CPMA Evaluation and Management (E/M) Practice Exam (Sample)

Study Guide

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. Which of the following is a common documentation problem in E/M coding?

A. Missing documentation

B. Excessive detail

C. Too many signatures

D. Over-documentation

2. Which CPT code range is used for Initial Hospital Care (inpatient admission) codes?

A. 99211-99213

B. 99221-99223

C. 99231-99233

D. 99354-99357

3. Which category includes an acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment that poses a threat to life or bodily function in the near term without treatment?

A. Stable, acute illness

B. Acute or chronic illness or injury that poses a threat to the life or bodily functions

C. Acute illness with systemic symptoms

D. Undiagnosed new problem

4. Standby services: which CPT code is used to report standby service requiring prolonged attendance?

A. 99360

B. 99361

C. 99362

D. 99363

5. If documentation only states that the patient has a condition treated by another provider, how is this treated for MDM leveling?

A. It is not considered for leveling unless there is additional documentation showing assessment or care coordination

B. It is always counted toward the level

C. It is never counted toward the level

D. It is counted only if the patient is seen by the same provider

6. Are ED visit codes exclusive to ED physicians?

A. True

B. False

C. Sometimes

D. Not applicable

7. Subsequent Hospital/Observation code for high MDM?

A. 99231

B. 99232

C. 99233

D. 99234

8. In ICD-10-CM, what does the 7th character A indicate in S39.012A for a lower back strain?

A. Initial encounter

B. Subsequent encounter

C. Sequela

D. Unspecified

9. In critical care coding, is the place of service the sole determinant of eligibility for critical care codes?

A. No

B. Yes

C. Only for pediatric

D. Only for outpatient

10. Which of the following is NOT a requirement for a Medicare consultation?

A. A request by a provider or appropriate source

B. A written report from the consulting provider to the requesting source

C. The consultation must be billed with a consult code

D. The consultant must recommend care for a specific condition

Answers

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

Explanations

1. Which of the following is a common documentation problem in E/M coding?

A. Missing documentation

B. Excessive detail

C. Too many signatures

D. Over-documentation

Missing documentation is the most common problem in E/M coding because you must have enough charted evidence to support the level of service reported. If essential elements—such as the patient's history, exam findings, medical decision making, or the plan of care—are incomplete or absent, the coder cannot justify the chosen code. This creates compliance risk and often leads to payer questions, recoding, or audits. While excessive detail or over-documentation can occur, they're less typical issues in practice and can even hinder efficiency; they don't routinely undermine the ability to justify the service the way missing information does. Likewise, the issue of too many signatures isn't a primary documentation problem affecting code justification.

2. Which CPT code range is used for Initial Hospital Care (inpatient admission) codes?

A. 99211-99213

B. 99221-99223

C. 99231-99233

D. 99354-99357

Initial hospital care codes are used for the first evaluation and management encounter when a patient is admitted to the hospital. They capture the physician's or qualified professional's initial assessment and the plan of care for an inpatient stay. The range 99221-99223 specifically covers this initial inpatient admission, with 99221 for lower severity, 99222 for moderate, and 99223 for higher complexity or risk at the time of admission. This set is distinct from codes used for subsequent hospital care (the ongoing inpatient visits after the first admission), outpatient office or other outpatient encounters, and prolonged services without direct patient contact. So, for the initial inpatient admission, the appropriate CPT codes are 99221-99223.

3. Which category includes an acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment that poses a threat to life or bodily function in the near term without treatment?

A. Stable, acute illness

B. Acute or chronic illness or injury that poses a threat to the life or bodily functions

C. Acute illness with systemic symptoms

D. Undiagnosed new problem

Urgency and potential harm if untreated drive this category. The category described covers situations where an illness or injury is acute or chronic but has exacerbation, progression, or treatment-related effects that could threaten life or bodily function in the near term if not treated. That breadth includes an acute illness with systemic symptoms, an acute complicated injury, and a chronic condition that's worsening or has adverse treatment effects—all posing immediate risk without care. This makes it the best fit because it explicitly accounts for the near-term threat to life or function across both acute and chronic problems, not just one narrow scenario. In contrast, a stable, acute illness lacks an imminent threat; an acute illness with systemic symptoms is only part of the picture and doesn't capture chronic progression or treatment side effects; an undiagnosed new problem doesn't necessarily imply an immediate threat.

4. Standby services: which CPT code is used to report standby service requiring prolonged attendance?

A. 99360

B. 99361

C. 99362

D. 99363

Standby services are time-based CPT codes used when a physician is on-site and available to provide care but is not actively treating the patient unless called. The amount of standby time drives which code is used, with a base code for the initial prolonged standby period and additional codes available if more time is required. In this scenario, the code chosen to report standby service with prolonged attendance is the base standby code, which captures the physician's prolonged on-site availability to attend if needed. If the standby time extends further, you would use the corresponding higher-time standby codes to reflect the added duration.

5. If documentation only states that the patient has a condition treated by another provider, how is this treated for MDM leveling?

A. It is not considered for leveling unless there is additional documentation showing assessment or care coordination

B. It is always counted toward the level

C. It is never counted toward the level

D. It is counted only if the patient is seen by the same provider

In MDM, you earn credit for what you actively do during the encounter: how many problems you address, what data you review, and the level of risk involved in the management decisions. If the chart only notes that the patient has a condition treated by another provider, with no documentation of your own assessment, plan, or care coordination related to that condition, it doesn't add to the MDM. It's not until there's additional documentation showing you assessed the issue or coordinated care with the other provider (or otherwise integrated management decisions) that it would count toward the level. So, this scenario is not counted for leveling unless a separate note demonstrates assessment or care coordination.

6. Are ED visit codes exclusive to ED physicians?

A. True

B. False

C. Sometimes

D. Not applicable

ED visit codes describe the level of evaluation and management performed in the emergency department and are not limited to ED physicians. Other qualified health professionals, such as nurse practitioners or physician assistants, can document and bill for ED visits when payer rules allow it and proper supervision or billing arrangements are in place. The encounter must meet the documented history, examination, and medical decision making criteria to justify the chosen level. So the statement is false because ED E/M codes are not exclusive to ED physicians.

7. Subsequent Hospital/Observation code for high MDM?

A. 99231

B. 99232

C. 99233

D. 99234

Subsequent hospital or observation visits are rated by the level of Medical Decision Making (MDM), not by a fixed time alone. Among the subsequent care codes, higher MDM calls for a higher code. When the encounter involves high MDM, the appropriate code is the one that represents the most complex level, reflecting multiple problems being managed, substantial data reviewed, and higher patient risk. That makes the top option the correct choice for high MDM. Codes in this group map to levels of complexity: the lowest corresponds to straightforward MDM, the next to low-to-moderate, and the highest to high MDM. The highest level is used when the documentation supports high MDM, leading to more intensive management. The other codes in the range are for lower levels of MDM, so they fit fewer problems, less data review, or lower risk. Codes based on time or observation discharge (such as some observation-time-based codes) are separate, and aren't the standard choice for a high-MDM, subsequent hospital/observation encounter. Therefore, for high MDM on a subsequent hospital/observation visit, the correct code is the highest level.

8. In ICD-10-CM, what does the 7th character A indicate in S39.012A for a lower back strain?

A. Initial encounter

B. Subsequent encounter

C. Sequela

D. Unspecified

The 7th character in injury codes like S39.012A tells you the encounter type for the injury. The letter A means an initial encounter—the first time the patient is treated for this injury. So S39.012A codes an initial encounter for a lower back strain. If the patient returned for follow-up care, you'd see a different character (typically D) to indicate a subsequent encounter. If the patient has a sequela, the character would be S. The option about unspecified isn't conveyed by this 7th character here; the A specifically designates the initial encounter.

9. In critical care coding, is the place of service the sole determinant of eligibility for critical care codes?

A. No

B. Yes

C. Only for pediatric

D. Only for outpatient

The key idea is that eligibility for critical care codes depends on the patient's condition and the physician's time spent delivering care, not just where the patient is treated. Critical care codes are used when a patient has a life-threatening condition that requires high-level, ongoing management, and the physician's direct time dedicated to that care on the day of the encounter meets the time criteria. The place of service matters for where the care occurs (ED, ICU, inpatient floor, etc.), but simply being in a particular location does not automatically qualify you for critical care billing. If the patient truly requires the level of time and effort defined as critical care, you can bill those codes in appropriate settings; if not, you bill standard E/M codes.

10. Which of the following is NOT a requirement for a Medicare consultation?

A. A request by a provider or appropriate source

B. A written report from the consulting provider to the requesting source

C. The consultation must be billed with a consult code

D. The consultant must recommend care for a specific condition

Medicare defines a consultation as an expert opinion requested by another clinician about a specific problem, with a report back to the requester. The required pieces are that there is a request from a provider or appropriate source, and the consultant must deliver a written report to that requester outlining the opinion and recommendations for managing the issue. In modern Medicare practice, you do not have to bill using a dedicated consult code; instead, the service is billed using the appropriate evaluation and management code for the encounter. The consultant's report should include recommendations for managing the problem, which is consistent with the purpose of the consult. The statement about billing with a separate consult code is not a requirement.

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://cpmaevalmgmt.examzify.com

We wish you the very best on your exam journey. You've got this!