AAPC Certified Evaluation and Management Coder (CEMC) Practice Exam (Sample)

Study Guide

BY EXAMZIFY

Everything you need from our exam experts!

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

• Practice answering questions under realistic conditions,
• Improve accuracy and speed,
• Review explanations to strengthen weak areas, and
• Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Don't worry about getting everything right, your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations, and take breaks to retain information better.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning.

7. Use Other Tools

Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly — adapt the tips above to fit your pace and learning style. You've got this!

SAMPLE

Questions

1. **Which word indicates a possible open fracture in medical records?**

   A. Comminuted

   B. Puncture

   C. Linear

   D. Transverse

2. **What modifier should be appended when an injection is given during an E/M service?**

   A. -25

   B. -32

   C. -77

   D. -99

3. **For most payers, what is required to receive credit for a complete ROS?**

   A. Documentation of every system separately

   B. At least one documented review of system element and a statement of negative reviews for others

   C. Only a verbal statement of symptoms

   D. A detailed report from multiple physicians

4. **What types of characteristics do the first three characters in a fracture diagnosis represent?**

   A. Severity of the fracture

   B. Type of treatment required

   C. General location of the fracture

   D. Risk of future fractures

5. **When can services provided by teaching physicians be billed to Medicare?**

   A. When all services are performed by residents only.

   B. When the physician's face-to-face presence is documented.

   C. When the teaching physician does not interact with the resident.

   D. When documentation fails to include the resident's services.

6. **How is risk generally measured in medical decision making?**

   A. Based on physician estimates of the patient's probability of illness

   B. According to the patient's previous diagnoses

   C. Based on the number of tests ordered

   D. By assessing patient demographics

7. **What is associated signs and symptoms within the HPI?**

   A. Symptoms that do not relate to the chief complaint

   B. Additional symptoms experienced by the patient

   C. Signs noted during the physician's examination

   D. Family history of similar issues

8. **Why is the splinting code not reported when casting a fracture?**

   A. Because splinting requires a separate charge

   B. Because it is bundled in the fracture care treatment

   C. Because it is performed outside of the E.R.

   D. Because a splint is less significant than a cast

9. **What must be documented for arthrocentesis procedures?**

   A. Insurance policy details

   B. The expected outcome of the treatment and specific diagnosis

   C. Patient's age and medical history only

   D. The name of the physician only

10. **What should be checked first for correct coding of a neoplasm?**

   A. Patient history

   B. Alphabetic Index for specific morphologic type

   C. Previous coding decisions

   D. Consultation notes

Answers

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

Explanations

1. Which word indicates a possible open fracture in medical records?

A. Comminuted

B. Puncture

C. Linear

D. Transverse

The word that indicates a possible open fracture in medical records is "comminuted." A comminuted fracture is characterized by bone being broken into multiple fragments, which can increase the likelihood of the fracture extending through the skin and becoming an open fracture. When assessing medical records, identifying the type of fracture using specific terminology is vital. Comminuted fractures often pose higher risks of complications, such as infection, if the bone ends create a pathway for bacteria. In contrast, the other terms—puncture, linear, and transverse—describe the nature of the fracture but do not inherently indicate that the fracture may be open. For example, a puncture may refer to a wound through the skin but doesn't directly relate to the bone's condition. Linear fractures indicate a simple break along the bone's length, while transverse fractures are horizontal breaks across the bone shaft, neither of which automatically suggests an open fracture scenario. Understanding these distinctions is essential when evaluating and coding for fractures in medical documentation.

2. What modifier should be appended when an injection is given during an E/M service?

A. -25

B. -32

C. -77

D. -99

When an injection is provided during an Evaluation and Management (E/M) service, the appropriate modifier to append is -25. This modifier indicates that a significant, separately identifiable E/M service was performed on the same day as the injection. In the context of coding, a significant E/M service means that the evaluation or management involved a medical decision-making process that is distinct from the procedure performed, such as an injection. By using modifier -25, the coder acknowledges that the E/M service being billed is separate from the injection and that it warranted its own reimbursement. Understanding that modifier -25 clarifies the situation for billing purposes is essential. It allows the healthcare provider to receive proper compensation for both the E/M service and the procedure performed, which in this case is the injection. Using the correct modifier ensures compliance with billing regulations and correct reimbursement by payers. Other modifiers listed may serve different purposes, but they are not appropriate for indicating an injection given during an E/M service. For example, modifier -32 indicates a mandated service, -77 denotes a repeat procedure by a different provider, and -99 is used for multiple modifiers. These do not apply to the situation of an injection provided concurrently with an E/M service.

3. For most payers, what is required to receive credit for a complete ROS?

   A. Documentation of every system separately

   B. At least one documented review of system element and a statement of negative reviews for others

   C. Only a verbal statement of symptoms

   D. A detailed report from multiple physicians

The requirement to receive credit for a complete Review of Systems (ROS) is accurately captured in the choice stating that at least one documented review of a system element along with a statement of negative reviews for others is necessary. This aligns with the guidelines set forth for evaluation and management coding, which defines a complete ROS as one that includes a review of multiple systems, where the provider should document positive findings for at least one system and acknowledge the absence of issues in other systems, often indicated by stating the negatives. This balanced approach ensures that coders and billers have sufficient documentation to support the medical decision-making and the level of service billed, adhering to payer expectations. Comprehensive documentation helps establish a clear picture of the patient's health status and informs clinical judgment while also meeting compliance requirements for billing purposes.

4. What types of characteristics do the first three characters in a fracture diagnosis represent?

   A. Severity of the fracture

   B. Type of treatment required

   C. General location of the fracture

   D. Risk of future fractures

In fracture diagnosis coding, the initial characters of the code provide essential information regarding the general location of the fracture. This is important because it helps to categorize the type of injury based on where in the body the fracture occurs. For instance, fractures can occur in various bones, such as the radius, femur, or humerus, and the beginning characters of the assigned code are designed to indicate the specific anatomical site.   Understanding the location is critical not only for proper diagnosis but also for appropriate treatment planning and impact on recovery. By identifying the location, healthcare providers can quickly assess the nature and complexity of the fracture which informs clinical decisions. The other options do not accurately represent the role of the first three characters in the diagnosis code. Severity, treatment types, or risks of future fractures are important aspects of fracture management but are categorized differently in the coding system and not encapsulated by the initial characters of a fracture diagnosis. This makes the understanding of general location pivotal when classifying and coding fractures correctly.

5. When can services provided by teaching physicians be billed to Medicare?

A. When all services are performed by residents only.

B. When the physician's face-to-face presence is documented.

C. When the teaching physician does not interact with the resident.

D. When documentation fails to include the resident's services.

The correct answer is based on the guidelines set forth for billing Medicare for services provided by teaching physicians. Teaching physicians must have their presence documented during the face-to-face patient encounter to bill for those services. This requirement ensures that the teaching physician is actively involved in the patient's care and provides oversight to the resident who is performing the service. In a teaching setting, the nature of the interaction between the teaching physician and the resident is crucial. The rules are in place to validate that while residents may deliver care, the teaching physician's presence and contribution to the decision-making process must be clearly documented, ensuring continuity and quality of patient care. Moreover, this requirement is rooted in Medicare's commitment to guaranteeing that patients receive appropriate supervision during their treatment and care, and it seeks to uphold the standards of medical education by clearly defining the roles of teaching physicians and residents.   Options that suggest scenarios in which services could be billed without appropriate involvement or documentation by the teaching physician do not align with Medicare's billing requirements, as they do not fulfill the necessary criteria for supervision and participation in patient care.

6. How is risk generally measured in medical decision making?

A. Based on physician estimates of the patient's probability of illness

B. According to the patient's previous diagnoses

C. Based on the number of tests ordered

D. By assessing patient demographics

Risk in medical decision making is primarily measured based on the physician's estimates of the patient's probability of illness. This approach takes into account various factors, such as the patient's clinical history, presenting problems, and the likelihood of progression or complications related to their condition. Physicians assess these probabilities to determine how aggressively to treat or monitor a patient, guiding their decision-making process regarding interventions, referrals, or follow-up care. This method is rooted in clinical judgment and relies on evidence-based medicine, integrating data from research, clinical guidelines, and individual patient circumstances to arrive at an estimate of risk. This understanding helps to create a more tailored approach to patient care, aligning treatment plans with the specific needs and risks faced by individual patients.

7. What is associated signs and symptoms within the HPI?

A. Symptoms that do not relate to the chief complaint

B. Additional symptoms experienced by the patient

C. Signs noted during the physician's examination

D. Family history of similar issues

The correct answer identifies additional symptoms experienced by the patient as part of the history of present illness (HPI). In the context of medical documentation, the HPI is a detailed account of the patient's chief complaint and includes various elements that provide a clearer picture of the patient's condition.   When documenting the HPI, it is essential to note not just the primary symptom that brought the patient in, but also any concomitant symptoms that may help to clarify the diagnosis or guide the treatment plan. These associated signs and symptoms can offer significant insights into the nature of the illness and how it affects the patient, providing valuable context for the medical provider.   For instance, if a patient presents with chest pain (the chief complaint), reporting associated symptoms like shortness of breath or nausea can indicate the potential severity of the situation or lead to a quicker and more accurate diagnosis. Thus, recognizing these additional symptoms is crucial in comprehensive patient care and effective coding.

8. Why is the splinting code not reported when casting a fracture?

A. Because splinting requires a separate charge

B. Because it is bundled in the fracture care treatment

C. Because it is performed outside of the E.R.

D. Because a splint is less significant than a cast

The correct choice emphasizes that splinting is typically included as part of the comprehensive fracture care treatment. When a fracture is managed with casting, the services provided, including the application of a splint, are often considered bundled into the overall treatment code for fracture care. This means that when a specific fracture treatment code is billed, it inherently covers the necessary preliminary steps, including splinting, and as such, providers do not bill for these services separately. Bundling is a common approach in coding to avoid duplicate charges for services that are part of a larger procedure or treatment plan. In this context, providing separate payment for splinting services when a cast is applied would not align with this bundling policy, reinforcing why the splinting code is not reported alongside the casting for fracture care.

9. What must be documented for arthrocentesis procedures?

A. Insurance policy details

B. The expected outcome of the treatment and specific diagnosis

C. Patient's age and medical history only

D. The name of the physician only

For arthrocentesis procedures, comprehensive documentation is essential to ensure proper coding, billing, and quality of care. The expected outcome of the treatment and specific diagnosis must be documented because this information establishes the medical necessity of the procedure. It provides context for the procedure performed and supports the rationale for why the arthrocentesis was necessary based on the patient's condition. Documenting the expected outcome helps inform both the patient and the physician about the goals of the procedure, guiding treatment decisions and patient expectations. Furthermore, specific diagnoses are crucial for accurately coding the procedure according to established guidelines, influencing reimbursement from insurance providers. Thorough documentation not only aids in clinical decision-making but also protects against potential disputes regarding the appropriateness of care delivered. It is particularly important in an environment where detailed records are required to justify services provided in case of audits or reviews.

10. What should be checked first for correct coding of a neoplasm?

A. Patient history

B. Alphabetic Index for specific morphologic type

C. Previous coding decisions

D. Consultation notes

To ensure accurate coding of a neoplasm, the first step should be to refer to the Alphabetic Index for the specific morphologic type. This is essential because the correct coding of neoplasms relies heavily on precise identification of their nature, such as benign, malignant, or in situ. The Alphabetic Index provides a systematic way to locate the correct code based on the type of neoplasm, ensuring that the appropriate code is assigned according to its characteristics and behavior. Checking the Alphabetic Index first allows coders to establish a foundational understanding of the specific neoplasm being documented, ensuring the subsequent coding process is both accurate and comprehensive. This step aids in confirming that all necessary details related to the neoplasm's morphology and location are properly captured, which is crucial for compliance and reimbursement purposes. Understanding the specific morphologic type also informs the healthcare provider and payer about the nature of the patient's condition, further validating the coding choice. The importance of this step underscores the necessity for coders to be familiar with the coding guidelines specific to neoplasms, as inaccuracies can lead to improper coding and potential auditing issues down the line.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

https://aapccemc.examzify.com

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