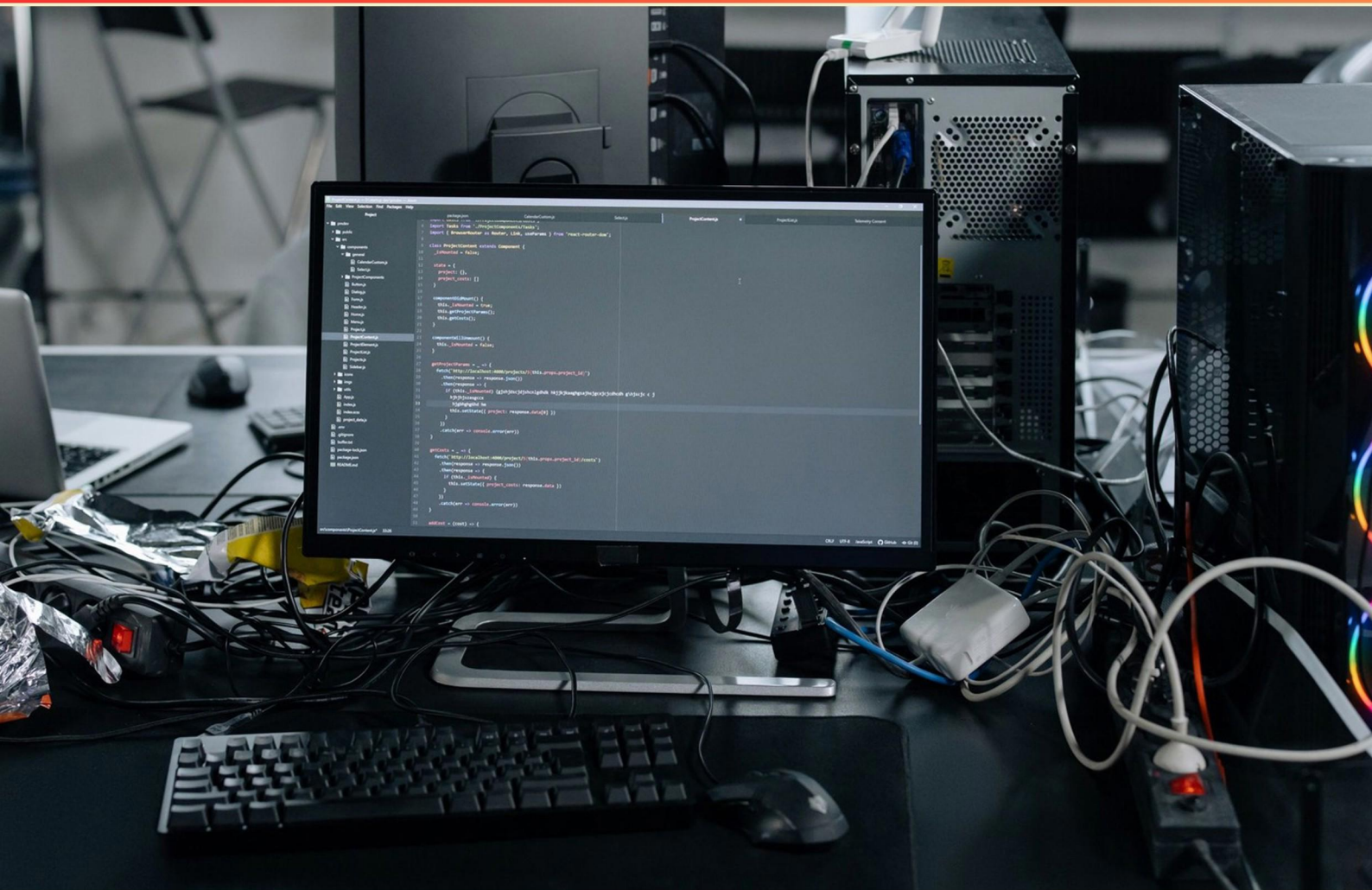


AAPC CERTIFIED EVALUATION AND MANAGEMENT CODER (CEMC) PRACTICE EXAM (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

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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

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- 1. 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
- 2. How many types of PFSH are there?**
 - A. One
 - B. Two
 - C. Three
 - D. Four
- 3. How are late effects (sequela) of burns or corrosions coded?**
 - A. With a separate code for each effect
 - B. With a burn/corrosion code with the 7th character as "s"
 - C. Using a general coding guideline for sequelae
 - D. With a code indicating the cause of the burn
- 4. What is essential to ensure in documentation for credit verification?**
 - A. The documentation must be solely in the provider's handwriting
 - B. It must support the medical necessity of the visit
 - C. Only the patient's name and date are required
 - D. It should be kept separately from patient records
- 5. What does the correct interpretation of E/M coding require?**
 - A. Flexibility
 - B. Consistency and citable references
 - C. In-depth medical knowledge
 - D. Training and experience
- 6. Toxic effect codes are classified under which category?**
 - A. T60 - T65
 - B. T70 - T75
 - C. T51 - T56
 - D. T31 - T37

- 7. When should Z79.4 or Z79.84 not be reported?**
- A. When insulin is given temporarily during the encounter
 - B. When the patient has Type-1 diabetes
 - C. When diabetes is a secondary manifestation
 - D. When the patient has hypertension
- 8. Under what conditions can an extended HPI be selected for scoring?**
- A. When the patient has had previous similar diagnoses
 - B. For patients with three or more chronic conditions
 - C. When the patient's insurance requires it
 - D. For first-time visits only
- 9. How do toxic effects differ from poisonings?**
- A. Toxic effects are only from medical sources
 - B. Toxic effects refer to substances chiefly non-medical in source
 - C. There are no differences
 - D. Both are coded the same way
- 10. What coding practice should be followed if the findings of a diagnostic test are significant?**
- A. Prioritize coding symptoms
 - B. Code only related signs
 - C. Code the significant findings
 - D. Do not code any findings

Answers

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

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Explanations

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1. 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.

2. How many types of PFSH are there?

- A. One
- B. Two**
- C. Three
- D. Four

The correct answer is two types of PFSH, which stands for Past Family Social History. PFSH is a critical component of the history portion of an evaluation and management (E/M) service. It specifically refers to a patient's previous medical history, any relevant family health history, and the social aspects that may affect the patient's health, such as lifestyle and environmental factors. When coding for E/M services, understanding the types of PFSH is essential. The two types include: 1. ****Past Medical History (PMH)****: This involves any significant illnesses, surgeries, medications, and allergies that the patient has experienced in the past. 2. ****Family History (FH) and Social History (SH)****: Family history focuses on illnesses and health conditions that may run in the patient's family, while social history includes information about the patient's lifestyle, occupation, substance use, and living arrangements. Recognizing these two distinct areas of PFSH helps in accurately documenting the patient's medical background and making informed clinical decisions. This also plays a significant role in determining the appropriate level of service provided and ensuring compliance with coding regulations.

3. How are late effects (sequela) of burns or corrosions coded?

- A. With a separate code for each effect
- B. With a burn/corrosion code with the 7th character as "s"**
- C. Using a general coding guideline for sequelae
- D. With a code indicating the cause of the burn

The proper coding of late effects (sequela) of burns or corrosions is achieved by using a burn or corrosion code that incorporates the 7th character "s." This character specifically signifies that the condition being addressed is a sequela of an initial injury, meaning the coding captures both the original cause of the burn or corrosion and the ongoing effects it has on the patient. This approach aligns with coding guidelines that ensure accurate tracking of the nature of medical conditions and their complications, providing a clear connection between the initial injury and its long-term consequences. By utilizing the appropriate burn or corrosion code alongside the 7th character "s," it allows for a streamlined process in documenting the nature of the injury and its residual effects, which is essential for proper medical record-keeping, treatment considerations, and reimbursement processes.

4. What is essential to ensure in documentation for credit verification?

- A. The documentation must be solely in the provider's handwriting
- B. It must support the medical necessity of the visit**
- C. Only the patient's name and date are required
- D. It should be kept separately from patient records

The correct answer highlights the importance of medical necessity in documentation for credit verification. When submitting claims for reimbursement, it is vital that the documentation clearly supports the medical necessity of the services provided during a visit. This means that the records should detail why the specific services were essential for the patient's health condition and how they align with established clinical guidelines and standards. Insurers rely on this information to determine whether the claim is valid and justifiable based on the patient's condition. Effective documentation of medical necessity not only impacts reimbursement but also helps in providing a clear rationale for the care provided, assisting in defending the claim in case of audits or reviews. When the documentation adequately supports the need for the services rendered, it significantly reduces the possibility of denials. In contrast, other options do not provide the necessary support for credit verification. For instance, requiring documentation only in the provider's handwriting does not address the adequacy or correctness of content. Merely having the patient's name and date does not provide a comprehensive context for the visit, as it lacks detail about the medical necessity. Additionally, keeping documentation separate from patient records could complicate retrieval and access, making it more challenging to verify claims effectively.

5. What does the correct interpretation of E/M coding require?

- A. Flexibility
- B. Consistency and citable references**
- C. In-depth medical knowledge
- D. Training and experience

The correct interpretation of E/M coding requires consistency and citable references because E/M codes are not only based on the medical services provided but also on a clear and methodical evaluation of the documentation present. This documentation, which includes details such as the patient's history, examination, decision-making, and the complexity of medical decision-making, must align accurately with specific guidelines set forth by the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA). Utilizing citable references ensures that coders are adhering to established guidelines and protocols, which provides the necessary framework to support the coding decisions made. This consistency is crucial when claims are submitted for reimbursement, as payers will look for well-documented support for the services billed. While flexibility, in-depth medical knowledge, and training and experience are important aspects of a coder's competency, they do not address the fundamental need for the interpretations to be grounded in standardized guidelines and documented references that can be cited during audits or reviews.

6. Toxic effect codes are classified under which category?

- A. T60 - T65
- B. T70 - T75
- C. T51 - T56**
- D. T31 - T37

The classification of toxic effect codes falls under the category T51 - T56. This range is specifically designated for codes that describe toxic effects related to various substances, including drugs, chemicals, and environmental factors. The coding system for toxic effects is critical in accurately capturing instances of poisoning or adverse reactions to substances, which are frequently encountered in medical settings. Each individual code within T51 - T56 further specifies the nature of the toxic effect, allowing for precise documentation and adequate care for affected patients. Understanding this classification is essential for correctly coding diagnoses and treatment involving toxic substances. This knowledge also aids healthcare providers in analyzing trends and outcomes associated with toxic exposures. Other categories mentioned do not pertain to toxic effects. For example, T60 - T65 involves codes related to the effects of alcohol and drugs, while T31 - T37 cover various injury-related conditions. Therefore, the T51 - T56 range is the definitive choice for toxic effect coding.

7. When should Z79.4 or Z79.84 not be reported?

- A. When insulin is given temporarily during the encounter**
- B. When the patient has Type-1 diabetes
- C. When diabetes is a secondary manifestation
- D. When the patient has hypertension

The rationale for not reporting Z79.4 (long-term use of insulin) or Z79.84 (long-term use of other antidiabetic medications) when insulin is given temporarily during the encounter is rooted in the definitions of these codes. Z79.4 and Z79.84 are specifically intended for long-term use situations—documenting ongoing treatment that is part of the patient's management plan for diabetes. If insulin is administered only temporarily, it does not reflect the patient's chronic management of their diabetes requiring long-term medication. Therefore, in such cases, the use of these codes would not accurately align with the patient's condition or treatment history. In contrast, circumstances surrounding the other answer choices do not align with the definition of temporary insulin use. For instance, in the presence of Type-1 diabetes, diabetes being a secondary manifestation, or hypertension, the long-term usage codes may still be applicable based on the patient's overall treatment plan and medical history. However, the key factor is whether insulin is used as part of a long-term management strategy, which would not apply in temporary scenarios.

8. Under what conditions can an extended HPI be selected for scoring?

- A. When the patient has had previous similar diagnoses
- B. For patients with three or more chronic conditions**
- C. When the patient's insurance requires it
- D. For first-time visits only

An extended History of Present Illness (HPI) can be selected for scoring when a patient has three or more chronic conditions. This is because, in the context of Evaluation and Management (E/M) coding, the complexity and detail required to document the patient's history increase significantly with multiple chronic issues. The guidelines provide that a more extensive HPI is appropriate in such cases, as it helps to capture the nuances of managing multiple health conditions and the time spent discussing them. When coding for E/M services, particularly in discussions about chronic conditions, the extent of the HPI directly impacts the level of service that can be documented and billed. This ensures that the healthcare provider can appropriately represent the complexity of the patient's medical situation during the encounter. In contrast, other choices would not meet the criteria for an extended HPI. Previous similar diagnoses do not automatically imply an extended HPI; insurance requirements do not dictate documentation standards; and first-time visits may not always necessitate an extended HPI unless several chronic conditions are present.

9. How do toxic effects differ from poisonings?

- A. Toxic effects are only from medical sources
- B. Toxic effects refer to substances chiefly non-medical in source**
- C. There are no differences
- D. Both are coded the same way

Toxic effects refer to harmful reactions that occur due to exposure to substances that are generally non-medical in origin. This can include chemicals, environmental pollutants, and other hazardous materials that can lead to adverse health effects. The differentiation is important because toxic effects typically arise from prolonged exposure or chronic intake of non-medical substances, while poisonings often relate to a singular or acute exposure to a toxic agent, regardless of its source. In the context of coding, understanding the source of toxicity can influence how the conditions are documented and billed. Poisonings are often associated with specific identifiable agents that may require urgent medical attention, while toxic effects might arise from less clear-cut scenarios involving prolonged exposure to harmful substances. Therefore, recognizing that toxic effects usually stem from non-medical sources provides clarity in medical coding and supports appropriate treatment protocols and public health initiatives.

10. What coding practice should be followed if the findings of a diagnostic test are significant?

- A. Prioritize coding symptoms
- B. Code only related signs
- C. Code the significant findings**
- D. Do not code any findings

In the context of coding practices for diagnostic tests, coding the significant findings is essential because it ensures that the patient's medical record accurately reflects their health status and the reason for their treatment. Significant findings from diagnostic tests are integral to understanding the patient's condition and informing the subsequent management and treatment options. This practice aligns with the coding guidelines that emphasize the importance of capturing relevant clinical information for proper documentation and billing. When coding significant findings, the focus is on the results that impact patient care, prognosis, and treatment plans. These findings guide clinicians in making informed decisions, and accurately coding them supports the continuity of care. Additionally, capturing significant findings helps in reporting outcomes, quality measures, and enhancing the overall understanding of patient care metrics. In contrast, prioritizing symptoms, coding only related signs, or not coding any findings would not provide a complete picture of the patient's condition and could lead to challenges in the clinical decision-making process and billing accuracy. Using appropriate codes for significant findings maximizes the integrity of health records and ensures compliance with coding regulations.

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!

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