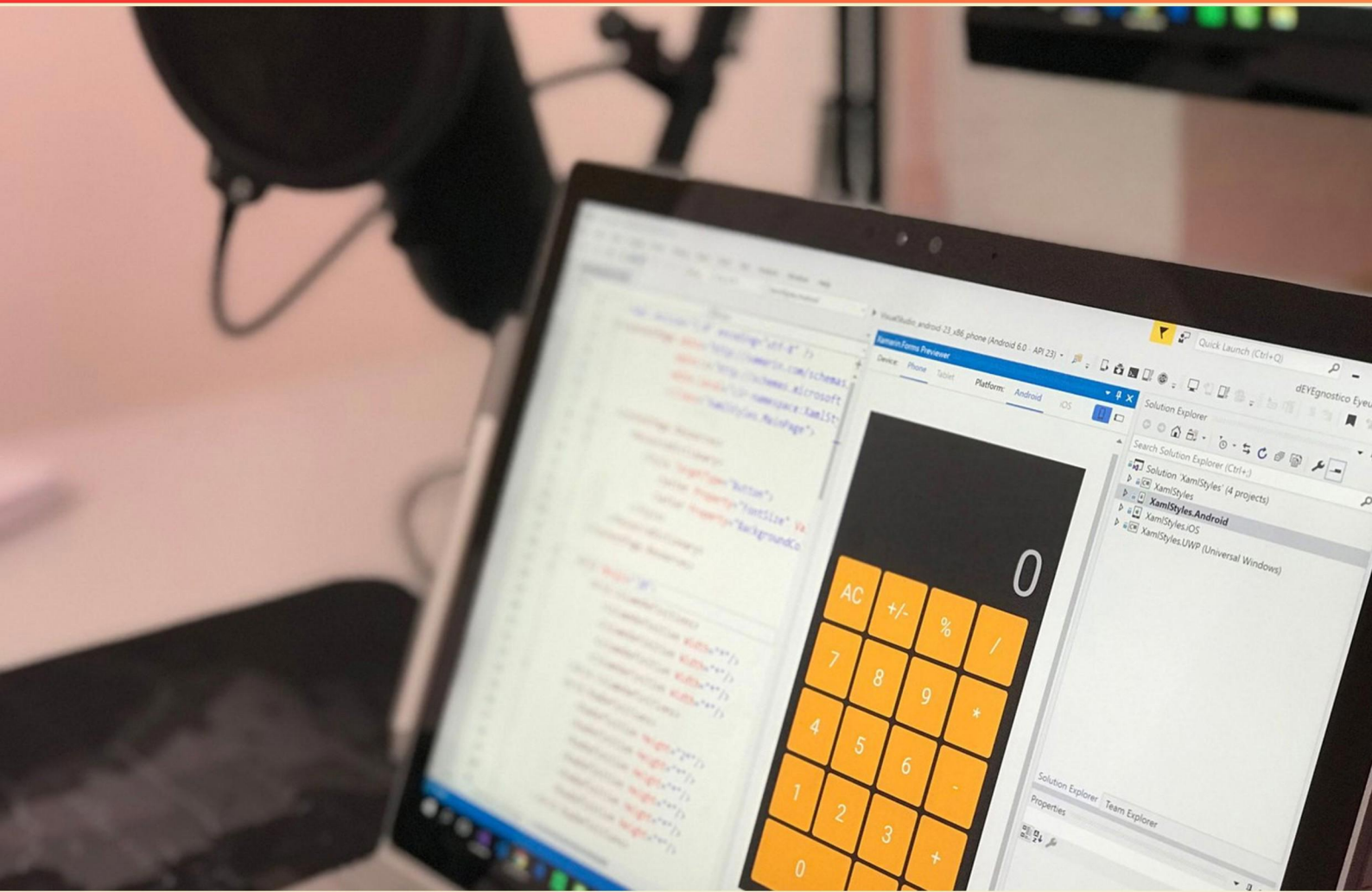


AAPC CERTIFIED EVALUATION AND MANAGEMENT CODER (CEMC) PRACTICE EXAM (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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. When an injection is the sole service provided, what is the correct billing procedure?**
 - A. Report only the drug code
 - B. Report the administration procedure code and the drug code
 - C. Report the E/M service code only
 - D. Report nothing as injections are free
- 2. The major consideration for coding prolonged services is based on what aspects?**
 - A. Location and time
 - B. Duration and urgency
 - C. Provider specialty and location
 - D. Patient age and diagnosis
- 3. If a patient is admitted after being seen in the ED, which codes does the ED physician choose?**
 - A. 99231 - 99233
 - B. 99281 - 99285
 - C. 99301 - 99305
 - D. 99221 - 99223
- 4. What must occur for an ECG interpreted by a computer to be considered properly interpreted?**
 - A. A physician must review and sign the results
 - B. The computer interpretation must be verified by another computer
 - C. A healthcare assistant must approve the results
 - D. The patient must agree to the interpretation
- 5. What condition would prevent incident-to billing for a service?**
 - A. The physician provides supervision remotely
 - B. The physician is providing treatment at a different facility
 - C. The service is unrelated to the physician's treatment plan
 - D. The service is performed after business hours

- 6. What should be reported when a patient receives multiple immunizations along with counseling?**
- A. Only the base code for the first vaccine
 - B. The base code plus add-on codes for each additional component
 - C. Only the add-on codes
 - D. None of the codes need to be reported
- 7. What does underdosing refer to in the coding context?**
- A. Taking more medication than prescribed
 - B. Taking less medication than prescribed
 - C. Taking medication with correct dosage
 - D. Taking expired medication
- 8. Which ICD-10-CM code category describes hypertension with chronic kidney disease?**
- A. K81.2
 - B. I12
 - C. M80.-
 - D. I10
- 9. When is it indicated to code for accidental intent?**
- A. When no intent is indicated
 - B. When the injury is self-inflicted
 - C. When the diagnosis is confirmed
 - D. When the patient refuses treatment
- 10. What should be reported if an inpatient admission occurs on the same date as observation care?**
- A. 99234 - 99236
 - B. 99291 - 99292
 - C. 99221 - 99223
 - D. 99217

Answers

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

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Explanations

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1. When an injection is the sole service provided, what is the correct billing procedure?

- A. Report only the drug code
- B. Report the administration procedure code and the drug code**
- C. Report the E/M service code only
- D. Report nothing as injections are free

When an injection is the sole service provided, the correct billing procedure involves reporting both the administration procedure code and the drug code. This approach ensures that both the service performed (the administration of the injection) and the specific drug or biological substance used are accurately documented and billed. Injections require a separate code to describe the administration process, which reflects the healthcare provider's work involved in giving the injection. Additionally, the drug code is necessary to detail the specific medication administered, which is important for both reimbursement purposes and patient safety. By reporting both codes, the billing accurately represents the services rendered during the patient encounter. This procedure aligns with the guidelines set forth by coding authorities, ensuring compliance with billing practices and promoting proper reimbursement. Therefore, option B captures the entire scope of the service provided during the injection administration.

2. The major consideration for coding prolonged services is based on what aspects?

- A. Location and time**
- B. Duration and urgency
- C. Provider specialty and location
- D. Patient age and diagnosis

The correct choice focuses on "Location and time," which are critical factors in coding prolonged services. In evaluating prolonged services, the coder must consider the amount of time spent on the service, typically beyond the usual time associated with the service performed, and the setting in which the service was delivered, such as an office or hospital. The time component is crucial as it serves as a basis for determining the additional codes for prolonged services, reflecting the extra effort and resources dedicated. Additionally, the location influences how the service is billed, given that different settings may have distinct code requirements and reimbursement considerations. Collectively, these elements help ensure that the coding accurately represents the service provided, guaranteeing appropriate reimbursement and compliance with healthcare regulations. While other options introduce relevant concepts, they do not encapsulate the primary determinants for coding prolonged services as effectively as the combination of "Location and time" does.

3. If a patient is admitted after being seen in the ED, which codes does the ED physician choose?

- A. 99231 - 99233
- B. 99281 - 99285**
- C. 99301 - 99305
- D. 99221 - 99223

The correct choice for coding when a patient is admitted after being seen in the Emergency Department (ED) is the range that corresponds to ED visit codes, which are specifically designed to classify the encounters in that setting. ED visit codes encompass the levels of complexity and service provided to patients who are treated in the emergency setting, reflecting initial assessments, treatments, and determinations of need for hospitalization or discharge. The range of codes from 99281 to 99285 accurately reflects the various levels of service that can be provided in the ED, including both straightforward cases and more complex cases requiring comprehensive evaluation or intervention. While other options suggest codes associated with different settings or levels of care, none apply to the context of an ED admission. The codes 99231 - 99233 are for subsequent hospital care, 99301 - 99305 are for initial hospital care with a different focus than ED visits, and 99221 - 99223 are for initial hospital inpatient consultations, which are also not relevant to the ED context. Thus, the best choice reflects the direct coding associated with the patient's visit to the ED prior to their admission.

4. What must occur for an ECG interpreted by a computer to be considered properly interpreted?

- A. A physician must review and sign the results**
- B. The computer interpretation must be verified by another computer
- C. A healthcare assistant must approve the results
- D. The patient must agree to the interpretation

For an ECG interpreted by a computer to be considered properly interpreted, it is essential that a physician reviews and signs the results. This process is crucial because while computer algorithms can provide quick interpretations of ECG data, they may not always account for nuances or specific clinical contexts that a trained physician would recognize. The physician's review serves as a verification step to ensure the accuracy and relevance of the interpretation before any clinical decisions are made based on those results. This requirement helps to uphold the standards of patient care and documentation in healthcare, ensuring that interpretations are reliable, especially when they may influence treatment options or further diagnostic testing. It is important to have a qualified healthcare professional oversee the interpretation of diagnostic tests, as their expertise provides a critical layer of validation that improves patient safety and care quality.

5. What condition would prevent incident-to billing for a service?

- A. The physician provides supervision remotely
- B. The physician is providing treatment at a different facility**
- C. The service is unrelated to the physician's treatment plan
- D. The service is performed after business hours

Incident-to billing allows healthcare providers to bill for services provided by non-physician practitioners, such as nurse practitioners or physician assistants, under the supervising physician's NPI number, ensuring that the services are considered part of the overall treatment plan. For incident-to billing to be applicable, the service must meet specific criteria, one of which is that the physician must be present in the same office or facility where the service is provided. If the physician is providing treatment at a different facility, they cannot directly oversee the service being rendered. This lack of immediate supervision would disqualify the service from being billed as incident-to, as it does not align with the necessary conditions set forth in the guidelines. Therefore, it is crucial for incident-to services to occur within the practitioner's established practice, while the supervising physician is available at that same location. This regulation ensures that the service is integrated into the overall treatment and oversight provided by the physician.

6. What should be reported when a patient receives multiple immunizations along with counseling?

- A. Only the base code for the first vaccine
- B. The base code plus add-on codes for each additional component**
- C. Only the add-on codes
- D. None of the codes need to be reported

When a patient receives multiple immunizations along with counseling, the correct coding approach involves reporting the base code for the first vaccine along with add-on codes for each additional component. The base code represents the primary service rendered—the first vaccine given to the patient. Each additional immunization administered during the same visit is captured through its respective add-on code. This method ensures that all services provided are adequately documented and reimbursed, demonstrating the provider's comprehensive care approach. Counseling related to immunizations is often bundled within these codes, but if multiple vaccines are administered, each should be reported separately as indicated. This way, the total complexity and effort involved in providing these multiple immunizations are accurately reflected in the medical coding.

7. What does underdosing refer to in the coding context?

- A. Taking more medication than prescribed
- B. Taking less medication than prescribed**
- C. Taking medication with correct dosage
- D. Taking expired medication

Underdosing refers to the situation where a patient takes less medication than what has been prescribed by a healthcare provider. In the coding context, this is significant because it can lead to inadequate treatment of a medical condition, potentially resulting in exacerbated symptoms or progression of the disease. Understanding underdosing is important for proper documentation and coding practices, as it impacts the patient's treatment plan and may present compliance issues. It can also have implications for healthcare claims and insurance reimbursements, highlighting the necessity of accurately capturing this scenario in patient records. In contrast, other options pertain to different aspects of medication management—overdosing involves taking too much, correct dosage refers to adherence to prescribed amounts, and expired medication involves using medications that are no longer effective due to passing their expiration date. Each of these has different implications for patient safety, treatment efficacy, and coding, but the focus in this question is specifically on taking less than prescribed, which is accurately represented by the correct answer.

8. Which ICD-10-CM code category describes hypertension with chronic kidney disease?

- A. K81.2
- B. I12**
- C. M80.-
- D. I10

The ICD-10-CM code category that describes hypertension with chronic kidney disease is I12. This category specifically addresses cases where hypertension is identified as a contributing factor to chronic kidney disease. The codes under I12 help in diagnosing scenarios where the kidney disease is caused or exacerbated by hypertension, reflecting the interrelated nature of these two conditions. In detail, the I12 category includes codes that capture both the essential hypertension and the stage of chronic kidney disease present, providing a comprehensive description of the patient's condition. This coding is crucial for accurate clinical documentation, proper billing, and effective treatment planning. The other options listed do not pertain to hypertension with chronic kidney disease. For instance, K81.2 corresponds to a gallbladder condition, M80 is related to osteoporosis with fractures, and I10 only represents essential hypertension without connecting it to any kidney disease. Therefore, the selection of I12 as the correct answer is essential for accurately representing hypertension's impact on chronic kidney disease within medical billing and record-keeping.

9. When is it indicated to code for accidental intent?

- A. When no intent is indicated**
- B. When the injury is self-inflicted
- C. When the diagnosis is confirmed
- D. When the patient refuses treatment

Coding for accidental intent is appropriate when there is no indication of intent to cause harm. This aligns with the importance of accurately reflecting the circumstances surrounding an injury or condition. If an injury occurs without any intent, then the coding must accurately classify it as an accident rather than an intentional act. In the context of medical coding, circumstances such as self-inflicted injuries imply an intention to cause harm, which would not support coding for accidental intent. Likewise, the confirmation of a diagnosis does not inherently pertain to the intent of the injury. Similarly, a patient refusing treatment does not relate directly to the nature of the injury or condition itself. Thus, the most fitting choice is when there is no indication of intent, as this reflects accurately the nature of the event in question.

10. What should be reported if an inpatient admission occurs on the same date as observation care?

- A. 99234 - 99236
- B. 99291 - 99292
- C. 99221 - 99223**
- D. 99217

When an inpatient admission occurs on the same date as observation care, the appropriate codes to report are the initial inpatient care codes, which include 99221 to 99223. These codes are specifically designed to capture the complexity and intensity of the medical decision-making involved during the initial evaluation of a new patient admitted to the hospital. In this scenario, when a patient is first admitted, the physician evaluates the patient and establishes the plan of care. These initial codes signify that the physician has performed a comprehensive assessment of the patient, which is essential for determining the patient's diagnosis and treatment plan. In contrast, the other codes listed are intended for different circumstances. The codes in the range of 99234 to 99236 pertain to observation care, which covers patients who are under observation but have not yet been admitted. The codes 99291 and 99292 are reserved for critical care services and would not apply to a regular admission process. Meanwhile, code 99217 refers specifically to the discharge of a patient from observation care and is not suitable for reporting an admission. Therefore, using 99221 to 99223 accurately captures the event of admission on the same day as observation care, highlighting the need for more complex and initial inpatient evaluation.

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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