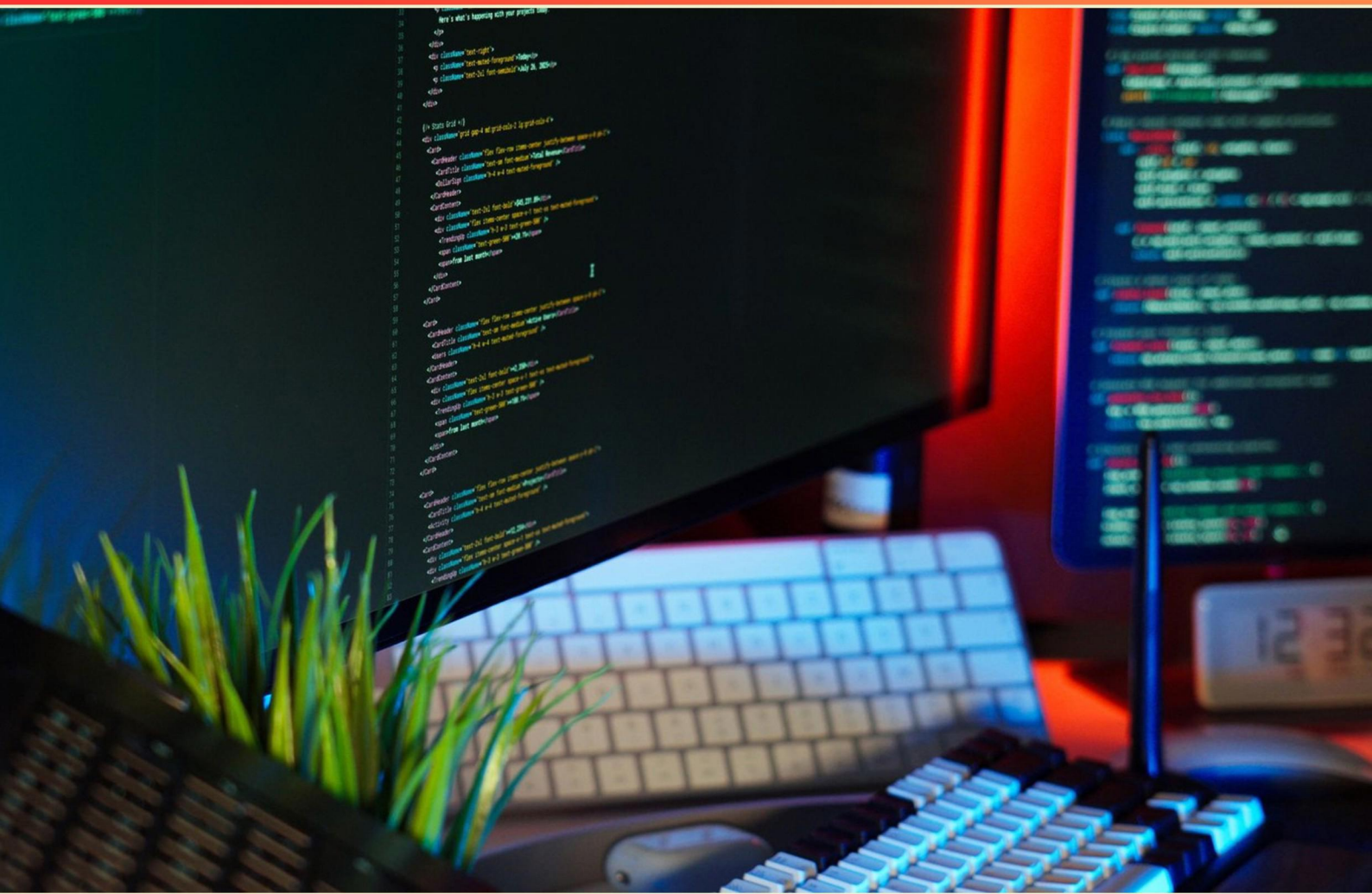


AAPC CERTIFIED EVALUATION AND MANAGEMENT CODER (CEMC) PRACTICE EXAM (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

<https://aapccemc.examzify.com>



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	16

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. Preventive medicine services cannot be billed in addition to what?**
 - A. Acute care visits
 - B. Preventive medicine visits
 - C. Chronic care management
 - D. Emergency services

- 2. What is the outcome if a provider does not document a detailed history and examination appropriately?**
 - A. The case may be rejected entirely
 - B. They must charge a lower rate
 - C. They may only bill for a subsequent care code
 - D. They can still charge for initial care without penalties

- 3. When reporting critical care time, what activities are excluded?**
 - A. Time spent performing E/M services
 - B. Time spent using telemedicine
 - C. Time spent providing directly related care
 - D. Time spent on the unit with the patient

- 4. What type of diabetes requires specific coding guidelines when reporting?**
 - A. Type-1 diabetes only
 - B. Secondary diabetes
 - C. Gestational diabetes
 - D. Type-2 diabetes only

- 5. Which emergency department codes can any provider use according to CMS?**
 - A. 99280 - 99284
 - B. 99281 - 99285
 - C. 99301 - 99305
 - D. 99291 - 99295

- 6. What type of diagnosis is reported when a definitive diagnosis is documented in a physician's interpretation?**
- A. Uncertain diagnosis
 - B. Speculative diagnosis
 - C. Confirmed diagnosis
 - D. Provisional diagnosis
- 7. What service includes a review of functional ability and safety during the IPPE?**
- A. Height and weight measurement
 - B. Review of past surgeries
 - C. Review of hearing and fall risk
 - D. Assessment of chronic illnesses
- 8. If a patient has multiple fractures, how should they be coded?**
- A. All fractures should be grouped together under one code
 - B. The fractures should be coded separately by site
 - C. Only the most severe fracture should be coded
 - D. The fractures can be coded by date of occurrence
- 9. When is "time" a determining factor for the level of E/M service?**
- A. When the patient has a chronic illness
 - B. When the patient presents with multiple issues
 - C. When a patient is given a new diagnosis
 - D. When the visit is for a routine check-up
- 10. What characterizes a brief HPI?**
- A. Documentation of four or more HPI elements
 - B. Documentation of one to three HPI elements
 - C. A focus on chronic conditions only
 - D. Patient's unfocused general health statements

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. Preventive medicine services cannot be billed in addition to what?

- A. Acute care visits
- B. Preventive medicine visits**
- C. Chronic care management
- D. Emergency services

Preventive medicine services cannot be billed in addition to preventive medicine visits because this would constitute billing for the same service twice. When a provider performs a preventive service, such as a wellness check or annual physical, they are already addressing preventive needs. Thus, billing a separate preventive service in conjunction with another preventive medicine visit is not permitted according to coding guidelines. This ensures that the codes reflect distinct and separately identifiable services. In contrast, acute care visits, chronic care management, and emergency services represent different categories of care that may coexist with preventive visits. Therefore, those types of services could be billed independently from preventive medicine visits, given the appropriate documentation and medical necessity.

2. What is the outcome if a provider does not document a detailed history and examination appropriately?

- A. The case may be rejected entirely
- B. They must charge a lower rate
- C. They may only bill for a subsequent care code**
- D. They can still charge for initial care without penalties

When a provider fails to document a detailed history and examination appropriately, they may only bill for a subsequent care code. This is primarily because the documentation is critical in justifying the level of service provided. Proper documentation not only supports the complexity and necessity of the care given but also aligns with the guidelines established by payers for coding levels. In the context of Evaluation and Management (E/M) coding, an initial visit typically requires comprehensive documentation that demonstrates the provider's assessment and the medical necessity for the services rendered. If the documentation is insufficient and does not meet the criteria for an initial visit (such as a full history and thorough examination), the coder must revert to a lower code for a subsequent visit, which reflects the level of care that is supported by the available documentation. This ensures that the claims are compliant with regulatory requirements. Billing for a higher code without the appropriate documentation may result in claims being denied or in financial penalties for the provider. Therefore, the inability to provide comprehensive documentation directly impacts the level of billing, restricting the provider's ability to claim higher initial care codes.

3. When reporting critical care time, what activities are excluded?

- A. Time spent performing E/M services
- B. Time spent using telemedicine**
- C. Time spent providing directly related care
- D. Time spent on the unit with the patient

When reporting critical care time, specific activities are classified differently to ensure accurate coding and billing. The correct answer highlights that the time spent using telemedicine does not count towards the critical care time being reported. This exclusion is critical because billing for critical care services is tied to face-to-face interactions and direct care provided to the patient. Telemedicine, while valuable, may not encompass the on-site assessment and immediate interventions required in a critical care environment. This distinction ensures that the integrity and intensity of the critical care service are maintained and accurately represented for reimbursement purposes. Time spent on telemedicine can involve clinical assessments and conversations, but it typically lacks the immediacy and hands-on environment that characterizes critical care, thus leading to its exclusion in time calculations. The other activities mentioned, such as those involving E/M services and care that is directly related to the patient, play a significant role in defining critical care time. These activities are essential for providing comprehensive and continuous care to critically ill patients, thus contributing to the critical care time allowance.

4. What type of diabetes requires specific coding guidelines when reporting?

- A. Type-1 diabetes only
- B. Secondary diabetes**
- C. Gestational diabetes
- D. Type-2 diabetes only

Secondary diabetes requires specific coding guidelines when reporting because it is a type of diabetes that occurs as a result of another medical condition or due to certain medications. It is essential to identify the underlying cause to ensure accurate coding and billing, as this type of diabetes does not have the same management and treatment protocols as primary types of diabetes (Type 1 and Type 2). Coding for secondary diabetes involves including details that specify the underlying condition that led to the diabetes, such as pancreatitis or hormonal disorders. This additional coding helps in reflecting the complexity of the patient's health status, which is important for both clinical management and reimbursement purposes. In contrast, while Type 1 diabetes, gestational diabetes, and Type 2 diabetes are also important for coding, they generally follow more established coding rules and do not have the same level of complexity in terms of specifying underlying causes. Thus, secondary diabetes stands out as needing particular attention regarding its coding guidelines.

5. Which emergency department codes can any provider use according to CMS?

- A. 99280 - 99284
- B. 99281 - 99285**
- C. 99301 - 99305
- D. 99291 - 99295

The correct response is based on the understanding of the coding structure for emergency department services as defined by the American Medical Association (AMA) and guidelines from the Centers for Medicare & Medicaid Services (CMS). In the context of emergency department visits, the range of codes from 99281 to 99285 specifically pertains to the evaluation and management (E/M) services provided in an emergency department setting. These codes allow various healthcare providers, including physicians, nurse practitioners, and physician assistants, to bill for services based on the level of complexity and clinical decision-making involved in the patient care. The code range is hierarchical, where 99281 represents the lowest complexity and 99285 represents the highest complexity in terms of the severity of the patient's condition and the extent of treatment provided. This flexibility allows diverse provider types to utilize these codes for billing purposes, ensuring appropriate reimbursement for the services rendered during emergency visits. In summary, these codes (99281 - 99285) are designed specifically to be used by any qualified provider in an emergency setting according to CMS guidelines, fulfilling the requirements of varying acuity levels in patient care situations.

6. What type of diagnosis is reported when a definitive diagnosis is documented in a physician's interpretation?

- A. Uncertain diagnosis
- B. Speculative diagnosis
- C. Confirmed diagnosis**
- D. Provisional diagnosis

When a definitive diagnosis is documented in a physician's interpretation, it is referred to as a confirmed diagnosis. This type of diagnosis indicates that the physician has gathered sufficient information, through examinations or tests, to support a specific diagnosis that accurately describes the patient's condition. A confirmed diagnosis is essential for determining appropriate treatment options and for giving a clear understanding of the patient's health status. The other types of diagnoses mentioned serve different purposes. An uncertain diagnosis suggests that the physician has not reached a conclusion or is still considering multiple possibilities. A speculative diagnosis implies that the physician is unsure about the accuracy of the proposed diagnosis. Meanwhile, a provisional diagnosis is made when a diagnosis is likely based on initial findings, but further investigation or confirmation is needed. Therefore, when a definitive diagnosis is made by a physician, it is distinctly categorized as confirmed.

7. What service includes a review of functional ability and safety during the IPPE?

- A. Height and weight measurement
- B. Review of past surgeries
- C. Review of hearing and fall risk**
- D. Assessment of chronic illnesses

The correct response highlights the importance of evaluating a patient's functional ability and safety during the Initial Preventive Physical Examination (IPPE). The review of hearing and fall risk is a critical component of this assessment because it directly addresses the patient's capacity to perform daily activities safely and highlights potential areas of concern, especially in older adults who may be at increased risk for falls and related injuries. This review helps healthcare providers identify and manage any issues that could negatively impact the patient's overall well-being and independence. By including an assessment of hearing and fall risk, the examination encompasses a thorough evaluation of the patient's functional status, which is vital for preventive care and intervention planning. In contrast, measurements like height and weight, while important, do not specifically assess functional abilities or safety. A review of past surgeries primarily focuses on medical history rather than current functional capability. The assessment of chronic illnesses, while crucial in overall health management, does not directly relate to immediate safety and functional capacity in the same targeted way that hearing and fall risk evaluations do.

8. If a patient has multiple fractures, how should they be coded?

- A. All fractures should be grouped together under one code
- B. The fractures should be coded separately by site**
- C. Only the most severe fracture should be coded
- D. The fractures can be coded by date of occurrence

Coding multiple fractures requires an understanding of the specific guidelines established by the coding system in use, often the ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification). When a patient presents with multiple fractures, each fracture should be coded separately by site. This is because fractures can vary widely in their impact on treatment and prognosis, and separate codes allow for more precise tracking of a patient's condition and the specifics of care. Separately coding fractures by site ensures that each injury receives its own code, accurately reflecting the patient's total medical situation. It also aids in the proper documentation for medical billing purposes, allowing healthcare providers to be reimbursed appropriately for the care provided for each individual fracture. This method complies with the guidelines set forth by coding authorities, reinforcing the importance of specificity in medical coding. In contrast to other options, grouping all fractures under one code would overlook the details of each injury, while coding only the most severe fracture fails to acknowledge the full extent of the patient's injuries. Coding by date of occurrence doesn't provide clarity on the fractures themselves, as it doesn't adhere to the recommended practice of coding by sight or type of fracture. Thus, coding separately by site is the most accurate and comprehensive method for recording multiple fractures.

9. When is "time" a determining factor for the level of E/M service?

- A. When the patient has a chronic illness
- B. When the patient presents with multiple issues
- C. When a patient is given a new diagnosis**
- D. When the visit is for a routine check-up

In evaluation and management (E/M) coding, "time" can be a crucial factor in determining the level of service when a patient is given a new diagnosis. This is because when a new diagnosis is made, it often requires a more detailed assessment and management plan, which may involve extended conversations with the patient, additional time spent on counseling, and more thorough discussion regarding treatment options. The definition of "time" in this context may include both the total time spent on the day of the visit and the time devoted to counseling and coordination of care related to the new diagnosis. This aligns with the guidelines that specify that time can be a factor if more than half of the visit involves counseling and care coordination, thus supporting a higher level of service. In contrast, while managing chronic illnesses, presenting multiple issues, or conducting routine check-ups may involve time considerations, these situations do not explicitly prioritize time as a determining factor for E/M service level in the same way that an encounter focusing on a new diagnosis does. Therefore, the emphasis on time when a new diagnosis is encountered reflects the complexity and the resources necessary to address the patient's healthcare needs effectively.

10. What characterizes a brief HPI?

- A. Documentation of four or more HPI elements
- B. Documentation of one to three HPI elements**
- C. A focus on chronic conditions only
- D. Patient's unfocused general health statements

A brief history of present illness (HPI) is characterized by the documentation of one to three HPI elements. In evaluation and management coding, HPI refers to details related to the patient's current condition and is a vital component that helps to establish the complexity of the visit. To adequately capture a brief HPI, it is essential to include only a limited number of specific elements that outline the patient's symptoms, their duration, and any associated factors. Each of these elements adds to the overall picture of the patient's current health status without necessitating an extensive narrative or a comprehensive account, which would be expected in a more detailed HPI. In contrast, documentation that includes four or more HPI elements would be classified as an extended HPI, while focusing only on chronic conditions or providing vague, unfocused general health statements does not adhere to the definition of HPI required for coding purposes. Proper understanding of these elements ensures accurate coding and billing and supports healthcare providers in delivering appropriate care based on the specific circumstances of each patient's condition.

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