segment of an occupation/profession, including a segment of an occupation predicated on the "level of experience"[1] of the segment. This assertion is supported in "Standard 14: Job Analysis":

> *Commentary:*
>
> …
>
> 2. Programs typically validate the delineated job-related elements by surveying current certificants and/or a representative sample of the population that is *the intended target audience for the certification.*[1] [Emphasis added.]

Targeting Different Segments/ Subsets

There are examples of certification programs that target one segment/subset of an occupation, and not all segments of an occupation, nor the occupation as a whole.

For example, there are occupations that have training programs at the high-school level and education programs at the postsecondary/post-high-school level. As one would expect, there are often certifications within the occupation that target completers of a secondary program and certifications that target completers of a postsecondary program. *These may be very different exams and certifications, even though they exist within the same occupation broadly defined.* To reiterate, different credentials and designations may be issued to those who pass (1) the exam for completers of high school programs and (2) the postsecondary exam—even though both exams are within the same occupation.

Examinations Varying in Content Coverage and Difficulty

For occupations that cover a broad range of knowledge, skills, and affective attributes and behaviors, a certifying body for the occupation may choose to create several exams, each of which covers subsets of the universe of knowledge, skills, and affective attributes. If such is the case, the accreditation of a certification program by the NCCA attests to the fact that the certification program has met the NCCA *Standards* in reference to the subset of knowledge, skills, and affective attributes, not in reference to all the occupation's knowledge and skills. Furthermore, based on issues of market positioning and strength of competition, there may be differences in the difficulty of the certification exams offered by a certifying body in a particular occupation broadly defined.

A Fundamental Misunderstanding, Now the Conventional Wisdom

The fundamental misunderstanding (in my opinion) within academic programmatic accreditation may be described as follows:

> If a certification program/exam within an occupation is accredited by the NCCA (or under *ISO 17024*), the programmatic accreditor is obligated (legally and/or by the standards of the programmatic accreditor) to accept performance on *any and all accredited certification programs* in the occupation broadly defined for measuring the outcomes of its accredited programs.

Certification programs within the same occupation broadly defined may vary significantly, depending on what subset of the knowledge, skills, and affective attributes and behaviors the certification program and its exam purport to measure. Consequently, results on certification exam(s) should be used for student outcomes *only to the extent that the exam(s) measure(s) the knowledge, skills, and affective attributes required by the programmatic accreditor to be included in the curriculum of accredited programs.*

In other words, my conviction is that the performance on certification exams should be used as an outcomes measure for programs and accreditors of programs if and only if the exam measures what is taught in the mandated curriculum of the program. Using the performance on a certification exam that does not measure (or partially or imperfectly measures) the knowledge, skills, and affective attributes taught in accredited programs leads to a flawed measure of student outcomes.

NCCA Policies Lend Support

The NCCA *Policy Manual*[3] supports my assertion that NCCA accreditation of a certification program/exam does not automatically mean that the certification is a suitable vehicle for measuring student achievement in an academic program in the profession:

> Matters Not Evaluated
>
> The [NCCA] does not evaluate the content of a program's assessment; the [NCCA *Standards*] are concerned with structure, process, and results.[3]

This brief NCCA policy is indicating that, in its review of certification programs, the NCCA makes sure that the *process* of constructing and administering the certification exam meets its *Standards*. Such a process includes but is not limited to:

- Conducting a psychometrically-sound and legally defensible job task analysis
- Creating a weighted content outline based on the results of the job task analysis
- Writing exam items (i.e., questions) that meet the specifications of the content outline
- Developing exam forms/versions that measure knowledge of the content in each domain/content area of the content outline and that are statistically equated to each other
- Using subject matter experts to establish a psychometrically defensible cut score
- Administering the exam in a manner that minimizes construct-irrelevant variance
- Reviewing the exam results to make sure that each item is performing acceptably

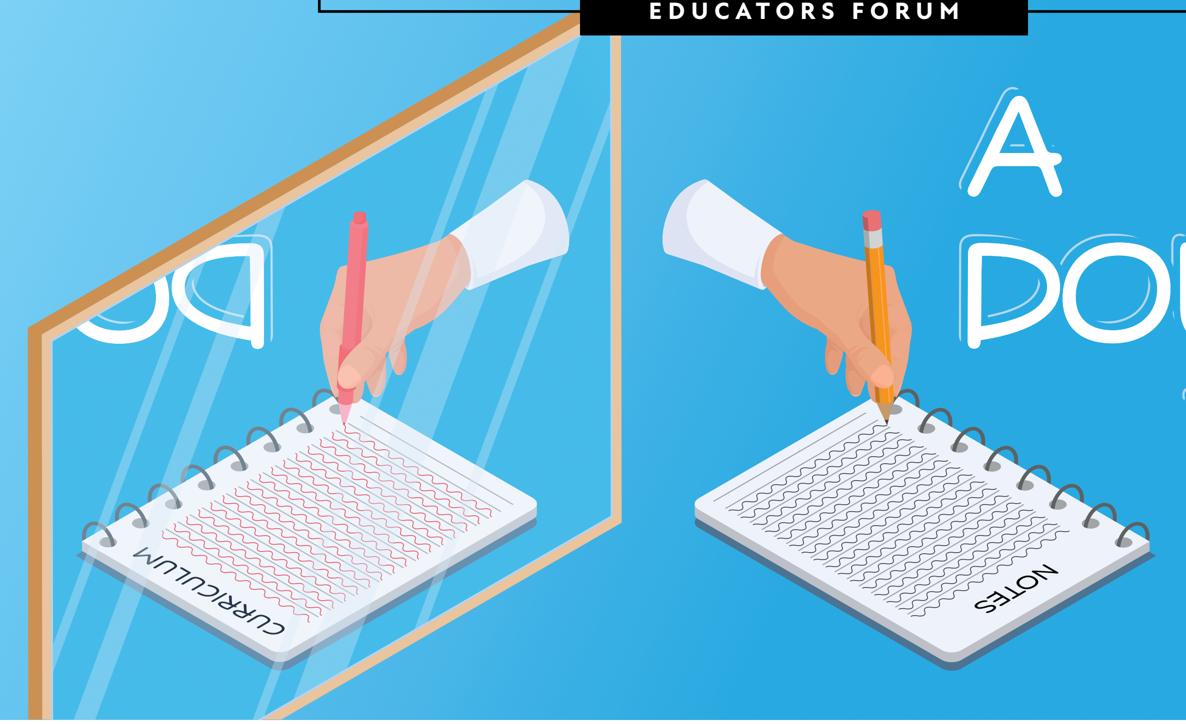
The NCCA does not attempt to "evaluate the content of a [certification] program's assessment"[3] or test to determine *whether the exam is testing what it should be testing.*

Consequently, I maintain, the responsibility of whether a particular exam is suitable for student outcomes measurement rests with the/a programmatic accrediting body of academic programs in the profession, not with the NCCA. ✦

Questions may be directed to CEO and Legal Counsel Donald A. Balasa, JD, MBA, at DBalasa@aama-ntl.org.

References

1. National Commission for Certifying Agencies. *Standards for the Accreditation of Certification Programs*. Revised October 2021.
2. International Organization for Standardization. *ISO/IEC 17024:2026: Conformity Assessment—General Requirements for Bodies Operating Certification of Persons*. March 2026.
3. National Commission for Certifying Agencies. *Policy Manual*. Revised August 13, 2024. Accessed June 17, 2026. https://www.credentialingexcellence.org/Portals/0/NCCA%20policies%20revised%208_13 -24_1.pdf



A DOUBLE TAKE

Students Can Likewise Educate Educators

By Cathy Cassata

When their days are spent teaching students, educators might sometimes find themselves on the other side of the dynamic: learning from students.

"Teaching is a reciprocal relationship," says Melody Gibson, CMA (AAMA), HHS, MHRD, CPT (ASPT), associate dean at Gaston College in Dallas, North Carolina. "I often tell my students that I am here to support them, but the truth is, their growth and feedback are what keep me ready and evolving as an educator."

Amanda Beaman, CMA (AAMA), AHI(AMT), department chair at Montgomery Community College in Troy, North Carolina, agrees. "I strongly believe that students provide valuable insight into our effectiveness not only as instructors but also as mentors," she says.

Here are ways you can learn from students to help improve your teaching skills:

A Two-Way Street

Gaining feedback from students can push you to improve the way you teach. Award-winning educators all regularly asked their students for feedback on what teaching styles and methods were and were not helpful, according to a study from 2019.[1] By providing feedback, students brought up questions regarding material and identified areas that needed improvement related to lessons, grading policies, and more.

April Jones, CMA (AAMA), who instructed at Everest Institute in Eagan, Minnesota, used SurveyMonkey, a platform for sending surveys and forms, to allow students to answer questions honestly and anonymously. "When we get more comfortable with interactive learning, face-to-face and group discussions can happen authentically," says Jones.

Gibson replaced a final exam in her medical law and ethics course with a reflective exam. She asked students to answer: "What topic resonated with you the most and why? Do you feel it could have been presented to you in another format?"

"I truly love reading these submissions. They have given me invaluable insight into how students process complex ethical dilemmas and which formats, reflections, case studies, or videos help those topics stick," she says. "This direct feedback allows me to pivot and refine the course in real time for the next cohort."

Beaman collects insight from students in multiple ways. Her institution administers course evaluations at the conclusion of each course, providing students with an opportunity to offer structured feedback on instruction and course design. Once students finish the program, they are invited to complete comprehensive surveys that assess their overall experience, including their practicum.

She also initiates in-person feedback. "During their time in the program, I meet with students at least once per semester to better understand their individual learning styles, identify their needs, and discuss ways to improve their overall experience," says Beaman. "This multifaceted approach allows for continuous evaluation and improvement of both teaching practices and curriculum."

Put Two and Two Together

The practicum serves as a comprehensive culmination of the student's experience within the medical assisting program, providing valuable insight into the effectiveness of both instructional methods and curriculum design.

"It allows me to identify potential gaps in content delivery or teaching strategies and evaluate whether prior instruction has adequately prepared students for real-world clinical performance," says Beaman. "This process is instrumental in determining how effectively the program equips students to perform at a high level and informs any necessary adjustments to enhance student readiness and success."

Gibson learns most from students who attend high-volume, busy clinics. "When students return with stories of the whirlwind nature of the job, I realize that a sterile, quiet classroom doesn't always prepare them for the reality of the field," she says.

As a result, she started building simulations that force students to multitask under pressure, mimicking a real-world clinic where phones are ringing and multiple patients need attention simultaneously.

"Practicums have taught me that my job is to prepare them for the chaos, not just the textbook," says Gibson.

Copy That

The greatest lesson Gibson learned from students is to receive their grace. "As an instructor, you often feel you must be the 'rock' or the one with all the answers. However, seeing students overcome personal hurdles to stay in the program has taught me the lesson of human resilience," she says.

She learned that when she models vulnerability and offers grace, she creates a safe space for excellence to grow. "It has taught me to be more patient … and to lead with empathy first," says Gibson.

When students perceive higher levels of empathy from their educator, they experience reduced stress, anxiety, and depression while enhancing their engagement in learning activities, according to a 2025 study.[2]

Getting to know students' experiences allows Beaman to gain empathy for their situations and refine her approach to better support their academic and professional development. "Engaging with students fosters greater empathy and a deeper understanding of their individual circumstances and learning needs," she says. "By taking the time to know students on an individual level, we are better positioned to provide meaningful support and guide them toward successful outcomes within the program."

Jones recalls a student who struggled to take a patient's blood pressure correctly during a one-on-one meeting that lasted almost two hours. "There were breaks to help keep us both from getting frustrated, but she taught me to keep digging into the issue, and we found out that the issue was she could not count backwards by twos," says Jones. "This was nearly 20 years ago, and I have never forgotten this lesson."

The solution they came up with was for the student to repeat "eight, six, four, two" multiple times and then Jones would call out a number for her to start counting backwards by two. "It was a sensitive moment because there was humility in play," says Jones. "My role was to mentor, encourage, and keep those moments safe."

Twice the Benefits

Having students teach other students not only helps them learn but can also inform educators about areas that need improvement when it comes to teaching students' skills.

Researchers observing more advanced medical students teaching beginner medical students found that teaching is about understanding how students think, not just whether they get the correct answer. Moreover, they determined that teachers learn more about student thinking and their own assumptions, when they focus on the process, not the outcome.[4]

Melody Gibson, HHS, MHRD, CMA (AAMA), CPT (ASPT), implemented a Peer Lab Leader program in her examination room and laboratory procedures courses. The leaders are students who have excelled in their evaluations and consistently step up to help others. "By setting up practice sessions, these leaders provide their peers with hands-on pointers and memory cues for the tougher skills," says Gibson. "We've found that students are often less intimidated by a peer than an instructor, which opens the door for better teamwork and critical thinking. Even though an instructor is always on campus to step in if needed, giving students this autonomy has really boosted their confidence and helped them move away from a constant reliance on their notes."

Couple Methods Together

Some students learn more effectively with words, visuals, or both. In fact, a meta-analysis from 2024 found that in the context of science, technology, engineering, and mathematics education, studies consistently show better learning outcomes when students use multiple representations (e.g., text, pictures, and graphs) versus just one. Benefits of this include stronger understanding and better problem-solving.[3]

Because students come from different backgrounds and have different levels of base knowledge and learning styles, Jones adapts her teaching styles to meet their needs. "Sometimes you need more explaining of a topic, and other times showing them how to do something or providing a visual is more effective," she says.

Recognizing that students have diverse learning styles has taught Beaman to ask students for guidance on how to enhance engagement, clarify content, and strengthen overall effectiveness. "This ongoing exchange allows me to continually adapt and grow as an educator to better meet the needs of all learners," she says.

Think Twice about Tech

Because of students, Gibson has learned that a course is only as effective as its accessibility.

"They've shown me the importance of staying current with technology while ensuring the core concepts remain basic," she says. "Balancing diverse learning needs and how technology evolves over time is an ever-evolving process." ✦

References

1. Kumar S, Martin F, Budhrani K, Ritzhaupt A. Award-winning faculty online teaching practices: elements of award-winning courses. *Online Learning*. 2019;23(4). https://doi.org/10.24059/olj.v23i4.2077
2. Ampofo J, Bentum-Micah G, Xusheng Q, Sun B, Mensah Asumang R. Exploring the role of teacher empathy in student mental health outcomes: a comparative SEM approach to understanding the complexities of emotional support in educational settings. *Frontiers Psychol*. 2025;16:1503258. Published 2025 Mar 20. doi:10.3389/fpsyg.2025.1503258
3. Rexigel E, Kuhn J, Becker S, Malone S. The more the better? A systematic review and meta-analysis of the benefits of more than two external representations in STEM education. *Educ Psychol Rev*. 2024;36(4). https://doi.org/10.1007/s10648-024-09958-y
4. Humphrey KN, Daulton RS, Weber D, Sall D, Kelleher M. Coproducing the learning environment: lessons learned from a year of near-peer teaching. *J Med Educ Curricular Dev*. 2022;9:238212052210962. https://doi.org/10.1177/23821205221096288

news to use

by Kelli Smith

PCOS Renamed as PMOS

After over a decade of worldwide discussion, **polycystic ovary syndrome** (PCOS), which affects an estimated 1 in 8 women worldwide, has officially been renamed as **polyendocrine metabolic ovarian syndrome** (PMOS). The name change was announced at the European Congress of Endocrinology in Prague, reports Healthline.

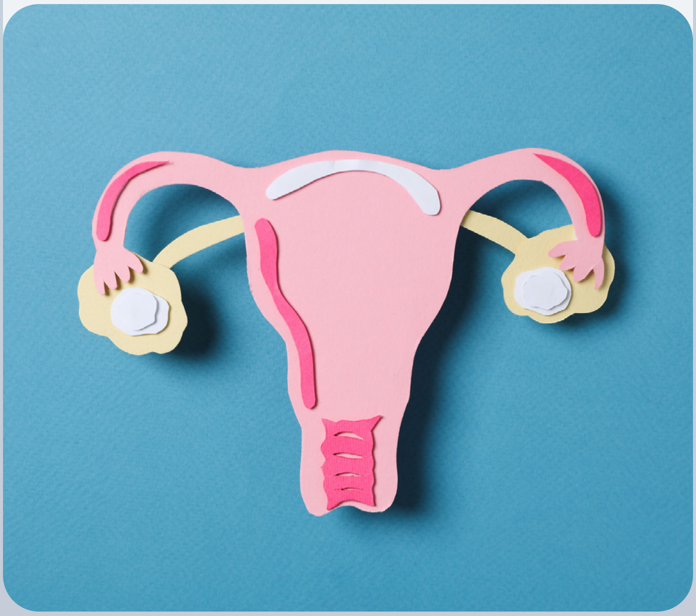
PMOS is a common condition that affects hormones. It causes irregular menstrual periods, excess hair growth, acne, and infertility, according to Cleveland Clinic.

Over the past 14 years, 56 clinical, academic, and patient organizations have campaigned to change the name of PCOS. Their goal was to make the name more accurate to the condition. This meant focusing on terms such as *ovarian*, *metabolic*, and *polyendocrine* to reflect the condition's effects on multiple systems in the body. This led to the consensus for the new name.

By putting *endocrine* and *metabolic* into the name of the diagnosis, PMOS communicates to clinicians that this condition affects the whole body, not just gynecological concerns. The accuracy of the name was also improved by removing the word cysts, because not everyone with PCOS experiences ovarian cysts.

The previously limiting and inaccurate name led to numerous consequences, such as diagnosis delays, fragmentation in care, and stigma. However, the new name addresses these issues by reflecting the hormonal complexity of the disorder and acknowledging the condition's strong metabolic and cardiometabolic effects.

Experts who were part of the renaming effort hope this change will help reshape how the condition is diagnosed, treated, and researched worldwide.



New Mammogram Guidelines for Older Women

Breast cancer is one of the most common cancers in women in the United States, accounting for nearly one-third of all new female cancers each year. On average, a woman in the U.S. will have roughly a 1 in 8 chance of developing breast cancer in her lifetime.

Breast cancer mainly occurs in middle-aged and older women, with most breast cancers found in women 50 years or older. The median age at the time of breast cancer diagnosis is 62.

Breast cancer screenings play a crucial role in enabling early detection, often before symptoms appear and when it is most treatable.

A new guidance statement from the American College of Physicians updates previous recommendations by advising that all asymptomatic women at average risk of breast cancer should receive mammography screening every two years between the ages of 50 and 74.

The guidance defines average-risk women as those without a personal or family history of breast cancer, any known high-risk gene variations, or prior high-dose chest radiation at a young age.

The American College of Physicians emphasizes that screening decisions should be guided by the best available evidence and tailored to individual patients.

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wear your achievement with pride!

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2. **Ensure your CMA (AAMA) certification is current.**
3. **Visit the AAMA store to view and purchase the pin.**

Note: You must be logged in to your AAMA account and your CMA (AAMA) certification must be current to view and purchase pins. See the product description for details.

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS®

Eyes on the Money

Non-Physician Practitioners Offer Practice Benefits but Require Attention to Billing

By Mark Harris

The demand for physician services is high. With an aging and growing population, high use of care, and other factors, the overall demand for health care services has also grown significantly in recent years. As a reflection of this growing demand, health care spending in the United States reached $5.3 trillion in 2024, marked by an increase of over 7% in 2024.[1]

Unfortunately, the supply of available physicians has not kept pace with the growing demand for services. This trend is also expected to continue for the foreseeable future. The projected total shortage of physicians could be as high as 86,000 by the year 2036, according to the Association of American Medical Colleges.[2] This includes an expected shortfall of between 20,200 and 40,400 primary care physicians over the next decade.[2]

In response, the number of non-physician practitioners (NPPs) working in the health system is on the rise. These include nurse practitioners, physician assistants, clinical nurse specialists, and other practitioners. In fact, advanced practice practitioners now constitute over 40% of the U.S. health care provider workforce.[3] This growth is largely found in primary care and surgical settings, but includes many specialties and areas of care.

Notably, NPPs are also often referred to as advanced practice providers (APPs). While the terms are generally synonymous, NPP tends to be used more in reference to billing or administrative matters, while APP refers more to the clinical practice or setting. The Centers for Medicare & Medicaid Services (CMS) describes NPPs as advanced practice non-physician practitioners.[4]

Check on Teams

For many medical practices, the use of NPPs (or APPs) as a practice resource is an increasingly attractive option, both financially and as a means to enhance patient access and satisfaction. Notably, a recent Medical Group Management Association (MGMA) Stat poll found 48% of medical practices added advanced practice providers to their clinical staff in 2025.[5]

Doing so can build on the team-based care approach that defines modern medical practices, observes Anders Gilberg, senior vice president of government affairs for the MGMA in Washington, D.C. "Advanced practice nurses and other practitioners are absolutely critical to that team-based setting," says Gilberg. "In this country, there are challenges now because of physician shortages. There are limits on graduate medical education slots for training physicians. There are shortages as well in some of the primary care specialties. Many medical practices leverage advanced practice providers in a way that is critical for patient access and for the bottom line of the practice. It depends on the physician specialty or whether it's a multispecialty practice, but advanced practice providers play a critical role in health care delivery in our country today."

Of course, the expanded use of nurse practitioners, physician assistants, and other NPPs in clinical care requires that medical practices clearly understand the billing responsibilities associated with their use. This is a key challenge for medical groups to avoid claims denials and potential Medicare or private payer audits.

Under Medicare, an NPP must be enrolled in the program under their own National Provider Identifier, or NPI.[4] In turn, when an NPP directly bills for medical services using their NPI, they can expect to be compensated at 85% of the Medicare physician fee schedule. However, two other billing options are available when NPPs and physicians collaborate in patient care. These are known as "incident to" services and "split/shared" services.[6]

The Fund-amentals of NPPs

Under Medicare, several types of practitioners are defined as advanced practice non-physician practitioners (NPPs). They include four categories of advanced practice registered nurses: certified registered nurse anesthetists, nurse practitioners, clinical nurse specialists, and certified nurse-midwives. Other NPP categories include physician assistants and anesthesiologist assistants.[6]

Invest in a Better Understanding

When an NPP provides office-based services under the supervision of a physician (e.g., MD or DO), the supervising provider can bill for those services under Medicare's incident-to rules. Using the supervising physician's NPI allows for the NPP to then be reimbursed at 100% of the Medicare physician fee schedule.[6] However, there are some important caveats that come with incident-to services. First, the billed medical service must be initiated by the supervising physician, who is responsible for the initial diagnosis and treatment plan. In turn, the NPP is required to follow that treatment plan in subsequent patient visits. Incident-to rules also require the supervising physician to be physically present in the practice when the NPP treats the patient.[7]

Despite the lower NPP compensation rate associated with billing directly, doing so is likely perceived by many medical practices as less of a compliance risk, finds Gilberg. "In my conversations over the years with administrators and executives of physician practices, that is the predominant way most practices handle it," he notes. "The other way is incident-to billing, but that comes with a lot of strings attached in terms of regulatory requirements, as well as contractual requirements if we're talking about a health insurance contract. The regulatory requirements where a physician has to initiate the course of services and then be in the office suite to supervise the care tends to be somewhat more limiting. We find a lot of our medical practices will bill the advanced practice providers at the 85% fee schedule because that allows them to not only have more autonomy, but they can also initiate new diagnoses. You can't do that under incident-to rules. Although they get paid a little less, the lessened liability risk for the compliance issues that could occur, as well as the autonomy within the practice to work as part of the team without direct physician supervision, is what most medical practices will do."

Notably, the 2025–2026 work plan of the Office of Inspector General continues to prioritize audits to ensure compliance with Medicare incident-to services.[8] "The

[Office of Inspector General] has had incident-to billing on its work plan for many years and is constantly keeping a close eye on this issue," cautions Gilberg. "On the regulatory side with the federal payers, I would just be very careful and really understand the requirements necessary for incident-to billing. I would advise practices to try to keep that part of the practice as simple as possible."

Bank on Each Other

"The more complex the payer regulations get, the more we have to lean on the rest of our team. Usually, medical groups will have the billing manager go through the updates and newsletters from every single payer. It's [their] job to stay on top of all of the policy updates. And that's often just not feasible, particularly if you have a working manager in billing or in practice administration. But if you have a billing team, even three people, you can delegate some of that work. It doesn't have to be one person who's responsible. A manager can say, 'Jennifer, your job is to stay on top of the Blue Cross policy updates' and, 'Khalil, it's your job to look at the United Healthcare updates. If there's anything that applies to this clinic, you need to escalate it up to me so that we can talk about it at the next billing meeting.' But what I often find is groups will just say they try to read through all the updates. That's not efficient. Or, 'it's everyone's job in billing.' If it's everyone's job, it's no one's job. That drives zero accountability.

"It's the same reason when you're taught CPR, they tell you to point at someone specific and tell that person to dial 911. It's because everyone will just assume somebody else did it. But when you have that kind of [delegated] accountability and have a regular cadence for your meetings or even just staff huddles, then your staff is encouraged to raise those billing issues. There are just so many rules and payer regulations, you can't default to one person or just say it's this department's job. You really have to get granular and assign accountability to a specific human."

—Shawntea "Taya" Gordon, MBA, FACMPE

Know the Costs

Admittedly, the billing landscape is a complex one to navigate and likely a source of confusion or uncertainty for many medical practices. While Medicare has consistent rules for billing NPP services, commercial insurance payers may apply different coverage policies. These may be similar to Medicare rules but can also differ in important ways.

Adding to these challenges, medical practices can conceivably work with many contracted private insurance payers. For this reason, practice leadership must establish clear billing policies and processes that enable staff to stay informed, up to date, and compliant with multiple payer requirements.

If a medical practice has plans to introduce or expand its use of NPPs, managers should anticipate and prepare for the multiple contractual obligations this could entail. "Every insurance company has [its] own rules and how they want things submitted," notes David J. Zetter, PHR, SHRM-CP, CHCC, president of Zetter Healthcare Management Consultants in Mechanicsburg, Pennsylvania. "If you're working with 10 different insurance companies, the first thing you should do when hiring any type of provider—whether it's a physician assistant, nurse practitioner, or other provider—is to go to the payer websites and find out what the requirements are for that provider to be credentialed in your state and what they're allowed to do to be eligible for reimbursement. Whether it's Blue Cross Blue Shield, Cigna, or Medicare, you've got to know all the rules on how they are allowed to bill, what the supervision requirements are, and more. This should all be figured out before you even hire someone. You'll know that they need to be credentialed. You'll know how long it's going to take. You'll know whether a physician assistant is going to be allowed to do an ultrasound or [whether] they need an interpretation by a physician to bill that procedure. Everything should be set up so the practice can bill properly and legally and get paid appropriately."

Given the complexity of NPP services, billing clarity should always be paramount, agrees billing expert Farida Chowdhury, CEO of FC Billing in Lansdowne, Virginia. "I get questions on these issues all the time from [physicians]," says Chowdhury. "I find there's a lot of confusion among medical practices about these rules. Unfortunately, [physicians] are often relying on hearsay. They'll say, 'Well, I talked to my friend and [they do] it this way.' Or they learned something in a Facebook or LinkedIn group. My advice is always to go directly to the source and ask, 'What's the rule?' Do not go by what other people are telling you. Don't talk to your friend; talk to the payer directly. I see thousands and thousands of dollars being taken back every year from one practice or another for relying on this type of hearsay."

Whether it involves Medicare or private payers, payment and claims audits are a fact of life for medical practices today, emphasizes Chowdhury. "Medical practices need to know the rules because no matter who they are, no matter how big or small the practice, they can expect to be audited at some point," she says. "In some instances, I have seen practices where a Medicare audit caught that physician assistants and nurse practitioners were continuously billing under a physician's name, which is considered incident-to billing. In the audits, Medicare actually asked for the [physician's] schedule. They then saw that most of the days these practitioners were billing, the [physician] wasn't even on-site as required."

While incident-to billing rules require careful adherence, they are not unmanageable for those who make the effort to understand them, explains Chowdhury: "If we're talking about dermatology, let's say the patient has a skin rash. The MD or DO will see the patient for the first visit and for that particular diagnosis and then set the treatment plan. They might also say the patient should return in six weeks to see the nurse practitioner. The nurse practitioner will then follow that treatment plan for the subsequent visits. Now, if they intend to bill a claim under the [physician], they will need to exactly follow that plan and also keep the [physician] updated on the patient's progress. If the nurse practitioner were billing on their own, they would get paid 85% of what the [physician] would get from Medicare. By billing under the MD or DO, they are getting 100% of the allowable fee. But that also means the medical [physician] is responsible for managing that particular diagnosis."

As such, this should be a clear, straightforward arrangement. But Chowdhury raises an interesting question: What if, in the course of the treatment, the patient develops a new dermatological condition? How would this affect the billing arrangement?

"In [the example] case, we know the patient is being treated for [a] skin rash," she says. "But what if this patient also develops a severe acne issue on the back? The acne issue is a separate problem. If the nurse practitioner is initiating treatment for the acne, they will need to bill on [their] own NPI, not the [physician's] NPI. That's because they are initiating treatment for a new diagnosis that the [physician] has not addressed or planned for. However, if they want to do incident-to billing, they will have to send the patient back to the MD or DO for the new diagnosis."

"This is what's often misunderstood by medical practices," says Chowdhury. "That's why I generally recommend [billing] under the provider who's actually doing the treatment. But if they do choose to use incident to billing, they will have to stick to the exact plan of the [physician]. They cannot sidestep the plan."

Organizational Change

As medical practices add NPPs to their groups, experts agree that it is necessary to develop a consistent approach toward how the practice manages and implements these staffing changes. Doing so requires managerial leadership, perspective, and informed input from staff at every level of the practice.

"For supervisors and managers, one of the critical things to understand is that adding an NPP to your practice means you're changing your care delivery model," says Shawntea "Taya" Gordon, MBA, FACMPE, an MGMA consultant and CEO of Atlas & Perpetua Healthcare LLC in Omaha, Nebraska. "Most groups think [that] if they understand the rules, they're fine, but most of the time when people get into trouble, it's because they didn't operationalize on those rules in a consistent way. They're missing those workflows or the documentation—the standardization in general—that really keeps them safe."

For instance, with incident-to services, Gordon cites an instructive example of the type of complication that could arise. "I worked with a medical group that has several locations, with four physicians and eight NPPs. Ratio-wise, supervisory-wise, that's fine, except there was one day a week when there was no physician at one of the locations. Yet that involved the designated supervising physician for the NPPs at that location on that day. So, it's a bit of a mismatch, right? Nobody had caught that there wasn't a physician there one day a week to provide direct supervision or to step into a room if there was a new problem or an emergency. It's issues like this that can happen when you don't have a consistent guideline or workflow around changes to your care model. What does that mean across every spectrum of the practice? What does it mean for new patients, established patients, and the workflow? That's really when I start to see people get tripped up."

Gordon also wants medical practices to understand that they should never view incident-to arrangements as a kind of "billing hack"—a way to obtain 100% of the revenue without meeting the credentialing or supervisory rules. "If you have to defend your practice in an audit or in court, you really want to make sure you are in a solid, secure place with that, which means your documentation isn't just copy and paste," she cautions. "This means you have a true policy for supervision and for escalation of a claim."

Small Change

"I think the smaller clinics do a better job of managing billing responsibilities. If you're a small clinic with one to four [physicians] and you have a small administrative team, they're working collaboratively already out of necessity. They really need to focus on every dollar that gets denied. They need to make sure that they are collaborating with the front desk for any coordination of benefits issue. So, they are working pretty interconnectedly.

"At the other end of the spectrum, ... large health systems ... have systems in place. They're big enough that they've built in the standardization and the protocols to drive that sort of efficiency.

"But in between these examples, there is this place where people haven't quite gotten to a point where they need systems as structured as the large systems. They're also not communicating or as interconnected as the small groups. Because you might not see half of the people that are employed at your peer level in a larger group, whereas in a small group you're working right next to them. As soon as you hang up the phone with a payer, you're going to say, 'You're never going [to] believe what I just heard from Blue Cross.' And you tell the person sitting next to you, and now the whole department is informed. So, there is something that gets lost when you grow beyond a certain size and you don't build those SOPs [standard operating procedures] into place."

—Shawntea "Taya" Gordon, MBA, FACMPE

"Split/Shared" Services

The other allowable exception to Medicare's NPP direct billing rules is "split/shared" billing. This is a billing arrangement that is strictly limited to facility-based settings, such as hospitals (both in-patient and outpatient services), emergency rooms, and nursing facilities. These are settings where incident-to billing is prohibited. Since 2021, split/shared services are also defined under the American Medical Association's *Current Procedure Terminology* (*CPT*) coding system. Accordingly, the place of service (POS) code is needed to understand a facility setting's eligibility for split/shared services.[9]

Essentially, split/shared services are an arrangement in which a physician and an NPP in the same group practice each perform portions of a patient visit in the same facility. As an evaluation and management (E/M) visit, split/shared billing can involve both new or established patients, initial or subsequent visits, and prolonged services.[10] Both the physician and the NPP must document their respective work in the clinical record to support the claim, which is identified with the modifier FS.[11]

Notably, the practitioner whose time constitutes the "substantive portion" of the visit will determine the billing provider eligible for reimbursement. The substantive portion is defined as more than half of the total time spent on the visit by either the physician or non-physician practitioner. This can include the time involved for core medical decision-making.[11]

"With split and shared visits, … the challenge is that often people are not looking at who the substantive provider was," notes Gordon. "In my experience, they tend to default to the higher billing provider as the substantive provider. But the actual regulations say that if there are two providers that helped deliver the care, whichever one spent more time or had the more substantive visit is the one who should be billing."

Gordon illustrates her point with an instructive example. "If you have a physician assistant who is seeing a patient for an established visit, they can do the entire review of systems and history of present illness and go through the majority of the visit," she says. "Then later in the visit, the physician sees the patient because [the physician assistant] needs [the physician's] opinion on something. Maybe the physician spends 10 or 15 minutes with the patient in an hour visit. In this case, the person who did the substantive portion of the visit will be the physician assistant, not the physician.

"This is where people can get confused," remarks Gordon. "They may automatically default to billing the physician because that's the higher reimbursement. But to do it compliantly, it has to be the person who did the substantive time for the visit. And not only that. The documentation for the visit has to clearly outline which provider did what and how much total time they spent. The documentation needs to state [that] this [physician] is the one who did the physical review. This [physician] is the one who did the medication list review. It has to be really clear."

Accordingly, Gordon believes documentation is a responsibility that deserves more attention from medical practices. "In my experience, as a legal record, most groups are not giving the sort of weight, intentionality, and respect to the documentation that it deserves," she remarks. "They're using it as just a means to an end, as just the receipt of how they get paid. Or the documentation is their reminder for the patient's next visit. But this document can get them into a lot of trouble. I'm usually banging that drum pretty loud, especially with split and shared visits where they will often default to the higher licensed provider."

Resources

Medical Group Management Association (MGMA)
https://www.mgma.com

Medicare Learning Network
https://www.cms.gov/training-education/medicare-learning-networkr-mln/resources-training

Adding Up Benefits

In today's administrative environment, NPPs certainly can offer medical practices many potential advantages. "Advanced practice providers can be incredibly valuable to the practice," concludes Gilberg. "They add value both as clinicians, the revenue they generate, and their ability to provide greater access for patients. There are so many different and important ways that a practice can leverage that additional clinical support."

As an experienced medical assistant, April Jones, CMA (AAMA), of South St. Paul, Minnesota, shares an appreciation for the benefits these practitioners can bring to a medical practice. "I think the advanced practice practitioners have tremendous value," she says. "I worked at an OB/GYN practice where advanced practice practitioners were quite prevalent and a major part of the practice. For instance, they were often the providers [who] could take the add-on patients—the ones that needed help right now."

With a background that includes experience as a surgery scheduler, clinic and operations manager, externship coordinator, and in other specialty areas, Jones says working with nurse practitioners and other NPPs has been quite positive: "In my experience, they tend to be highly personable and explain things well, and that helps me to do my job better. Some of the advanced practitioners bring so much more to patient care. I believe they can play an amazing role in a practice."

All the more reason, perhaps, for medical practices to ensure NPP services are billed accurately and appropriately. "In health care, billing responsibilities are definitely challenging," concludes Jones. "Basically, it's about always dotting your i's, and there's very little wiggle room. Knowing the parameters NPPs as providers need to work in is so important to documentation. With Medicare audits too, the amount of charts they may want to review can be a big challenge. It's all a big deal actually. If it isn't documented, it didn't happen."

To support the essential role of advanced practice NPPs in medical practices, it is fundamental to avoid falling into loose or improper habits or interpretations of billing rules and requirements. Despite the challenges, the good news is that compliance with regulatory and industry payer rules as they apply to these practitioners is an entirely manageable responsibility.

"If you are in a medical group where you're comfortable putting together new processes and protocols, having conversations and working collaboratively with staff to make sure that everything's in alignment, the rules are pretty clear, especially in CMS," concludes Gordon. "In most cases, what we hope for is that a practice has clear guidelines on care delivery, on how patients access and schedule care. We want to know they have all of the scheduling and document templates in place. If the practice is comfortable working with that level of consistency and standardization, then there's no reason they can't do it the right way and bill incident-to services. They just have to make sure that it's not a default billing just to capture the extra 15% of billing. They have to be willing and all in to really change their entire delivery model and curate a model to include the NPPs and expand access to care."

The use of NPPs represents a growing model of health care, both in primary care as well as in specialty areas such as dermatology, cardiology, and elsewhere. As the health care system continues to grow and evolve, it is incumbent upon medical practices and their billing teams to ensure they remain compliant with the regulatory and commercial requirements necessary to the system's continued integrity and smooth functioning. ✦

The CE test for this article can be found on page 26.

AAMA CEU CREDIT

References

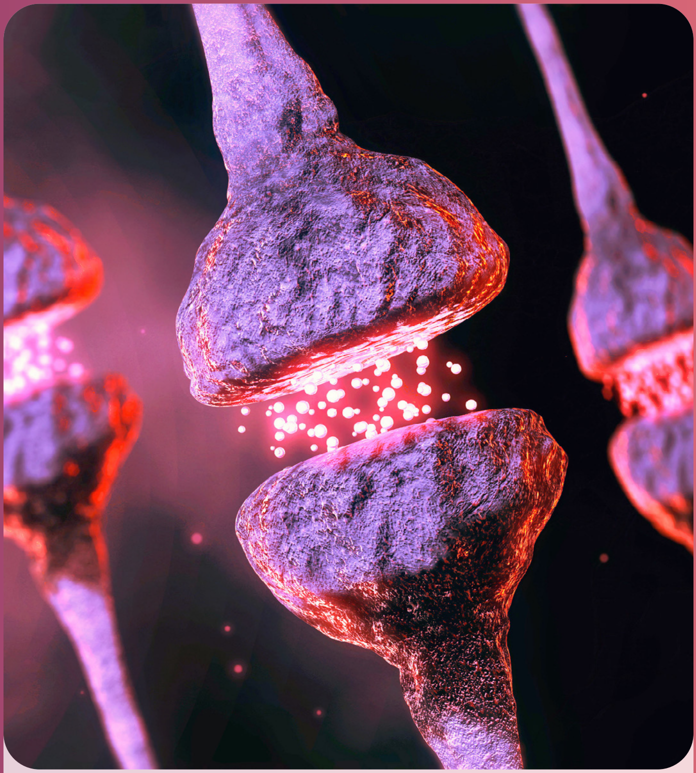
1. Harman M, Martin AB, Lassman D, Catlin A. National health care spending increased 7.2 percent in 2024 as utilization remained elevated. *Health Aff.* 2026;45(2). https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.01683
2. Association of American Medical Colleges. *The Complexities of Physician Supply and Demand: Projections From 2021 to 2036*. March 2024. Accessed June 15, 2026. https://www.aamc.org/media/75231/download
3. Shryock T. Nonphysician clinicians make up 40% of U.S. health care workforce, report finds. Medical Economics. May 7, 2025. Accessed June 15, 2026. https://www.medicaleconomics.com/view/non-physician-clinicians-make-up-40-of-u-s-health-care-workforce-report-finds
4. Advanced practice non-physician practitioners. Centers for Medicare & Medicaid Services. Updated May 13, 2026. Accessed June 15, 2026. https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-practice-non-physician-practitioners
5. Harrop C. APP utilization and how care team redesign continues into 2026. MGMA Stat. November 12, 2025. Accessed June 15, 2026. https://www.mgma.com/mgma-stat/app-utilization-and-care-team-redesign-in-2026
6. What is a nonphysician practitioner (NPP)? AAPC. Accessed June 15, 2026. https://www.aapc.com/resources/what-is-a-nonphysician-practitioner-npp
7. Ulmer GE, Harris AV. *Billing for Non-Physician Provider Services to Support the Delivery of Physician Care*. FPM. 2023. Accessed June 15, 2026. https://www.aafp.org/pubs/fpm/issues/2023/0100/billing-for-npp-services.pdf
8. Medicare Part B payments for incident to services. US Department of Health and Human Services. November 15, 2024. Updated November 15, 2024. Accessed June 15, 2026. https://oig.hhs.gov/reports/work-plan/browse-work-plan-projects/medicare-part-b-payments-for-incident-to-services/
9. Nicoletti B. Incident-to and shared services: demystifying billing for care provided by multiple professionals. FPM. 2024. Accessed June 15, 2026. https://www.aafp.org/pubs/fpm/issues/2024/0500/shared-services-billing.html
10. Medicare Learning Network. *Updates for Split or Shared Evaluation & Management Visits*. Accessed June 15, 2026. https://www.cms.gov/files/document/mm13592-updates-split-or-shared-evaluation-management-visits.pdf
11. Medicare Learning Network. *Evaluation and Management Services*. May 2026. Accessed June 15, 2026. https://www.cms.gov/files/document/mln006764-evaluation-management-services.pdf

 by Kelli Smith

Hit the Nail on the Head

If your nails are constantly breaking, peeling, or feeling thin, you're not alone. Nail health largely depends on daily habits, nutrition, and hydration. By following these tips from GoodRx and Women's Health, you can start seeing stronger, healthier nails in no time:

- **Pay attention to your diet.** Your nails, just like any other part of the body, rely on nutrients to function. For strong nails, eat foods rich in protein, biotin, vitamin A, vitamin D, iron, zinc, and omega-3s.
- **Keep your nails dry.** Nails absorb water when your hands get wet, which can weaken the structure of your nails over time. Make sure to fully dry your hands after washing, avoid long soaks, and wear gloves while doing dishes and other chores.
- **Moisturize your nails and cuticles.** Nails need to stay hydrated to be less likely to crack. Use hand cream or cuticle oil, especially after washing your hands.
- **Take breaks from gel or acrylics.** Too many manicures can thin your nails. Give your nails a reset period between treatments.
- **File gently in one direction.** Filing in both directions in a sawing motion can create fraying.
- **Take a biotin supplement.** Biotin is a popular supplement for nail growth. It helps the body make proteins, such as keratin, which help strengthen the nails.



Serotonin Boost

Serotonin plays a major role in mood, sleep, and emotional balance. While the chemical is made in the body, certain foods can support its production by providing key nutrients like vitamin B_6, magnesium, omega-3, and tryptophan. If you're looking for easy ways to support your mental health through your diet, these foods containing tryptophan—and recommended by Healthline and Vogue—are a great place to start:

- **Eggs** support serotonin production. Just don't leave out the yolks!
- **Salmon** is packed with omega-3s and vitamin D, which can support healthy bones, skin, eye function, and muscles.
- **Turkey** is considered a complete protein, which means it contains all nine essential amino acids.
- **Soy products** like tofu can be used in place of pretty much any protein.
- **Cheese and other dairy products** are great sources of tryptophan. Try cottage cheese and hard cheeses, such as Parmesan, Gouda, and cheddar.
- **Nuts** like cashews and **seeds** like sunflower seeds are also great sources of fiber, vitamins, and antioxidants.
- **Dark chocolate** has maximum benefits with a cocoa content of at least 70%.

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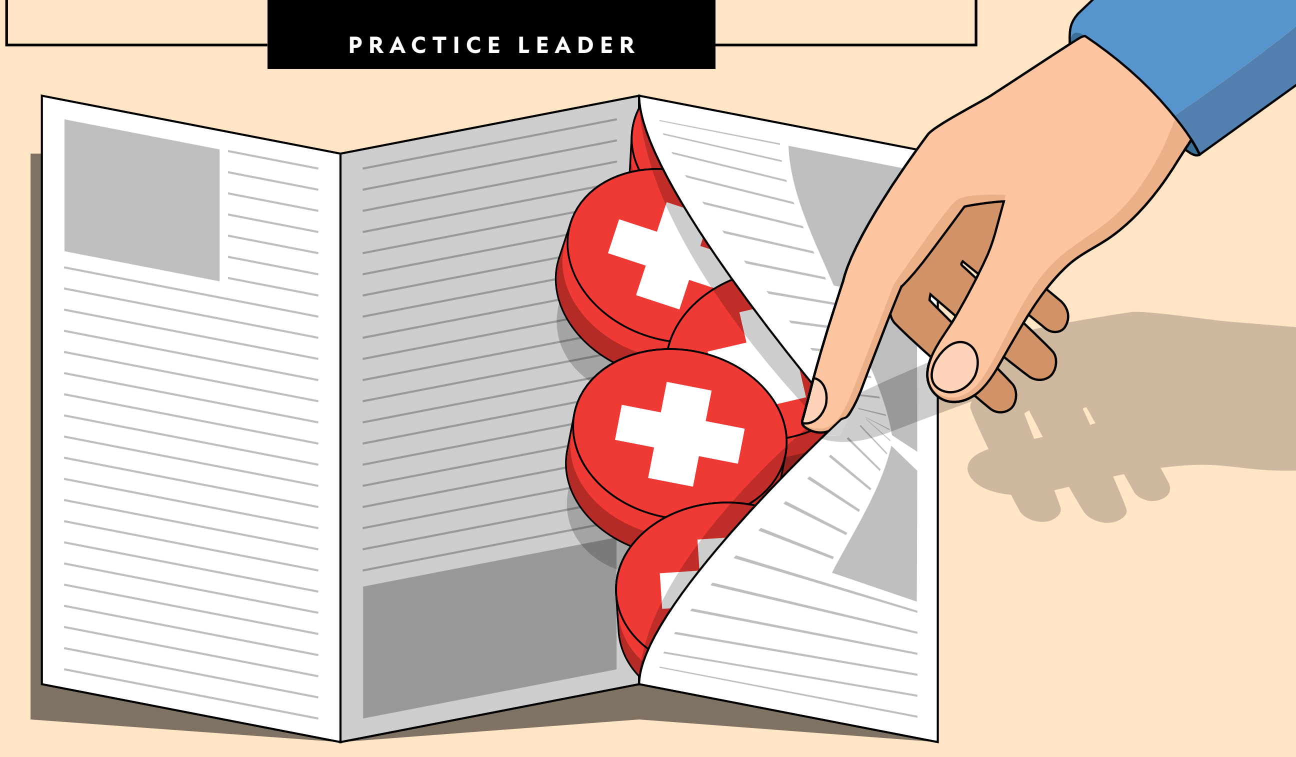


BEYOND the BROCHURE

Create Patient Education Materials that Connect with Patients

By Brian Justice

After a practice visit, the next step a patient takes is crucial: departing with the information they need to adhere to treatment, speed recovery, and stay healthy.

Understanding those materials depends on thoughtful delivery, especially with the many communication channels available today. That information must be both convenient and easily understood, regardless of the patient's literacy level, physical abilities, or language.

"The way practices share education allows information to be delivered throughout the entire care journey," says Kathleen Shortridge, MS, RN, program director of patient and family education for Chicago-based Endeavor Health. "This supports more connected engagement and helps patients understand what to expect before, during, and after care."

Info To-Go

All aspects of health care are becoming more complicated, and that includes patient education materials—so much so that governmental and regulatory agencies such as the Department of Health and Human Services, the Agency for Healthcare Research and Quality,[1] and the Centers for Disease Control and Prevention[2] provide guidance for creating uniform and easily understood communication materials, including directions for measuring readability, accuracy, and accessibility.

Mikee Wyszynski, CMA (AAMA), who works at Duly Health and Care in Romeoville, Illinois, sees this complexity firsthand. "Sometimes updates don't make it into the print material," he says. "Then it's in my hands."

Patient education materials must meet a diverse range of needs for a similarly diverse patient population. Often, using mixed media works best to address unique patient needs.[3] Various formats are being used in practices, including videos, interactive tutorials, and information distributed through electronic patient portals.[1]

"We send education content through our patient portal," says Robin Atkins, CMA (AAMA), who works at Augusta University Student Health Services in Augusta, Georgia. "We also have a Roku channel, College Health, playing in our waiting room with short educational videos geared toward college-age students. Short, focused education material works best for that age group."

"Online patient portals have improved the way we educate patients," confirms Angela Murphy, MEd, RN, CHES, manager of organizational health literacy and patient education with Henry Ford Health in Detroit. "They also provide a feedback loop that didn't exist when we had only printed material. Now, we can see when the material was opened and how far the patient scrolled through it."

These digital tools allow patients to access their laboratory results and instructions, as well as ask follow-up questions at any time and from home.

"We have a patient portal that I regularly send consent forms and educational materials through," says Anika Foster-Powell, CMA (AAMA), who works at Northwest Rheumatology Associates in Portland, Oregon. "Our own site has information on diagnoses and medications, along with direct links to other websites that patients can access directly."

Materials are also becoming increasingly customized through multiple formats, from large print and braille versions to captioned and sign language videos.[1] Major health care

ACCESSIBILITY MATTERS

Literacy, language, and readability remain barriers to understanding health information, and federal resources and plain-language standards are helping to close the gap.

As of 2024, 21% of American adults were illiterate.[6] "Many of our patients have high rates of illiteracy or limited literacy, especially about health," says Taylor Mora, BSHCA, CCMA-AS, who works at the Native American Health Center in Oakland, California. "The more we use pictures or pictograms and plain, everyday language, the more helpful it is."

The Plain Writing Act of 2010 requires that all federal agencies use language that the public can "understand the first time they read or hear it."[2] "All patient education materials should be written at a 4th- to 6th-grade reading level," advises Kathleen Shortridge, MS, RN. Fortunately, ever-expanding technology is helping creators adhere to that standard. Artificial intelligence is making it easy to check reading levels and ensure that people are receiving information that they can understand, she adds: "That includes cultural references, imagery, examples, and voice styles selected for different backgrounds and identities, which makes the patient feel respected and represented."

There is easily accessible federal help too. The Centers for Disease Control and Prevention offers materials in more than 25 languages, and the National Institute of Health offers materials in more than 50 languages. Both address a wide range of topics, ranging from common ailments to end-of-life care.[4]

organizations, such as the American Heart Association, American Stroke Association, and American Diabetes Association, also provide patient education materials with detailed information and advice.[4]

On the Same Page

These education materials must help patients participate in their own care, so they should be written as plainly as possible, present the most important information first, aim for sentences of 20 words or fewer, and be in the active voice.[5] For example, materials could say "Take your medication with food" instead of "Medication should be taken with food," or "Your physician will call you with the results" rather than "You will be contacted by your physician." Even these small shifts make information easier to read, remember, and act on.

Health care professionals may easily slip into using jargon. As much as possible, use terms that are simple and to the point—"high blood pressure" instead of "hypertension," "heart attack" rather than "myocardial infarction," and so on.[2] These simple substitutions make messaging more readable and to the point.

Spread the Word

As patient education materials become more varied, sophisticated, and accessible, medical assistants' role must expand too. Medical assistants can usually tell when a patient does not fully grasp their diagnosis, recommendations, or follow-up plans. Now medical assistants must be navigators, helping patients understand health information across platforms other than print.

"As a medical assistant, my job is to bridge the gap between the patient and the provider," says Amanda Kulesza, CMA (AAMA), of Pascack Valley Medical Group in Emerson, New Jersey. "Sometimes that means explaining a treatment in simpler terms than the provider offered. If a patient requires a different resource and we don't have something readily available, I'll generate an information sheet or suggest adding it to our company's materials."

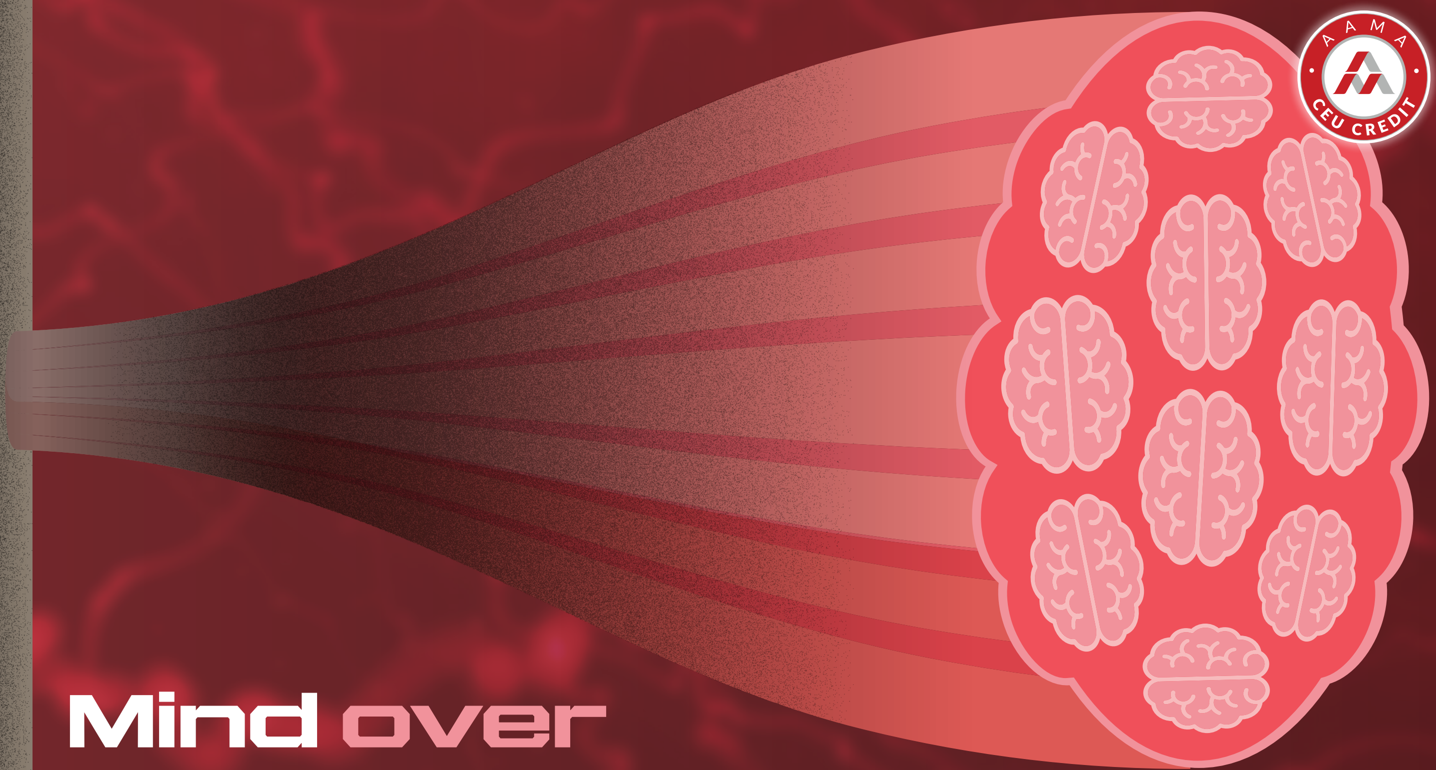
This process begins with assessing each patient's preferred learning style, what information they need, their concerns, and potential barriers to learning. The next steps are to plan with the patient, agree on realistic learning objectives, and select resources that fit the patient's needs.[3] Medical assistants are often the ones who make these real-time adjustments, translating clinical instructions into plain, actionable steps that match the patient's readiness, language, and confidence level.

People Make the Difference

Clear, accurate, and accessible patient education is essential to improving outcomes and building trust between patients and their care teams. As materials evolve and technology expands, so too must the human connection that brings them to life. While technology often allows for continuous communication and access to resources, medical assistants provide the empathy, context, and adaptability that software cannot. Medical assistants, clinicians, and educators must work together to ensure that every patient not only receives information but also understands how to use it to stay healthy. ✦

References

1. Health literacy universal precautions toolkit, 3rd edition. Agency for Healthcare Research and Quality. February 2024. Reviewed April 2024. Accessed December 15, 2025. https://www.ahrq.gov/health-literacy/improve/precautions/tool11.html
2. Plain language materials & resources. Centers for Disease Control and Prevention. July 21, 2025. Accessed December 15, 2025. https://www.cdc.gov/health-literacy/php/develop-materials/plain-language.html
3. Choosing effective patient education materials. National Library of Medicine. Reviewed October 13, 2023. Accessed December 15, 2025. https://medlineplus.gov/ency/patientinstructions/000455.htm
4. Petty A. The language of care: resources for treating patients with limited English proficiency. The DO. September 30, 2025. Accessed December 15, 2025. https://thedo.osteopathic.org/columns/the-language-of-care-resources-for-treating-multilingual-patients/
5. Guidelines for effective writing. Centers for Medicare & Medicaid Services. Updated September 10, 2024. Accessed December 15, 2025. https://www.cms.gov/training-education/learn/find-tools-to-help-you-help-others/guidelines-for-effective-writing
6. Literacy statistics 2024-2025. National Literacy Institute. Accessed December 15, 2025. https://www.thenationalliteracyinstitute.com/2024-2025-literacy-statistics



Mind over Muscle

Understand Cerebral Palsy's Definition, Diagnosis, and Treatment

By Pamela Schumacher, MS, Prosci, RYT

Cerebral palsy (CP) is a lifelong neurological condition that affects movement, muscle coordination, and posture. Caused by abnormal brain development or damage to the developing brain before, during, or shortly after birth, CP is the leading cause of childhood disabilities in the United States. It affects individuals in different ways and to varying degrees—someone with mild CP may not need any assistance or may have slight problems, while a person with severe CP might need special equipment and lifelong care.[1]

"Medical assistants interact with patients with cerebral palsy at nearly every point in [a health care] journey—from rooming appointments and taking vitals to scheduling, prior authorizations, and patient education," says Elaine Lin, MD, codirector of the Cerebral Palsy and Spasticity Center at Boston Children's Hospital in Boston, Massachusetts. "It's important to recognize that there are so many little things that can help a family feel supported, no matter how complicated or complex the situation may be. Families want to be heard, respected, and listened to, and even if you don't have all the solutions, it's OK."

CP Defined

"Cerebral palsy is not a disease. It is a condition that results from some type of injury to the developing brain that leads to difficulty with movement and coordination," says Laurie Glader, MD, section chief of complex care and medical director of the Cerebral Palsy Program at Nationwide Children's Hospital in Columbus, Ohio.

"CP has a wide range of ways in which it manifests," she says. "Some children can run and climb, with minimally visible challenges in balance and coordination. Others may be more affected and need a wheelchair pushed by someone else to get around. CP is different for everyone, and there are different types of CP. Also, CP is not just a childhood condition. It is lifelong and affects even more adults than children."

Physicians classify CP according to the main type of movement disorder involved. Depending on which areas of the brain are affected, one or more of these movement disorders can occur[1]:

- Stiff muscles (spasticity)
- Uncontrollable movements (dyskinesia)
- Poor balance and coordination (ataxia)

"It's important to understand that no two patients with CP are identical," says Dr. Lin. "Also, unlike other neuromuscular disorders, CP is not progressive—the brain lesion does not change. However, the functional consequences of CP—pain, contractures, and spasticity—can get worse with time. CP is defined as a motor impairment, and while intellectual disability is common, it is not a defining feature."

"A lot of people think of CP as something that went wrong during birth—something that the ob-gyn did wrong. We now understand that's very rarely the case," says Eric Chin, MD, assistant professor of neurology, neurological surgery, and pediatrics at Kennedy Krieger Institute in Baltimore, Maryland. "Most often, causes like premature birth, a stroke, or genetic differences aren't easily preventable. That means there's nothing that the parents, the ob-gyn, or the pediatric team did wrong."

Risk Factors, Signs, and Symptoms

Certain events and medical conditions during pregnancy may increase the risk of cerebral palsy. These factors can affect the developing brain before birth and may contribute to complications associated with CP. Common risk factors include the following[2]:

- Low birth weight or preterm birth
- Multiple gestations
- Infertility treatments
- Infections during pregnancy
- Fever during pregnancy
- Unmatched blood factor between the mother and fetus
- Maternal medical conditions (e.g., abnormal thyroid function, intellectual and developmental disability, too much protein in the urine, and seizures)
- Complicated labor and delivery
- Jaundice
- Seizures

Symptoms of CP can differ widely depending on the type and severity of the condition. One of the earliest signs may be delays in reaching developmental movement milestones, such as rolling over, crawling, or standing.[1]

"Medical assistants often notice developmental concerns during intake. Early signs to look for include the infant not meeting milestones like sitting or walking, favoring one side of the body, persistent muscle stiffness or floppiness, and difficulty feeding," says Shannon Richardson, CMA (AAMA), supervisor at Klickitat Valley Family Medicine in Goldendale, Washington. "Accurate documentation by the medical assistant of milestones, caregiver concerns, and observations can prompt further evaluation."

Diagnosis

To diagnose CP, a physician will order a series of tests to evaluate the child's motor skills. During visits, the physician will monitor development, growth, muscle tone, motor control, hearing and vision, posture, and coordination. An ultrasound or MRI may be used to show the location and type of damage.[3]

"There may be signs of developmental delay and abnormal tone, so Early Intervention, a federally mandated program that can provide physical, occupational, and speech therapy to infants from birth to age 3, is critical during this time," says Dr. Lin.

Once a diagnosis is made, the mobility and gross motor skills of people with CP are categorized into levels I–V, using the Gross Motor Function Classification System (GMFCS). The levels are based on functional limitations, the need for hand-held mobility devices (such as walkers, crutches, or canes) or wheeled mobility, and quality of movement.[4]

The GMFCS levels are[4]:

- Level I: A child can walk and climb stairs without using hands for support, as well as run and jump. They have decreased speed, balance, and coordination.
- Level II: A child can walk and climb stairs using a railing and can minimally run or jump. They will have difficulty with uneven surfaces, inclines, or while in crowds.
- Level III: A child can walk with assistive mobility devices on level surfaces and may be able to climb stairs using a railing. They may propel a manual wheelchair, but may require assistance for long distances or uneven surfaces.
- Level IV: A child's walking ability is severely limited, even with assistive devices. They use a wheelchair most of the time and may propel their own power wheelchair. They may participate in standing transfers.
- Level V: A child has physical impairments that restrict voluntary movement control and the ability to maintain head and neck position against gravity. They experience impairment in all areas of motor function and cannot sit or stand independently, even with adaptive equipment. They cannot independently walk, though may be able to use powered mobility devices.

"Generally, a child over the age of 5 won't improve their GMFCS level. For example, if a child is classified at a Level IV when they're 6, then it's likely that they'll need to use a mobility device throughout their lifetime," says Dr. Lin.

Treatment

Although CP cannot be cured, early inter-

Types of Cerebral Palsy

Cerebral palsy presents in several main types[1]:

- **Spastic CP** affects about 80% of people with CP. People with spastic CP have increased muscle tone, meaning their muscles are stiff and their movements can be awkward.
- **Dyskinetic CP** causes problems with controlling the movement of one's hands, arms, feet, and legs. Sometimes the face and tongue are affected. Movements are uncontrollable and can be slow and writhing or rapid and jerky. Muscle tone can change (varying from too tight to too loose) not only from day to day, but even during a single day.
- **Ataxic CP** causes problems with balance and coordination. People might be unsteady when they walk or have a hard time with quick movements or movements that need a lot of control, like writing.
- **Mixed CP** involves symptoms of more than one type of CP. The most common type of mixed CP is spastic-dyskinetic CP.

vention and ongoing treatment can help improve a child's movement, communication, and daily functioning. A multidisciplinary care plan will be created, typically including referrals to pediatric neurology, physiatry (rehabilitation medicine), physical and occupational therapy, speech-language therapy, and sometimes nutrition and orthopedics.[3]

"A typical lifetime journey for a patient with CP would include early intervention with physical, occupational, and speech therapy," says Dr. Lin. "With school-age children, we focus on maximizing functional independence, educational inclusion, managing tone—with medications or surgeries, and minimizing pain. In adolescence, puberty may make spasticity or seizures worse, and the recommendation is for transition to adult care discussion to start by age 14. As comorbid conditions arise or as the level of disability becomes more apparent, optimizing function and comfort should be considered at all stages."

CP is frequently accompanied by comorbidities that affect multiple bodily systems, with some of the most common being intellectual disability (48% of cases), epilepsy (42%), and speech/language disorders. Other common co-occurring conditions include visual impairments, feeding difficulties, and gastroesophageal reflux disease.[5]

"Comorbid conditions are all due to the primary brain lesion affecting motor pathways and subsequently other interconnected areas of the brain," says Dr. Lin. "Some patients with CP may have technology dependence—e.g., gastrostomy tube, tracheostomy, etc.—due to these comorbidities. To properly address the comorbid conditions, clinicians should have a systematic approach and provide anticipatory guidance to families."

Dr. Lin suggests looking for the following:

- **Seizures.** Any concerning movements or behaviors should be assessed for possible seizure activity and referred to neurology for evaluation and possible medication.
- **Nutrition and feeding issues.** There are CP-specific growth curves that should be reviewed in addition to Centers for Disease Control and Prevention and World Health Organization growth curves. Difficulty swallowing can cause aspiration, and patients should be referred for feeding and swallowing assistance.
- **Constipation**. Monitoring bowel movement frequency and consistency is important, as well as intervening with dietary changes and medication. Referral to gastroenterology may be required to help with motility or feeding intolerance issues.
- **Orthopedic complications.** Hip and spine screening is recommended at certain intervals based on functional classification (I–V); the American Academy of Cerebral Palsy and Developmental Medicine has good guidance on this.
- **Pain.** Pain can come from one or several sources and can be very hard to differentiate when the patient is nonverbal. Process of elimination can help determine the source of pain.
- **Drooling.** Drooling is seen in up to one-third of patients with CP and may be due to gastroesophageal reflux, dysphagia, or medication side effects. Drooling is a problem when hygiene becomes challenging or when difficulty swallowing occurs. There are medications and possibly surgical interventions (e.g., salivary Botox, salivary gland excision).
- **Mental health and behavior.** Depression and anxiety are not uncommon, and a referral to psychiatry or behavioral health team may be needed for management.
- **Vision and hearing.** Screening may need to be performed by a specialist and should be done routinely for patients throughout childhood. A referral to audiology and ophthalmology may be necessary for management.

Symptoms

The Institute of Neurological Disorders and Stroke lists common symptoms of CP[3]:

- Ataxia
- Delays in reaching movement milestones
- Difficulty with fine motor skills
- Dystonia
- Epilepsy
- Growth and development delays
- Hearing and vision issues
- Incontinence
- Intellectual or learning difficulties
- Osteoarthritis
- Problems with the spine
- Spasticity
- Speech and language challenges
- Stiff or floppy muscle tone
- Unusual gait
- Weakness in one or more arm or leg

"Remember, during any assessment, it could be painful to move a spastic limb. Just doing a blood pressure check could hurt," says Christina Marciniak, MD, professor of physical medicine and rehabilitation and neurology at the Northwestern University Feinberg School of Medicine in Chicago, Illinois. "Some patients with CP have terrible tone in their elbow flexors or another limb. In addition, people can have asymmetries, and one side works differently than the other. Ask the patient what works best for them."

Growing Up and Out of the System

Today, more adults than children are living with CP in the United States. Advances in medical care and early interventions have increased life expectancy, allowing many individuals with CP to live long and active lives into adulthood. And yet, many adult patients have difficulty maintaining consistent medical care.[6]

"The transition from pediatric to adult care is challenging—the biggest issue is that there are no equivalent adult CP centers where patients can get multidisciplinary care," says

Dr. Lin. "Care becomes fragmented across neurology, physiatry, orthopedics, and primary care. In pediatrics, there is often a strong medical home overseen by the primary care physician or a care coordinator who helps families navigate the health care system as well as their educational and home services. The transition away from school into vocational or day programs is very challenging, and the lack of school-based therapy is a huge loss for families. The transition in insurance coverage can also disrupt therapies, equipment, medical supplies, and home care services."

"Adults with CP face all the things we face as adults, including cardiovascular problems, obesity, and hypertension, … along with the impairments they may have had since childhood," says Dr. Marciniak. "However, they may have new issues sooner. For instance, in people with severely limited mobility in childhood, osteoporosis can be seen much earlier in adulthood because their bone development is impaired, the bones are less dense from inactivity, and some antiseizure medications worsen bone health. Patients with severe osteoporosis are more likely to have fractures, and this can occur with even typical activities, such as a transfer. Further, progression in common impairments such as contractures, spasticity, pain, and arthritis may lead to an earlier loss of function, such as ambulation abilities. Also, as they get older, you should assume patients with appropriate cognitive abilities with CP, even with severe motor impairments, may be sexually active. Women should be offered regular gynecologic care."

Throughout their care and treatment, don't forget to approach each patient as an individual, reminds Dr. Glader: "There can be a misconception that just because a person has difficulty controlling their body, they do not lead a fulfilling life. This is a myth! With therapies and support, most people with CP thrive. Many people with CP can live independently, drive cars, and have families and a career." ✦

Medical Assistant Checklist

Communication and Interaction

- Engage directly: Speak to the patient, not just their caregiver. Often, people with CP hear and understand more easily than they can communicate back.
- Use augmentative and alternative communication devices: Be familiar with or facilitate the use of tools, such as communication boards or speech-generating devices.
- Avoid assumptions: Do not assume all patients with CP have cognitive issues.
- Be patient: Allow extra time for responses.

Scheduling and Environment

- Flexible scheduling: Offer longer, earlier, or later appointments to accommodate transportation issues and reduce anxiety.
- Accessibility: Ensure walkways are clear and that there is step-free access to the building and examination rooms.
- Create a comfortable environment: Adjust lighting, reduce noise, and offer supportive seating to minimize sensory distress and muscle spasticity.

Clinical and Practical Support

- Positioning and safety: Assist with safe transfers and ensure proper positioning in the examination room to prevent skin breakdown or discomfort.
- Medication and therapy coordination: Assist with, or provide reminders for, scheduling specialized treatments, including Botox injections, orthopedic assessments, and physical therapy.
- Pain management: Actively inquire about pain levels.

Transitioning to Adult Care

- Support specialized care: Assist with transitioning from pediatric to adult care by coordinating with specialized clinics.
- Advocate: Speak up for accommodations, ensure patient concerns are heard, and promote inclusive care practices.
- Consider screenings: As they transition to adulthood, patients may need screenings such as DEXA scans, cholesterol tests, or gynecologic care.

The CE test for this article can be found on page 27.

AAMA CEU CREDIT

References

1. US Centers for Disease Control and Prevention. About cerebral palsy. February 27, 2026. Accessed June 15, 2026. https://www.cdc.gov/cerebral-palsy/about/index.html
2. US Department of Health and Human Services. What are the risk factors for cerebral palsy? Reviewed May 11, 2021. Accessed June 15, 2026. https://www.nichd.nih.gov/health/topics/cerebral-palsy/conditioninfo/risk-factors
3. National Institute of Neurological Disorders and Stroke. Cerebral palsy. Reviewed March 13, 2026. Accessed June 15, 2026. https://www.ninds.nih.gov/health-information/disorders/cerebral-palsy
4. Gross Motor Function Classification System (GMFCS). Cerebral Palsy Alliance Research Foundation. https://cparf.org/what-is-cerebral-palsy/severity-of-cerebral-palsy/gross-motor-function-classification-system-gmfcs/
5. Minocha P, Sitaraman S, Sachdeva P. Clinical spectrum, comorbidities, and risk factor profile of cerebral palsy children: a prospective study. *J Pediatr Neurosci*. 2017;12(1):15-18. doi:10.4103/1817-1745.205622
6. Peterson, MD. Reframing cerebral palsy as a lifelong physical disability. *N Engl J Med*. 2024;391:1668-1670. doi:10.1056/NEJMp2403366

NPP Billing Management

Deadline: Postmarked no later than **September 1, 2026**

Credit: 2.5 AAMA CEUs (gen/admin) **Code: 145717**

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Directions: Determine the correct answer to each of the following, based on information derived from the article.

T F

☐ ☐ 1. Non-physician practitioners (NPPs) (also known as advanced practice providers) are reimbursed by Medicare at 100% of the amount that physicians are reimbursed by Medicare.

☐ ☐ 2. The supervising physician must be physically present in the delivery setting when a patient is being treated by an NPP, according to the Medicare incident-to rule.

☐ ☐ 3. For NPPs treating Medicare patients, obtaining a National Provider Identifier number is not required for receiving Medicare reimbursement.

☐ ☐ 4. Split/shared services are an arrangement in which a physician and an NPP in the same group practice each perform portions of a patient visit in the same facility.

☐ ☐ 5. The supply of physicians in the United States has kept pace with the demand for physician services.

☐ ☐ 6. Commercial insurers invariably follow the coverage policies and reimbursement rates of Medicare.

☐ ☐ 7. For split/shared billing, the physician and NPP must document in the clinical record the specific services they provided to the patient.

☐ ☐ 8. Private payers and Medicare are authorized to conduct audits of providers.

☐ ☐ 9. If an NPP is beginning treatment for a new diagnosis, the NPP must bill under their National Provider Identifier number.

☐ ☐ 10. Adding an NPP to a medical practice usually does not necessitate changes in the care delivery mode.

☐ ☐ 11. NPPs play an important role in facilitating the provision of team-based care.

☐ ☐ 12. The Medicare rule that a physician be on the premises of the delivery setting can be waived if the physician is available by electronic means.

T F

☐ ☐ 13. Split/shared billing is available only in facility-based settings, such as nursing facilities and emergency rooms.

☐ ☐ 14. When NPP services are billed incident to the services of a physician, the services of the NPP are reimbursed at 85% of the amount established by the Medicare physician fee schedule.

☐ ☐ 15. Split/shared services can include only established patients, not new patients.

☐ ☐ 16. NPPs practice in both specialty delivery settings and primary care settings.

☐ ☐ 17. For split/shared billing, the billing provider is the physician or NPP who spends the most time with the patient.

Cerebral Palsy

Deadline: Postmarked no later than **September 1, 2026**

Credit: 1 AAMA CEU (gen/clin) **Code: 145718**

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Directions: Determine the correct answer to each of the following, based on information derived from the article.

T F

☐ ☐ 1. Cerebral palsy (CP) is caused by abnormal brain development before, during, or shortly after birth.

☐ ☐ 2. Comorbid conditions of CP are not caused by the primary brain lesion but by metastatic brain lesions.

☐ ☐ 3. Dyskinesia is a common movement disorder that can occur with CP.

☐ ☐ 4. CP is a progressive neuromuscular disorder.

☐ ☐ 5. CP is not necessarily a lifelong condition and can be eliminated in some patients.

☐ ☐ 6. A risk factor for CP is preterm birth.

☐ ☐ 7. Despite advances in medical care, life expectancy for people with CP has not changed for several decades.

☐ ☐ 8. Intellectual disability is a defining feature of CP.

☐ ☐ 9. CP symptoms such as seizures and spasticity may improve during and after the onset of puberty.

T F

☐ ☐ 10. A federally mandated program known as Early Intervention provides speech, physical, and occupational therapy to infants from birth to age 3.

☐ ☐ 11. More children than adults are living with CP in the United States.

☐ ☐ 12. CP is rarely a result of medical malpractice during birth.

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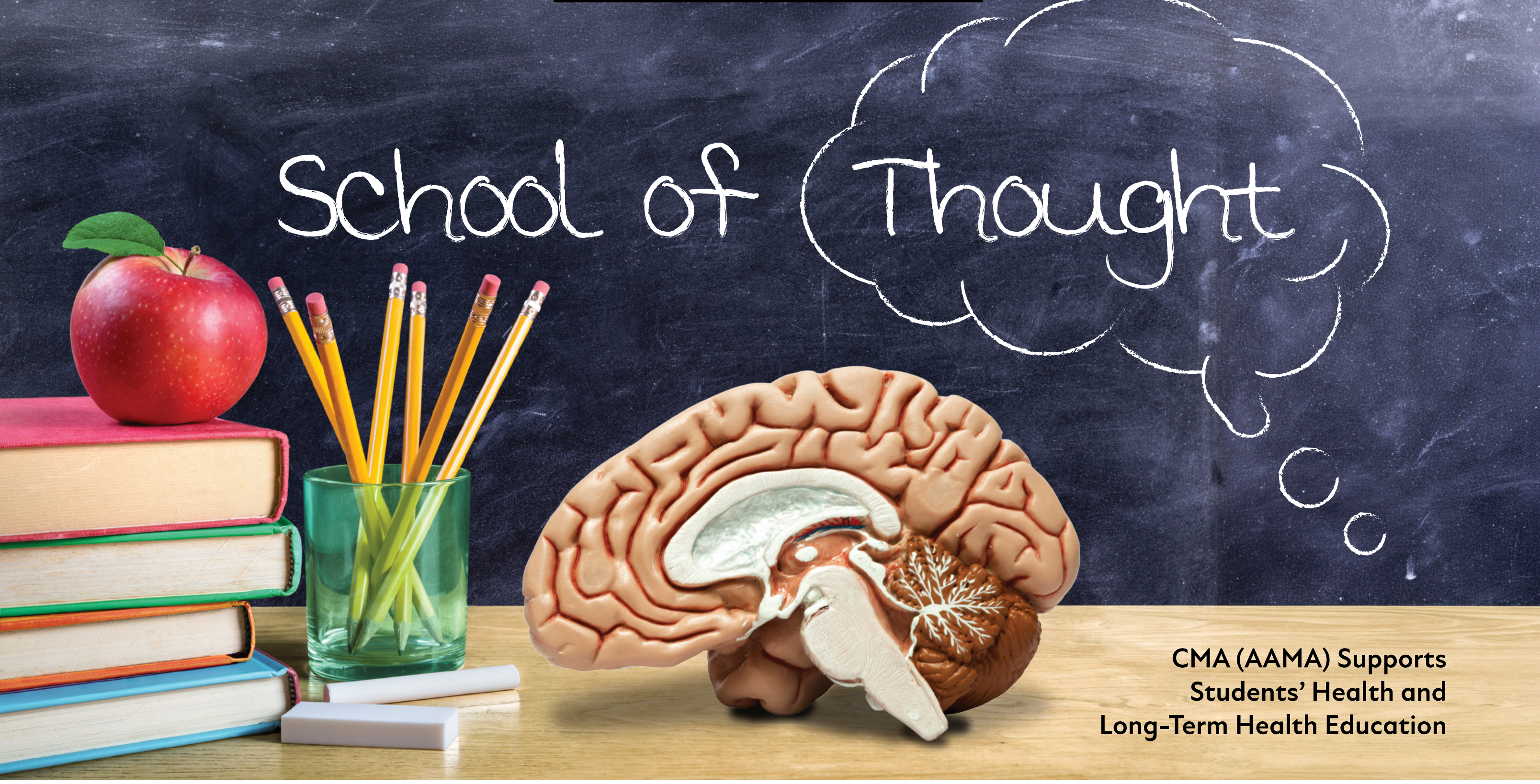

School of Thought

CMA (AAMA) Supports Students' Health and Long-Term Health Education

By Cathy Cassata

For 28 years, Heather Olson, CMA (AAMA), has provided care to elementary, middle, and high school students in the school setting. "The days are really busy and never boring. I love helping the kids and talking with them," she says.

She assists the school physician and registered nurses by handing out students' daily medications and tending to recess injuries. "The three schools are a few yards away from each other, so over the years, I've gone between them all," says Olson. "This year, I'm in the 4K [4-year-old kindergarten] through second grade building, so [my role involves] lots of helping little ones with scraped knees and boo-boos."

Because she is certified as an automated external defibrillator (AED) instructor for the school district, she is tasked with teaching coaches how to safely and effectively use AEDs during cardiac emergencies. "A lot of continuing education goes along with it. Every two years, I have to take more classes to stay up to date," says Olson.

She is also trained to use Narcan (naloxone hydrochloride) for opioid overdoses, as well as epinephrine for allergic reactions. Occasionally she attends monthly meetings that the nurses hold with parents about their children's physical health, mental health, and behavioral health conditions. "They come up with a plan to keep students safe at school," explains Olson. "Things are changing all the time, so it's interesting to be part of these meetings."

She enjoys the administrative side of tracking students' medical forms. "Every single year, any medication, whether it's an inhaler or EpiPen, has to be entered into our system," she says.

Olson embraces the task of ensuring that all students in the district have submitted their immunization paperwork. "I really like recordkeeping and keeping everything organized," she says. "At the beginning of the school year, I run reports and see whether we have any students who have not submitted information on immunizations. I also submit it all into the state registry."

Still, her favorite part of the job is face-to-face interaction with the kids. "Every spring, we go into the classrooms and teach the kids how to wash their hands properly. I really get to know them and connect with them during this because I'll engage them in activities like drawing and singing," she says.

She teaches them to sing "Happy Birthday" twice, so they know how long to wash their hands for. "It's funny—I've had a few parents call me and tell me they hear their child singing while washing their hands at home," says Olson.

She also gets students thinking about their dental health every February for Dental Awareness Month. "We do dental experiments. … This year, we did a virtual trip to the dental office, which the kids really liked," says Olson. "Connecting with them while teaching them about health makes my job really fun."

An added workplace bonus is getting to see the kids move through the schools. "I recently stopped by the high school and saw students who I worked with many years ago, and I loved learning that they still remember the handwashing class," she says. "Also, my daughter works at the high school and coaches volleyball there, so I'll go to games. There's nothing more heartwarming than when the kids are really happy to see me." ✦

HEART OF GOLD

State President and Educator Exudes Passion for Community Service

By Kelli Smith

Jessica Hunter, CMA (AAMA), 2025-2026 AAMA state society president of Idaho, has had a passion for community—and community service—for as long as she can remember. “Ever since I was young, we’ve always been involved in charity stuff, whether it be church, community groups, or anything like that. My family has always participated in giving back to the community,” says Hunter.

Hunter’s upbringing was challenging. Her mom was a single mother of five children, and they struggled to make ends meet financially. “We relied a lot on help from the community, and I cannot tell you how impactful that was to get things—Thanksgiving dinner, Christmas dinner, even Christmas presents, or anything like that from the community,” says Hunter. “And so, charity work kind of really started way back then.”

Hunter’s medical assisting career path has proven insightful on how medical assisting and community service can go hand in hand in an immediate, person-to-person way.

When Hunter worked in pediatric oncology, she’d often see families struggle financially and emotionally through their children’s cancer treatment.

“That cancer is expensive,” explains Hunter. “It is outrageously expensive for those treatments, and they’re doing anything and everything they can to try and keep their family intact … and keep their children as healthy as they can. And that oftentimes means that one or both parents cannot work due to the amount of care that they have to provide for these kids.

“That’s where it kind of linked with me. Like, wait a second, I see it: I’m a medical assistant. I deal with these people all the time, and they’re sharing their stories with us on a daily basis. And who better to hear it than medical assistants, because we’re doing those intakes, building those bridges, and really communicating strongly with our community. So, we really know what their needs [are],” says Hunter.

So, Hunter began providing free meals at her husband’s restaurant to families of those who were undergoing cancer treatment. She wanted these families to be able to forget their worries for an evening and enjoy a free meal together.

“When you have that much debt and that many bills and that many concerns, the least of your worries is a night out with the family doing something fun, and oftentimes, going out to eat or anything like that is just a luxury at that point. So, it was kind of a fun thing to be able to do for couples and for families and to let them get out of the house for a minute,” she explains.

“All of us can do something [for others],” adds Hunter, whatever situation we’re in or the recipient is in. “I can’t tell you how many times I go through McDonald’s … or I’m at the coffee shop and pay for the person behind me,” she explains. “I don’t know these people, but when it happens to me, it just lights me up, and I feel special for the day.”

GOOD INFLUENCES

Part of Hunter’s immense passion for the medical assisting field stems from her involvement in the AAMA. Her medical assisting educator was an advocate for the organization, which led Hunter to become an AAMA member in 2012. But that educator’s influence wouldn’t stop there.

After nearly a decade in oncology, Hunter began transitioning into education.

Her former medical assisting educator was retiring and showed Hunter the ropes. First, Hunter taught a phlebotomy course as an adjunct educator until a full-time position opened up. She went for it.

"I've been there just over six years at the College of Eastern Idaho," says Hunter, "and I absolutely love teaching. I love seeing the new students and getting them inspired, and education is kind of creative. It's fun, and I like that part of it."

Naturally, as part of her role, she hosts at least one charitable event per year with her students. This year, they collected toys for Toys for Tots, in which the medical assisting students gathered over 1,000 toys for children in the community.

In 2025, they held a successful coat drive to provide warmth to individuals and families in need during the harsh winter months. In total, they collected over 150 coats and delivered them to the Idaho Falls Area Humanitarian Center, which provides resources such as food, clothing, and shelter to people in the region who are experiencing homelessness and financial hardship.

"My car was completely full," recalls Hunter. "The students just were rock stars, and that kind of … plants that little seed. So, when they go out into their [practices], and they see whatever the need is, they jump in and take ownership over it."

COMMUNITY BUILDING

Hunter hopes the impact these charitable events have on her community and her students continues. To that end, Hunter urges her students to combine collective action and a medical assisting–dedicated community through joining the AAMA.

"They're all members of the AAMA before they leave [the program]," she says. "They all know about the community, and that's why it's so important for them to attend the state conference … not only for the CEUs, but more so for the community. Because you get to see what's out there; you get to see what other groups are doing."

This year, Hunter hopes to bring some of her students to the AAMA Annual Conference. "That's how we're going to get more people into the AAMA. We show them how amazing their community is, and then they just want to do more. And that's what happened to me. I went to that first [conference,] and then I was like, 'Oh my gosh. I never want to not go again,' " she recalls.

Hunter further drives home the value of the AAMA community by encouraging her students to apply for AAMA scholarships, such as the Maxine Williams Scholarship, during her classes. "I made every single one of them apply," she explains. Thanks to AAMA scholarships funded by the AAMA's medical assisting community, students can experience a concrete, firsthand example of this community's pay-it-forward nature.

LIFE LESSONS

Hunter emphasizes the key role that medical assistants play in the well-being of their communities: "We can't change our community or our situation if we're not aware of what's going on. And as medical assistants, we are placed in the key center of our communities by being in our [practices], … [so] you can see those deficits and where [patients are] at and advocate for them."

If Hunter's students can take away one thing from her medical assisting philosophy, it is this: "If you've made the choice to be a health care worker, you've made the choice to help your community," she concludes. ✦

STUDENTS: ENTER THE EXCEL AWARDS

Educators, are your students involved in community service? Encourage them to apply for a new AAMA Excel Award category: the Medical Assistant Student Group Excellence in Community Service Award!

This award recognizes the best student group in health-related community service programs (e.g., health awareness walks or events, blood drives, and food drives). Submit entries via the AAMA website.

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