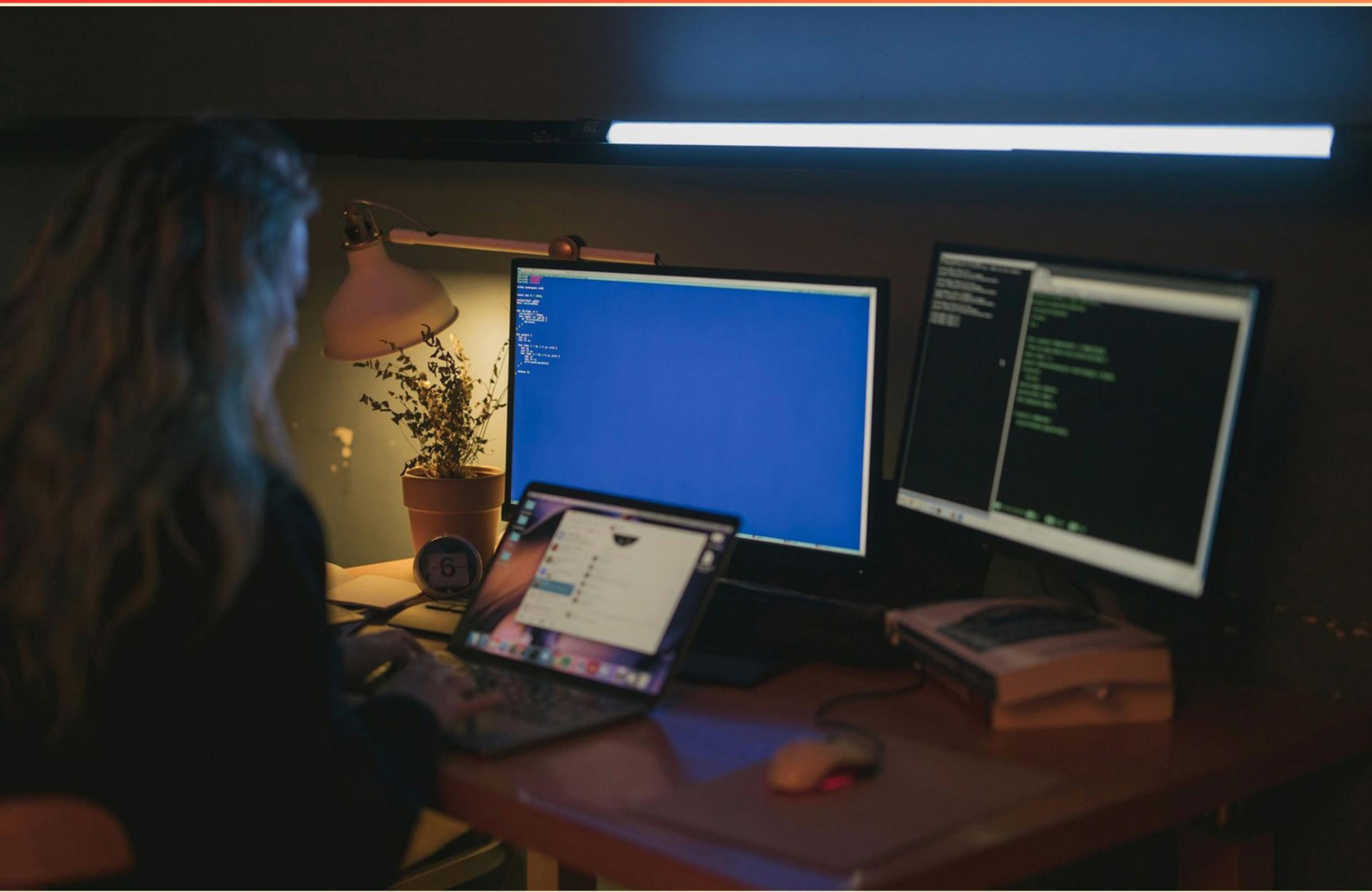


AAPC CERTIFIED EVALUATION AND MANAGEMENT CODER (CEMC) PRACTICE EXAM (SAMPLE) STUDY GUIDE



Prepare with structure. Pass with confidence



Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.

ALL RIGHTS RESERVED.

No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.

Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.

SAMPLE

Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	15

SAMPLE

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

SAMPLE

- 1. What is required for the level of history to be met?**
 - A. Three of the three elements must be met or exceeded
 - B. All systems must be reviewed
 - C. Only two elements need to be met
 - D. No requirements are necessary
- 2. What should be included with the code for burns/corrosions to indicate their source?**
 - A. A description of the burn severity
 - B. An external cause code
 - C. A code for the patient's health status
 - D. Details on the treatment process
- 3. For gestational hypertension, which category coding should be assigned?**
 - A. 013
 - B. 011
 - C. 010
 - D. 012
- 4. What is the value for an independent or second interpretation of an image tracing or specimen?**
 - A. One point
 - B. Two points
 - C. Three points
 - D. Four points
- 5. What does the term "subsequent encounter" refer to in the context of patient care?**
 - A. The first visit after diagnosis
 - B. Routine care after active treatment
 - C. Emergency treatment
 - D. Long-term follow-up care

- 6. What is the highest category level for hypertension under control by therapy?**
- A. I10
 - B. I11
 - C. I12
 - D. I13
- 7. Which characteristic is not required in the documentation of diabetes?**
- A. Type of diabetes
 - B. Body system affected
 - C. The patient's diet
 - D. Complications involved
- 8. For injuries, which character indicates the initial encounter?**
- A. A
 - B. D
 - C. S
 - D. C
- 9. When coding pre-existing conditions, what should the assigned diagnosis code identify?**
- A. The current reason for medical management
 - B. The patient's last visit diagnosis
 - C. The prognosis of the condition
 - D. The duration of the condition
- 10. What is the purpose of the rules for reporting additional diagnoses?**
- A. To simplify coding systems
 - B. To clarify illnesses unrelated to hospital care
 - C. To detail conditions affecting patient care
 - D. To mandate follow-up visits

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. What is required for the level of history to be met?

A. Three of the three elements must be met or exceeded

B. All systems must be reviewed

C. Only two elements need to be met

D. No requirements are necessary

To meet the level of history required for coding, it is essential that three out of the three elements be met or exceeded. In the context of Evaluation and Management (E/M) services, these history elements typically include the chief complaint, a detailed history of present illness (HPI), and a review of systems (ROS) related to the patient's related conditions. By adhering to this standard, coders can ensure that the documentation meets the necessary criteria for a higher level of service. The requirement for three elements establishes a level of comprehensiveness in patient evaluation, which reflects the complexity of the patient's condition and justifies the level of service billed. In contrast, the other options do not align with the established guidelines for documenting history in E/M coding. For example, simply meeting only two elements or stating that no requirements are necessary fails to demonstrate the thoroughness needed for accurate coding, which ultimately can impact reimbursement and compliance. Similarly, the implication that all systems must be reviewed overlooks that only the relevant systems related to the patient's condition are required for an appropriate history. Thus, the requirement to meet or exceed three out of three elements not only fulfills regulatory criteria but also enhances the quality of patient care through comprehensive assessment and documentation.

2. What should be included with the code for burns/corrosions to indicate their source?

A. A description of the burn severity

B. An external cause code

C. A code for the patient's health status

D. Details on the treatment process

To accurately code for burns or corrosions, it is essential to include an external cause code. This coding provides crucial information about the source or cause of the burn, which is necessary for proper classification within the coding guidelines. External cause codes help indicate whether the burn was due to thermal contact with flames, hot liquids, chemicals, or other materials, thereby providing context about the incident and facilitating data analysis for future prevention strategies. In clinical documentation, identifying the external cause of the burn allows for more detailed epidemiological studies and contributes to public health data. This comprehensive approach to coding enhances the clarity of the patient's medical record and assists in billing purposes, as payers often require such detail for reimbursement. While the other options might seem relevant in certain contexts, they do not directly refer to the requirement for indicating the source of the burn. For instance, while a description of the burn severity or treatment details can be important for medical records and health management, they do not specifically address the origin of the injury. Similarly, coding the patient's health status might provide additional context about overall health but is not required to indicate the cause of the burn.

3. For gestational hypertension, which category coding should be assigned?

A. 013

B. 011

C. 010

D. 012

The correct coding category for gestational hypertension is 013. This category corresponds specifically to hypertensive disorders of pregnancy, which is pertinent when dealing with hypertension that develops during pregnancy. 013 indicates gestational hypertension and hypertension that occurs during the second half of pregnancy and resolves after delivery. This is crucial for accurately documenting the condition as it reflects the specific circumstances surrounding the mother's health during gestation. In understanding the other coding categories, 011 refers to pre-existing hypertension complicating pregnancy, making it suitable for cases where the patient had high blood pressure before pregnancy. 010 denotes essential hypertension, which is hypertension that exists independently of pregnancy. 012 refers to mild pre-eclampsia, which represents a different complication and condition during pregnancy. Hence, these categories do not accurately represent gestational hypertension, underscoring why 013 is the appropriate choice.

4. What is the value for an independent or second interpretation of an image tracing or specimen?

A. One point

B. Two points

C. Three points

D. Four points

The value for an independent or second interpretation of an image tracing or specimen is set at two points, reflecting the standard established in evaluation and management coding guidelines. In contexts where diagnostic imaging and pathology are concerned, the additional interpretation signifies that a review has been conducted that meets specific criteria for complexity and oversight. This two-point value recognizes the necessity for additional expert review to ensure the accuracy and reliability of diagnostic conclusions. Such interpretations often come from different perspectives or specialties, enhancing the quality of care provided and potentially altering treatment decisions based on varied insights. In contrast, the one, three, and four-point values do not reflect the established practice standards for these types of interpretations, thereby affirming the rationale for assigning two points specifically.

5. What does the term "subsequent encounter" refer to in the context of patient care?

A. The first visit after diagnosis

B. Routine care after active treatment

C. Emergency treatment

D. Long-term follow-up care

The term "subsequent encounter" specifically refers to the patient's visits that occur after the initial treatment of a condition has begun. It typically involves routine assessments or continued management of a patient's care following an acute episode of a health issue. This aligns closely with the concept of providing ongoing care after the active treatment phase, ensuring that the patient is recovering as expected or addressing any complications that may arise. This choice accurately captures the essence of what happens during subsequent encounters – patients often return for evaluations or continued management that does not involve immediate or emergency intervention, but rather a structured approach to monitor outcomes and promote recovery. The focus on ongoing care after active treatment is a key feature of subsequent encounters in various medical contexts.

6. What is the highest category level for hypertension under control by therapy?

- A. I10**
- B. I11
- C. I12
- D. I13

The highest category level for hypertension under control by therapy is classified as I10. This code specifically indicates essential hypertension, which represents a primary condition without the presence of heart disease or any other complications. It encompasses patients whose hypertension is effectively managed through medication or lifestyle changes. In the ICD-10 coding system, the other codes provided refer to different categories or conditions associated with hypertension. For instance, I11 denotes hypertension with heart disease, indicating the presence of an associated heart condition, which elevates its severity. Similarly, I12 and I13 codes correspond to hypertension related to chronic kidney disease and hypertensive heart AND chronic kidney disease, respectively. These categories indicate a greater level of complexity and associated health risks compared to essential hypertension, which is why I10 remains the highest category for hypertension that is under control.

7. Which characteristic is not required in the documentation of diabetes?

- A. Type of diabetes
- B. Body system affected
- C. The patient's diet**
- D. Complications involved

The characteristic that is not required in the documentation of diabetes is related to the patient's diet. While it is important for healthcare providers to be aware of a patient's dietary habits as part of overall diabetes management and patient education, documentation specifically for coding purposes does not mandate the inclusion of dietary information. In contrast, documenting the type of diabetes is essential because it affects the coding and management of the condition. The body system affected is important as it relates to the comprehensive assessment of the patient's health and the potential complications that diabetes can present. Additionally, recording complications involved is crucial for proper coding, as diabetes can lead to various complications that impact treatment and management. Thus, while dietary information can be beneficial for management, it is not a necessary component of documentation from a coding standpoint.

8. For injuries, which character indicates the initial encounter?

- A. A**
- B. D
- C. S
- D. C

In the context of coding for injuries, the character that denotes the initial encounter is indeed the letter A. This is part of the coding guidelines used in the ICD-10-CM system. When a patient is seen for a condition or injury for the first time, it is essential for accurate medical coding to specify this encounter as 'initial'. The use of the character A indicates that the patient is receiving active treatment for the injury, which is crucial for proper coding and billing processes. Understanding this system is vital for coders, as it helps communicate the stage of the treatment process accurately. In contrast, other characters like D or S signify subsequent encounters or sequelae, respectively, which do not apply when a patient is being treated for the first time. This distinction is important in ensuring that the healthcare provider is reimbursed appropriately, as well as in maintaining accurate patient records.

9. When coding pre-existing conditions, what should the assigned diagnosis code identify?

- A. The current reason for medical management**
- B. The patient's last visit diagnosis
- C. The prognosis of the condition
- D. The duration of the condition

The correct response emphasizes that the assigned diagnosis code for pre-existing conditions should reflect the current reason for medical management. This means that when coding, the focus should always align with the condition that is currently being treated or managed during the patient's visit. For accurate coding, it's essential that the diagnosis code not only indicates the pre-existing condition but also correlates directly to the patient's current medical needs. This approach ensures that the medical encounter is appropriately documented and billed, allowing for proper reimbursement from payers for the services rendered. In a clinical context, coding for the current reason for medical management aids healthcare providers in formulating treatment plans and communicating with other providers about the patient's health status. This ensures that all parties involved in the patient's care are informed about the specific issues being addressed at this time. Choosing this code allows for a clearer picture of the patient's current health status and treatment requirements, which improves care coordination and supports the overall healthcare system's integrity.

10. What is the purpose of the rules for reporting additional diagnoses?

- A. To simplify coding systems
- B. To clarify illnesses unrelated to hospital care
- C. To detail conditions affecting patient care**
- D. To mandate follow-up visits

The purpose of the rules for reporting additional diagnoses is to detail conditions affecting patient care. This means that when a provider documents and codes additional diagnoses, it is essential to capture all health conditions that impact the patient's treatment or complicate the clinical scenario. By thoroughly documenting these additional conditions, healthcare providers can ensure that the severity and complexity of the patient's health are fully understood, which in turn helps in accurately reporting and billing for the services provided. It also aids in clinical decision-making, aligns with proper treatment protocols, and ensures that the patient's complete health status is represented in their medical records, facilitating better continuity of care. This focus on capturing relevant diagnoses ensures that the patient receives tailored and appropriate care, rather than simply meeting administrative coding requirements or facilitating follow-up visits without context.

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!

SAMPLE