

CPMA EVALUATION AND MANAGEMENT (E/M) PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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. According to CPT guidelines, if a history and/or physical examination is medically appropriate and performed, what is true?**
 - A. They are included in the service
 - B. They must be billed separately
 - C. They are optional
 - D. They are never billed

- 2. Initial Hospital/Observation code for moderate MDM?**
 - A. 99221
 - B. 99222
 - C. 99223
 - D. 99224

- 3. What does MDM most accurately reflect?**
 - A. The amount of work a provider performs during E/M service.
 - B. The total time spent with the patient.
 - C. The number of procedures performed during the visit.
 - D. The patient's satisfaction with the encounter.

- 4. An established patient in the office visits an 18 month old infant admitted to hospital from the office to rule out sepsis. If cultures are negative and the patient remains afebrile for 48 hours, which CPT code is reported for this visit?**
 - A. 99222, 99214-25
 - B. 99222
 - C. 99214
 - D. 99223

- 5. Which is a top error in Evaluation and Management coding?**
 - A. The chief complaint is missing
 - B. The patient name spelling
 - C. The facility address
 - D. The CPT code is correct

6. For Medicare prolonged service, which code is used instead of 99417?
- A. G2212
 - B. 99215
 - C. 99354
 - D. 99423
7. Hospital Inpatient services use the same set of E/M codes that are used for Observation Care Services.
- A. True
 - B. False
 - C. Not sure
 - D. Depends on payer
8. Medicare inpatient consultations should be reported using which ranges for initial and subsequent care?
- A. Initial 99221-99223; Subsequent 99231-99233
 - B. 99202-99205
 - C. 99304-99306
 - D. 99241-99245
9. A basic metabolic panel (BMP) CPT 80047 is considered what in data counting?
- A. It is counted as multiple tests.
 - B. It is counted as a single panel test.
 - C. It is not counted as a test.
 - D. It counts only if results exceed thresholds.
10. A 45-year-old established female with dizziness and vertigo; EKG ordered; labs drawn; final diagnosis suspected benign paroxysmal positional vertigo. What CPT code is reported for the established patient visit?
- A. 99214
 - B. 99215
 - C. 99203
 - D. 99204

Answers

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

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Explanations

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1. According to CPT guidelines, if a history and/or physical examination is medically appropriate and performed, what is true?

- A. They are included in the service**
- B. They must be billed separately
- C. They are optional
- D. They are never billed

In CPT coding, the history and physical examination are bundled into the evaluation and management service. When a history and/or physical is medically appropriate and performed during an encounter, those elements help determine the level of service but are not billed as separate codes. The E/M code you choose already accounts for the work of taking history and conducting the exam, along with the medical decision making. Only in cases where a distinctly separate and independently billable service is performed would you bill separately; the H&P itself isn't billed on its own.

2. Initial Hospital/Observation code for moderate MDM?

- A. 99221
- B. 99222**
- C. 99223
- D. 99224

For an initial hospital encounter, the level of medical decision making (MDM) determines the code, and the hospital inpatient set uses 99221, 99222, and 99223 for increasing complexity. Moderate MDM falls in the middle, which is coded as 99222. If the patient were in observation status, the initial observation codes (99218–99220) apply, with moderate MDM mapped to 99219—not an option here. So, given the scenario and choices, the best match for moderate MDM on an initial hospital encounter is 99222.

3. What does MDM most accurately reflect?

- A. The amount of work a provider performs during E/M service.**
- B. The total time spent with the patient.
- C. The number of procedures performed during the visit.
- D. The patient's satisfaction with the encounter.

MDM measures the complexity of the physician's decision making during the encounter. It reflects how much cognitive and interpretive work is required to evaluate problems, review data, and determine management. The level of MDM depends on factors like how many problems are being addressed, the amount and complexity of data reviewed (tests, records, literature), and the risk of complications or morbidity associated with the proposed management. That combination drives how "heavy" the decision making is. This is why the best answer uses language about the amount of work involved in the E/M service—it captures the overall effort and complexity of the decisions the provider must make. It's not about total time spent (time-based coding), not simply the number of procedures performed, and not patient satisfaction, which do not determine MDM. For example, a single problem with straightforward data and low risk yields low MDM, whereas multiple problems requiring substantial data review and high-risk management yields high MDM.

4. An established patient in the office visits an 18 month old infant admitted to hospital from the office to rule out sepsis. If cultures are negative and the patient remains afebrile for 48 hours, which CPT code is reported for this visit?

A. 99222, 99214-25

B. 99222

C. 99214

D. 99223

When a patient is admitted to the hospital from an outpatient office visit, you bill the admission with an initial hospital care code for the day of admission. If there was a separate, identifiable office E/M service on the same day, you also report the office visit code and append modifier -25 to show it's a distinct service. In this scenario, the 18 month old is an established patient seen in the office and then admitted to the hospital to rule out sepsis. The appropriate initial hospital care level for the admission is 99222. Since there was an office visit on the same day that is a separate service, you also bill the office E/M code 99214 and add modifier -25 to indicate the office visit is distinct from the admission. So, the correct reporting is 99222 and 99214-25. The initial hospital admission code captures the inpatient care, while the Office visit code with the -25 modifier ensures reimbursement for the separate, concurrent office evaluation.

5. Which is a top error in Evaluation and Management coding?

A. The chief complaint is missing

B. The patient name spelling

C. The facility address

D. The CPT code is correct

The most fundamental element here is the reason for the visit. The chief complaint anchors the entire encounter—it's what justifies the patient's visit, guides what history and examination elements are needed, and supports the medical necessity for the level of service reported. When the chief complaint is missing, the chart loses the narrative that ties the patient's problem to the care provided, making it hard to justify the chosen CPT code and to demonstrate that the visit was medically appropriate. Auditors consistently flag missing chief complaints as a leading documentation error because it undermines the purpose and justification of the encounter. Administrative details like spelling of the patient's name or the facility address are important for record accuracy, but they do not drive the coding level or medical necessity in the same way. Having the CPT code correct is important, but without a clear chief complaint, the rationale for the service remains unclear, which is why missing the chief complaint is the top error.

6. For Medicare prolonged service, which code is used instead of 99417?

A. G2212

B. 99215

C. 99354

D. 99423

Medicare reports prolonged office or outpatient evaluation and management time with a HCPCS code rather than the CPT prolonged-service code. When the encounter requires more time beyond the usual E/M service, use G2212 to indicate the additional prolonged time. This Medicare-specific code stands in for the CPT 99417 in the outpatient setting, ensuring the extra work is captured correctly on the claim. The base E/M code (the standard office visit code) still describes the overall visit, but the extra time is documented with the G-code. The other options either pertain to different settings (for example, home/domiciliary visits) or are not the Medicare mechanism for reporting prolonged outpatient time.

7. Hospital Inpatient services use the same set of E/M codes that are used for Observation Care Services.

- A. True**
- B. False
- C. Not sure
- D. Depends on payer

The essential point is that hospital inpatient care and observation care are billed using different CPT E/M code sets, even though both occur in the hospital setting. Documentation concepts such as history, exam, and medical decision making (or time) apply in both, but the actual codes you select depend on the encounter type. Inpatient initial, subsequent, and discharge encounters use one set of codes (for example, initial hospital care, subsequent hospital care, hospital discharge), while observation care uses its own distinct set of codes (initial observation care, subsequent observation care, and observation discharge). Because of this separation, the statement that they use the same set of E/M codes is not correct. Payer rules don't change the fundamental code ranges; the setting determines which codes to apply.

8. Medicare inpatient consultations should be reported using which ranges for initial and subsequent care?

- A. Initial 99221-99223; Subsequent 99231-99233**
- B. 99202-99205
- C. 99304-99306
- D. 99241-99245

Inpatient hospital care is coded differently from outpatient visits, with a clear distinction between the first encounter after admission and subsequent follow-ups during the same stay. For Medicare inpatient consultations, use the initial hospital care levels 99221 through 99223 for the first encounter on the admission day, and use the subsequent hospital care levels 99231 through 99233 for follow-up visits during the hospital stay. This reflects how the service is delivered inside the hospital setting and avoids using older or non-hospital consultation codes. The other options don't fit because they correspond to outpatient office visits, nursing facility/inpatient non-hospital care, or historical inpatient consultation codes that Medicare no longer uses for inpatient reporting.

9. A basic metabolic panel (BMP) CPT 80047 is considered what in data counting?

- A. It is counted as multiple tests.
- B. It is counted as a single panel test.**
- C. It is not counted as a test.
- D. It counts only if results exceed thresholds.

A single panel code represents a bundled set of related measurements performed together, so it is counted as one test unit in data counting. A basic metabolic panel (CPT 80047) includes several analytes, but the CPT code stands for the whole group, not each component separately. This keeps lab activity data consistent and prevents inflating counts by adding up every component individually. It isn't counted as multiple tests, and there isn't a threshold rule that changes its count. If separate tests outside the panel are ordered or billed, those would count separately, but the panel itself remains one test.

10. A 45-year-old established female with dizziness and vertigo; EKG ordered; labs drawn; final diagnosis suspected benign paroxysmal positional vertigo. What CPT code is reported for the established patient visit?

A. 99214

B. 99215

C. 99203

D. 99204

In established patients, the code level reflects how much history you obtain, how thorough your exam is, and how complex the medical decision making is. Here, dizziness with vertigo prompts a detailed history—characteristics of the dizziness, onset, duration, triggers, associated symptoms, and prior episodes—and a thorough vestibular/neurological exam, which may include maneuvers to assess BPPV. Ordering an EKG and labs adds data to review and plan, contributing to moderate complexity in decision making. The overall documentation fits a detailed history, a detailed or extended exam, and low-to-moderate medical decision making, which corresponds to the established-patient level 99214. Higher levels (99215) would require high complexity MDM or more than one significant problem, which isn't indicated here, and the new-patient codes (99203/99204) are for patients who are new, not established.

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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!

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