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. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

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

4. Track Your Progress

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

5. Simulate the Real Exam

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

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

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

Questions

1. **What is the classification status of malignant neoplasms determined by?**

   A. The patient's prior medical history

   B. Pathologist's designation

   C. Symptom severity

   D. Radiation treatment history

2. **Which of the following describes the time definition in the outpatient setting?**

   A. Total time spent from arrival to departure

   B. Unit/floor time of care

   C. Face-to-face time with the patient

   D. Office hours recorded in the patient's file

3. **How are the Official Guidelines for ICD-10-CM divided?**

   A. Into three sections

   B. Into five sections

   C. Into four sections

   D. Into two sections

4. **What should coders use to determine the correct ICD-10-CM code?**

   A. Only the Tabular List

   B. The Alphabetic Index and the Tabular List

   C. Only the Alphabetic Index

   D. The previous coding year's records

5. **Which documentation aspect must reflect a recent update on previous information for the ROS and PFSH?**

   A. Provider's signature

   B. Date and location of review

   C. Last patient encounter

   D. Patient's acknowledgment

6. What is a limitation regarding the occurrence of late effects?
   A. Time limit, such as 90-days, one year, etc
   B. Medical interventions prior to effects
   C. Genetic predisposition to conditions
   D. Patient age and health status

7. Which of the following should NOT be reported separately when attributable to a definitive diagnosis?
   A. Related findings
   B. Additional procedures
   C. Signs and symptoms
   D. Comorbidities

8. What must a provider do to ensure full credit for an exam documentation regarding drowsiness and fatigue?
   A. Document normal findings
   B. Provide a clear diagnosis
   C. Elaborate on abnormal findings
   D. Use standardized coding

9. Under which documentation type should attention difficulties and language dysfunction be categorized?
   A. Cardiovascular
   B. Psychiatric
   C. Neurologic
   D. Musculoskeletal

10. What guidelines was the Marshfield Clinic E/M worksheet designed from?
    A. 2021 DGs
    B. 1995 DGs
    C. 2000 DGs
    D. 2010 DGs

Answers

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

Explanations

1. **What is the classification status of malignant neoplasms determined by?**

   A. The patient's prior medical history

   B. Pathologist's designation

   C. Symptom severity

   D. Radiation treatment history

The classification status of malignant neoplasms is primarily determined by the pathologist's designation. When a tissue sample is examined under a microscope, the pathologist assesses various features, such as the type of cells present, the degree of differentiation, and the characteristics of the tumor. This examination helps in accurately determining whether a neoplasm is benign or malignant and provides vital information about the potential behavior of the cancer, including its stage and grade. The pathologist's findings are essential for guiding treatment decisions and predicting outcomes. Their expertise allows for a standardized classification based on pathology reports, which are critical in the management of cancer. This classification informs clinicians about the aggressiveness of the tumor and is the foundation for staging and treatment plans. Markers such as prior medical history, symptom severity, and radiation treatment history are significant in the overall management of a patient's cancer but do not directly determine the classification of the neoplasm itself. The classification relies specifically on the microscopic and histological evaluation conducted by a pathologist.

2. **Which of the following describes the time definition in the outpatient setting?**

   A. Total time spent from arrival to departure

   B. Unit/floor time of care

   C. Face-to-face time with the patient

   D. Office hours recorded in the patient's file

The time definition in the outpatient setting specifically refers to the face-to-face time with the patient. This concept is crucial for determining the appropriate level of service billed for a patient encounter. In outpatient evaluations and management coding, the focus is primarily on this direct interaction because it significantly influences the intensity and complexity of the service provided. Accurate documentation of face-to-face time helps ensure that the services rendered align with the level of care required and billed. This measurement is important for establishing the context of the visit, such as whether it was for a new patient or a follow-up, and it directly impacts the coding process. Understanding and applying this definition correctly ensures compliance with coding standards and guidelines. In contrast, the other options do not align with how time is defined for outpatient evaluation and management services. For instance, total time spent from arrival to departure includes waiting time and other non-direct patient care activities that are not considered when determining the specific level of service based on time. Similarly, unit/floor time and office hours recorded do not refer specifically to the critical face-to-face interaction that drives coding decisions. Thus, recognizing the importance of face-to-face time is essential for proper coding and billing practices in the outpatient setting.

3. How are the Official Guidelines for ICD-10-CM divided?

A. Into three sections

B. Into five sections

C. Into four sections

D. Into two sections

The Official Guidelines for ICD-10-CM are organized into four distinct sections, each serving a specific purpose in guiding coders on how to apply the coding system accurately. The first section provides general guidelines applicable to all coding practices. It outlines fundamental coding conventions, including definitions and the structure of codes. The second section focuses on the hierarchy and specific rules for selecting codes, including principles like combination codes and code specificity. The third section provides guidelines for coding and reporting specific conditions and situations, addressing nuances in various clinical scenarios. Finally, the fourth section contains guidelines pertinent to external causes of morbidity and injury, which includes specific instructions related to coding those circumstances. This structured division allows coders to navigate the guidelines effectively and ensures that they use consistent methods in coding diagnoses and procedures, leading to more accurate data collection and reporting in healthcare settings.

4. What should coders use to determine the correct ICD-10-CM code?

A. Only the Tabular List

B. The Alphabetic Index and the Tabular List

C. Only the Alphabetic Index

D. The previous coding year's records

To accurately determine the correct ICD-10-CM code, coders should use both the Alphabetic Index and the Tabular List. The Alphabetic Index provides a structured way to look up diagnoses or conditions by their common terms. This index allows coders to quickly find potential codes related to the diagnosis. Once a coder finds a potential code in the Alphabetic Index, they must then verify and finalize their selection using the Tabular List. The Tabular List organizes codes in a systematic way, including additional guidelines, code descriptions, and notes that provide crucial information about the application of each code. This comprehensive approach ensures that coders select the most precise and specific code appropriate for the documentation. Relying on only one of these resources—either just the Tabular List or just the Alphabetic Index—can lead to incomplete or incorrect coding, as each serves a distinct purpose in the coding process. Additionally, using records from a previous coding year may not reflect the most current guidelines or code assignments, limiting the accuracy and compliance of the coding work. Thus, the combined use of both the Alphabetic Index and the Tabular List is essential for accurate ICD-10-CM coding.

5. Which documentation aspect must reflect a recent update on previous information for the ROS and PFSH?

A. Provider's signature

B. Date and location of review

C. Last patient encounter

D. Patient's acknowledgment

The requirement for the documentation regarding the Review of Systems (ROS) and Past, Family, and Social History (PFSH) is that it must reflect a recent update on previous information, which is best captured by the date and location of review. This aspect of documentation is critical because it confirms that the information has been reviewed and updated during the current visit.   Including the date provides clarity on how current the information is, ensuring that both the provider and any other healthcare professionals involved in the patient's care are aware of what was considered during the encounter. The location of the review also adds context to the care setting, which can be relevant for understanding the patient's history and current health status. While the other options involve important aspects of documentation—such as the provider's signature, the specifics of the last patient encounter, and the patient's acknowledgment—none directly address the need for this recent update in the ROS and PFSH. Thus, the option that specifically highlights the importance of recency and relevance in the context of the patient's ongoing care is the date and location of the review.

6. What is a limitation regarding the occurrence of late effects?

A. Time limit, such as 90-days, one year, etc

B. Medical interventions prior to effects

C. Genetic predisposition to conditions

D. Patient age and health status

The correct answer highlights a specific limitation associated with the occurrence of late effects, which are long-term consequences of an injury or illness that surface long after the initial event. One of the key limitations is related to the time frame in which these effects can manifest. For instance, certain conditions or complications may only develop within a designated period following the initial injury or treatment. This temporal limitation is crucial in clinical settings, as it helps health care providers determine the appropriate coding and classification for services rendered, particularly in relation to insurance and reimbursement processes. The existence of a defined time limit, such as 90 days or one year, ensures that medical records accurately reflect the timeline of patient care and outcomes while informing further medical intervention and follow-up strategies. Recognizing and understanding these time frames helps coders and providers align their documentation with the current guidelines and regulations surrounding late effects. This adherence is essential for compliance and effective patient management, which underlines the importance of the correct classification of late effects based on timely occurrence.

7. Which of the following should NOT be reported separately when attributable to a definitive diagnosis?

   A. Related findings

   B. Additional procedures

   C. Signs and symptoms

   D. Comorbidities

In the context of coding and billing for medical services, signs and symptoms that are associated with a definitive diagnosis are not reported separately because they are typically considered part of the comprehensive picture represented by the primary diagnosis. When a definitive diagnosis is established, the underlying signs and symptoms leading to that diagnosis are inherently included within the scope of that diagnosis and do not warrant additional billing.   For example, if a patient presents with a cough and is ultimately diagnosed with pneumonia, the cough is not separately coded, as it is an integral part of the clinical picture for the pneumonia diagnosis. This approach ensures that coding remains clean and avoids redundancy, allowing for more accurate data collection and reimbursement processes.   On the other hand, related findings, additional procedures, and comorbidities can be reported separately because they can affect the treatment plan or resource utilization associated with the patient's care. Each of these elements may require distinct considerations in terms of coding and billing, ensuring they are reflected appropriately in medical documentation and reimbursement workflows.

8. What must a provider do to ensure full credit for an exam documentation regarding drowsiness and fatigue?

   A. Document normal findings

   B. Provide a clear diagnosis

   C. Elaborate on abnormal findings

   D. Use standardized coding

To ensure full credit for exam documentation regarding drowsiness and fatigue, a provider must elaborate on abnormal findings. This approach is crucial because it provides a comprehensive view of the patient's condition and supports the medical necessity of the services rendered.   When a patient presents with symptoms such as drowsiness and fatigue, merely recording these complaints is not sufficient. The provider should delve into the specifics of the findings to present a clearer picture of the patient's status. This includes detailing any abnormal test results, the duration and severity of the symptoms, potential contributing factors, and the impact on the patient's daily life. By doing so, the documentation will reflect the complexity of the case and the clinical reasoning behind the evaluation and management decisions.   Such thorough documentation is vital not only for adequate reimbursement but also for facilitating continuity of care and providing essential information for any future encounters with the patient. Thus, elaborating on abnormal findings directly supports the provider's coding and billing for the level of care delivered.

9. Under which documentation type should attention difficulties and language dysfunction be categorized?

A. Cardiovascular

B. Psychiatric

C. Neurologic

D. Musculoskeletal

Attention difficulties and language dysfunction are primarily related to the functioning of the brain and nervous system. Therefore, categorizing these issues under the neurologic documentation type is appropriate. Neurologic documentation encompasses a range of conditions that affect the central and peripheral nervous systems including cognitive functions, motor skills, and speech, which are all related to attention and language processing. In practice, neurologic evaluations may involve assessing neural pathways, brain function, and the patient's ability to communicate effectively. Attention deficits can be associated with neurological disorders such as attention deficit hyperactivity disorder (ADHD) or other cognitive impairments, while language dysfunction could relate to conditions like aphasia or dyslexia, which stem from neurologic issues. Hence, the neurologic category is the appropriate classification for these difficulties.

10. What guidelines was the Marshfield Clinic E/M worksheet designed from?

A. 2021 DGs

B. 1995 DGs

C. 2000 DGs

D. 2010 DGs

The Marshfield Clinic E/M worksheet was designed based on the 1995 Documentation Guidelines (DGs). These guidelines outline how healthcare providers should document evaluation and management (E/M) services to ensure that the level of service appropriately represents the complexity of patient encounters. The 1995 guidelines provide a detailed framework for determining the complexity of office visits and include stipulations on components such as history, examination, and medical decision-making. Understanding these guidelines is crucial for coders and providers to ensure compliance with coding standards and to maximize reimbursement accuracy. While there have been revisions and updates to the documentation guidelines following the 1995 version, specifically in 1997 and again in 2021, the Marshfield Clinic's use of the 1995 guidelines indicates a focus on the foundational documentation practices established during that period. This allows the clinic to apply standardized criteria that many providers are familiar with, ensuring clarity and consistency in their coding processes.

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!