AAPC

CFPC™

Certified Family Practice Coder

STUDY GUIDE

2026

2026

Specialty Study Guide: CFPC™

FAMILY PRACTICE

Contents

2026 Specialty Study Guide: CFPC™ Introduction

The *Specialty Study Guide: CFPC™* is designed to help family practice coders, billers, and other medical office professionals prepare for the CFPC™ examination. This guide is by no means comprehensive. Your primary resource for the exam will be your years of hands-on experience in coding for family practice.

Healthcare in the 21st century is complex and requires expertise in proper coding to obtain payment for procedures, services, equipment, and supplies. Becoming a CFPC™ shows your expertise in coding family practice. Membership in AAPC lends integrity to your credentials, provides a large network of coders for support, and allows you access to continuing education opportunities. The *Specialty Study Guide: CFPC™* is designed to provide an overall review of coding and compliance information for the more experienced coder, or for someone preparing for the CFPC™ examination.

We will review the importance of using the coding guidelines within ICD-10-CM and CPT® as well as emphasize the importance of correct evaluation and management (E/M) leveling. You will need the 2026 versions of ICD-10-CM, CPT®, and HCPCS Level II code books for the study guide and CFPC™ exam as well.

ICD-10-CM Coding

Proper diagnostic coding not only reports the medical necessity of procedures performed but also contributes to data that determines health policies for tomorrow. Because physicians have traditionally been paid by CPT® code values, coders have sometimes given little importance to correct ICD-10-CM coding. Regulatory trends show that diagnoses will play a larger role in future reimbursement. It is important to code correctly now, so you can be prepared for that day.

We will discuss the major topics of diagnosis coding for family practice. The examinee must become familiar with the ICD-10-CM Official Guidelines for Coding and Reporting, know how to select the appropriate ICD-10-CM codes, and be able to properly sequence diagnosis codes when more than one code is required to report a patient's conditions. This year's guidelines can be found at https://www.cms.gov/files/document/fy-2026-icd-10-cm-coding-guidelines.pdf. The examinee must understand the conventions, general coding guidelines, and chapter specific guidelines in the ICD-10-CM code book.

Evaluation and Management Coding

Office visits consume a lion's share of the physician's time in most practices and consequently represent the largest revenue source. Compliance is an increasing concern at practices, and the E/M material will focus on the E/M services for family practice, while underscoring the importance of modifier use. An understanding of the AMA E/M guidelines and subsection notes is an important foundation for accurate code selection that is provided in your CPT® code book.

An E/M calculator is provided for the online exam (https://www.aapc.com/codes/em-calculator) and your CPT® code book provides a Medical Decision Making (MDM) table to level an E/M service.

CPT® Coding

Surgical procedures specific to family practice will be discussed in this section. Special attention will be given to the guidelines, coding conventions, and parenthetical phrases associated with procedures. The examinee must be able to select the appropriate CPT® codes and sequence the codes correctly when multiple procedures are performed. CPT® codes are sequenced based on the most complex or labor-intensive procedures. The codes with the highest Relative Value Units (RVUs) are sequenced first.

Top 10 Missed Coding Concepts

We will review the Top 10 Missed Coding Concepts for the CFPC™ certification exam. The list is not presented in any specific order. The information is determined after an evaluation by the AAPC exam department of the commonly missed questions on the exam.

Practice Exam

The practice exam and the exam were written by coders with extensive experience in coding for family practice. The practice exam mimics the format and content of the CFPC™ certification exam.

AAPC has developed specialty credentials to enable coders to demonstrate superior levels of skill in their respective disciplines. Here is information on the CFPC™ credential:

- CFPC™ is a certification which does not require that the examinee to holds a base credential such as the CPC®, COC®, or CIC® credential.
- Exams aptly measure preparedness for real world coding by being entirely operative/office-note based. These notes are redacted notes from real practices.

The CFPC™ examination tests your knowledge of coding concepts, anatomic principles, and coding guidelines only.

When you take the exam, remember that individual payer rules are not a consideration when choosing the right answer. Unless it is specifically stated in the case note or exam question that the patient is covered by Medicare, you should follow the CPT® coding guidelines.

The exam tests competency. The candidate most qualified to pass the exam will be proficient in understanding:

- Medical terminology and anatomy
- Medical physiology
- Teaching physician guidelines
- Incident-to guidelines
- Split/Shared services
- HIPAA (Health Insurance Portability & Accountability Act of 1996) regulations
- Proper use of an Advance Beneficiary Notice (ABN)
- ICD-10-CM coding
- E/M code selection using the AMA CPT® E/M guidelines
- CPT® coding for common procedures
  - 10000 Series
  - 20000 Series
  - 30000 Series
  - 40000 Series
  - 60000 Series
  - Laboratory and Pathology
  - Radiology
  - Medicine
- CPT® and HCPCS Level II modifier usage
- HCPCS Level II coding

Familiarity with practical coding and the code books are essential, as time is an important element in successfully completing the exam. Approach the exam as you would approach your work—by demonstrating coding abilities essential to success. This is not a general aptitude test, and each question has a specific goal for measuring your competency. The practice exam within the *Specialty Study Guide: CFPC™* course is highly representative of the subject matter and level of difficulty you will encounter in the full-length exam.

Test Answers and Rationales

The final chapter in the book contains the answers to the practice exam. Accompanying each answer is a rationale that explains the coding guidelines contributing to selecting the right answer. These rationales should help you understand what is needed to successfully approach and answer questions on the real exam, because they allow you a glimpse into the minds of the test's creators.

Examinees that pass the CFPC™ certification examinations will receive recognition in AAPC's monthly magazine, *Healthcare Business Monthly* and receive a diploma.

About AAPC

AAPC was founded in 1988 in an effort to elevate the standards of medical coding by providing training, certification, ongoing education, networking, and recognition.

AAPC provides medical coding certification exams for coders in physician practices and the outpatient/facility environment. AAPC has expanded beyond outpatient coding to include training and credentials in documentation and coding audits, inpatient hospital/facility coding, regulatory compliance, and physician practice management. The purpose of AAPC coding certifications is to test an examinee's knowledge of coding principles and proficiency in coding accurately and efficiently. AAPC examinations measure a coder's skill of both coding accuracy and efficiency.

AAPC Member Code of Ethics

Members of AAPC shall be dedicated to providing the highest standard of professional service for the betterment of healthcare to employers, clients, vendors, and patients. Professional and personal behavior of AAPC members must be exemplary.

It shall be the responsibility of every AAPC member, as a condition of continued membership, to conduct themselves in all professional activities in a manner consistent with ALL of the following ethical principles of professional conduct:

- Integrity
- Respect
- Commitment
- Competence
- Fairness
- Responsibility

Adherence to these ethical standards assists in assuring public confidence in the integrity and professionalism of AAPC members. Failure to conform professional conduct to these ethical standards, as determined by AAPC's Ethics Committee, may result in the loss of membership with AAPC.

Introduction to ICD-10-CM Coding Guidelines

The National Center for Health Statistics (NCHS) developed ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) in consultation with a technical advisory panel, physician groups, and clinical coders to assure clinical accuracy and utility. ICD-10-CM coding guidelines are developed by the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics. Healthcare providers must begin using the most recent ICD-10-CM code revisions on Oct. 1 of each year, with no "grace period" to transition to the changes.

All versions of the ICD-10-CM code book typically include the ICD-10-CM Official Guidelines for Coding and Reporting. These guidelines are an invaluable source for diagnosis coding information, and provide instruction supplemental to that found in the Tabular List and the Alphabetic Index of the ICD-10-CM code book.

ICD-10-CM codes are utilized to facilitate payment of health services, to evaluate utilization patterns, and to study the appropriateness of healthcare costs. Case-by-case success in achieving these goals requires an open line of communication between the coder and the documenting physician.

The Official Guidelines note, "A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures." Each ICD-10-CM code assigned must be supported by documentation linked to that claim (individual dates of service must stand alone), and coders must be mindful not to assume or extrapolate information from the medical record, for example: coding a condition as "acute" when it isn't documented as such.

The Official Guidelines are divided into four sections:

- Section I lists ICD-10-CM Conventions, General Coding Guidelines, and Chapter Specific Guidelines.
- Section II explains the Selection of Principal Diagnosis. The Uniform Hospital Discharge Data Set (UHDDS) defines the principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
- Section III gives rules for Reporting Additional Diagnoses, in addition to the principal diagnosis that affects the patient's care.
- Section IV provides Diagnostic Coding and Reporting Guidelines for Outpatient Services. These include information about coding signs and symptoms, when to report chronic diagnoses, ambulatory surgery, routine outpatient prenatal visits, and more.

General Tips for Using ICD-10-CM

Use the Alphabetic Index and Tabular List of the ICD-10-CM code book together to determine the diagnosis code. When attempting to select an ICD-10-CM diagnosis code, begin by searching for the main term—such as "lesion," "burn,"—in the Alphabetic Index. Follow all cross-references and "*see also*" entries. When you have located the code you are seeking, turn to that code in the Tabular List. Be sure to pay close attention to disease definitions, footnotes, color-coded prompts, and other instruction. Read all supplemental information completely to be certain you are choosing the correct code.

The first-listed diagnosis should describe the most significant reason for the procedure or visit. The first-listed diagnosis will be reflective of the patient's chief complaint. Relevant co-existing diseases and conditions, as well as related history or family history conditions, are reported as secondary diagnoses. When coding preexisting conditions, make sure the assigned diagnosis code identifies the current reason for medical management. Do not report conditions that no longer exist, or do not pertain to the visit.

Many patients will have numerous chronic complaints. Report a chronic complaint diagnosis *only* when that chronic condition is treated or becomes an active factor in the patient's care.

Always select ICD-10-CM codes to the highest level of specificity supported by documentation. For example, diagnosis coding for fractures of the wrist and hand requires a 5th code character (which specifies location), a 6th code character (which specifies the laterality and whether the fracture is displaced or nondisplaced), and a 7th code character (which specifies the episode of care). If this information is not documented, appropriate code selection is impossible. You should work with the provider to ensure that the information necessary for proper coding is always noted.

General ICD-10-CM Guidelines

Signs/Symptoms and Confirmed/Unconfirmed Diagnoses

Use of codes that describe signs and symptoms are acceptable when the provider has not established a related, definitive diagnosis. Report only confirmed diagnoses. Uncertain diagnoses described as "probable," "possible," "suspected," "likely," "rule out," "consistent with," "compatible with," etc., are not coded. Code the highest level of certainty known, using codes that describe known signs, symptoms, abnormal test results, etc.

For example, if a patient has a breast mass and the provider suspects breast cancer, you should not report breast cancer as the diagnosis. Instead, report the signs and symptoms, such as breast mass, that prompted the exam. If testing later confirms cancer, only then should you report the cancer diagnosis.

For outpatient encounters that include diagnostic tests which have been previously interpreted by a physician, and the final report is available at the time of coding, report any confirmed or definitive diagnoses documented in the interpretation. If a definitive diagnosis is known, do not code related signs and symptoms as additional diagnoses. That is, if the test is positive, you report the findings. For tests interpreted as "normal" code the condition, symptom, or sign that necessitated the diagnostic study.

In rare occurrences, a test is ordered without a clear indication of reason, and the ordering physician is not available to gather enough information prior to treating the patient. Verify the signs and symptoms from the chart or order if possible, or code from the findings if abnormal.

When you are provided with both a preoperative and postoperative diagnosis, always report the *postoperative* diagnoses codes if the pre and postoperative diagnoses differ.

Signs and symptoms attributable to a definitive diagnosis should not be reported separately. Cite additional signs and symptoms beyond the primary diagnosis only when they are not integral to the disease process. Report only those additional conditions that affect treatment, and that the provider documents for the current visit.

For example, a patient presents with shortness of breath and the physician determines the patient has pneumonia, but the physician feels that the shortness of breath may be due to a cardiac condition. In such a case, you may still report the shortness of breath as a sign and symptom with pneumonia because the physician has documented reason to believe that the conditions are unrelated.

Above all, do not extrapolate or assume information. Select codes only from what is apparent in the available documentation.

Acute vs. Chronic

The doctor makes the determination as to when a condition becomes chronic. Coders will select an appropriate code for acute or sub-acute (primary) versus chronic (secondary) conditions based on the available documentation. For example, a torn meniscus (S83.-) will become an internal derangement of knee (M23.-) after a defined period of time.

If a patient's condition is described as being *both* acute/sub-acute and chronic, and a single code does not describe this combination, the ICD-10-CM code book provides instruction that you would report the acute (sub-acute) code as first-listed, with the chronic code secondary.

Sequela

Sequela (late effects) codes are usually reported as secondary diagnoses, with the effect or reason for the visit as primary. There is no time limit (such as 90 days, one year, etc.) in which late effects can occur.

Sequela of cerebrovascular disease fall specifically to category I69, which indicates conditions classifiable to I60-I67 (hemorrhage, occlusion, stenosis, etc.) as the cause of sequela. Guidelines indicate that the late effects include neurologic deficits caused by cerebrovascular disease and may be present from the onset or may arise at any time after the onset of the condition classifiable to categories I60-I67. Codes from category I69 may be assigned on a medical record with codes from I60-I67 if the patient has a current cerebrovascular accident (CVA) and deficits from an old CVA.

Some of the codes in category I69 that specify hemiplegia, hemiparesis and monoplegia also identify whether the dominant or nondominant side is affected. If the dominance is not stated (right-handed, left-handed, or ambidextrous), and the classification does not indicate a default, then the following applies:

- For ambidextrous patients, the default is always dominant
- If the left side is affected, the default is nondominant
- If the right side is affected, the default is dominant

Multiple Conditions Reported with a Single Code

In some cases, ICD-10-CM will employ a single code to describe two or more conditions concurrently, such as a primary diagnosis with an associated secondary process (manifestation),

Evaluation and Management Coding for Family Practice

This chapter examines the documentation requirements for the evaluation and management (E/M) codes used by physicians and non-physician practitioners (NPPs) to bill for their services.

The E/M documentation requirements chapter is designed to provide a detailed approach to the accurate identification of documentation elements as they are defined by the American Medical Association (AMA) Guidelines for E/M services. The goal of this material is to offer the necessary insight to develop proficiency and correct technique to accurately select levels of E/M services for the exam. This material is not meant to influence policy, rather to refer to as coding guidelines for the CFPC™ exam.

This chapter should be reviewed with the CPT® guidelines for E/M services found in the current CPT® code book. This guide is a general summary that explains commonly accepted aspects of selecting E/M codes. The goal is that, after completing your training, you will be confident that you will not under or over code a visit.

An Introduction to the Documentation Requirements Associated with E/M Services

The E/M Documentation Guidelines (DGs) have perhaps inspired more discussion than any other non-clinical topic based in the industry. In an ever-increasing effort to ensure that correct payments are made for visits and consultations, Medicare and the AMA have been working together for well over a decade. In 1992, Medicare transitioned to the Resource-Based Relative Value Scale (RBRVS) physician payment system and the AMA introduced E/M codes in CPT® to report visits and consultations.

By 1994, in response to confusion and the inaccurate interpretation of the codes, the Office of Management and Budget mandated that Medicare adopt DGs to expand the definition that was, at that time, only provided by CPT®. Medicare and the AMA jointly developed this initial set of E/M DGs which were deployed in 1995 and became known as the 1995 Documentation Guidelines or DGs. As auditing showed a pattern of continued misuse of the E/M Codes, the 1995 DGs were criticized as unfair to specialists because they seem to account for extended single system examinations with as much weight as limited multiple system exams.

Within two years, the E/M DGs were revised to improve physician and provider understanding and payment accuracy by extending the definitions to include specialty specific guidance. This set of DGs was scheduled to replace the 1995 DGs and became known as the 1997 DGs. The only problem was that the physician community loudly objected to the 1997 DGs. They were criticized as burdensome with documentation requirements that were too detailed and very difficult to achieve. Medicare decided to not replace the 1995 DGs but to instead allow physicians and providers to choose between the 1995 and the 1997 DGs.

In 2021, in an attempt to simplify the guidelines, the AMA changed the descriptions of the Office or Other Outpatient E/M Services codes 99202-99215. In addition, guidelines for the use of these codes were printed in the CPT® code book. The guidelines added in the 2021 CPT® code book were specific to Office or Other Outpatient E/M Services. In 2023, the AMA expanded the use of the guidelines introduced in 2021 to other E/M categories, eliminating the need for the 1995 and 1997 DGs.

Documentation Guidelines

There are three general principles regarding documentation to ensure credit can be thoroughly verified. It is important to follow these rules of thumb:

1. Documentation should be legible to someone other than the documenting physician or provider and their staff.
2. The date of service, name of the patient, and the name of the provider of service should be easily demonstrated by the documentation.
3. The documentation should support the nature of the visit and the medical necessity of the services rendered.

For most E/M visits, the provider performs three main components: history, exam, and medical decision making (MDM). The history directs the provider to troubleshoot the chief complaint based on an interview with the patient. The exam portion is the provider's physical exam and evaluation of the patient. The MDM includes the provider's assessment and plan.

The guidelines for E/M Services, along with the code descriptors, indicate that a "medically appropriate history and/or physical examination, when performed" is included in the service. While the history and exam should be documented, they are not used in the determination of the level of the code.

The guidelines also include pertinent definitions for terms necessary to understand when determining the level of MDM. You should read through the definitions provided in your CPT®

code book and refer back to them as we go through the MDM components below.

The E/M guidelines provide instructions for selecting the appropriate level of service based on either of the following:

1. The level of the MDM as defined for each service; or
2. The total time for E/M services performed on the date of the encounter.

The provider can determine to support the E/M level of the visit based on MDM or time on a case-by-case basis. Regardless of which element is used to determine the level of visit, documentation should support the medical necessity of the visit. Payers may also have regulations on when MDM or total time is used.

Determining the Medical Decision Making (MDM)

The MDM most accurately reflects the amount of work a provider performs during an E/M service. Four levels of MDM are recognized: straightforward, low, moderate, and high. The level of MDM directly correlates to a level of service.

EXAMPLE: OFFICE VISIT MDM TO CODE CORRELATION

New Patient Code	Established Patient Code	Level of MDM
	99211	N/A 99211 is reported for services that typically do not require the presence of a provider. As such, the concept of MDM does not apply to code 99211.
99202	99212	Straightforward
99203	99213	Low
99204	99214	Moderate
99205	99215	High

To adequately determine the level of visit, the MDM is selected based on three components:

1. The number and complexity of problems addressed at the encounter;
2. The amount and complexity of data to be reviewed and analyzed; and
3. The risk of complications and/or morbidity or mortality of patient management.

To determine the levels of these components appropriately, the definitions provided in your CPT® code book must be understood. Using a grid method, we will discuss each component. Be sure to refer back to the definitions listed in the E/M Guidelines as needed.

Number and Complexity of Problems

The number and complexity of problems identifies the nature of the presenting problem and is based on the relative difficulty level in making a diagnosis. For the problem to be considered in the number of problems, the problem must be addressed within that encounter.

Per CPT®, symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Multiple problems of lower severity may, in aggregate, create higher risk due to interaction.

The final diagnosis alone does not determine the complexity or risk to the patient. The documentation should be reviewed for comorbidities or underlying diseases that are addressed that increase the level of risk to the patient. Simply listing a chronic illness in the documentation is not sufficient. The documentation should indicate that the provider addressed the conditions during the encounter or that the condition contributed to the severity of the case.

When a patient sees multiple providers for different aspects of their care, you may see a physician document the condition is being managed by another provider. When the documentation only states that the patient has the condition and that it is being treated by another provider, it is not considered for the leveling of the visit. If there is additional documentation showing assessment or care coordination regarding that diagnosis, other than the statement of the condition being treated by another provider, it is then considered toward the level of service.

TESTING TECHNIQUE

Read through the entire note to get an understanding of the conditions that are addressed and analyzed during the visit. Simply relying on the chief complaint will not always give an accurate description of the number and complexity of problems for the encounter.

There are four levels identified under the number and complexity of problems addressed; minimal, low, moderate, and high. As demonstrated by the table below, the level of Number/Complexity of Problems Addressed increases as the difficulty of the patient's health increases.

Top 10 Missed Coding Concepts on CFPC™ Exam

The concepts discussed are not in a particular order. The tips provided below are based on the AAPC exam department observations of the most missed coding concepts.

1. **Sequencing CPT® codes:** When multiple procedures are performed, the codes should be sequenced in Relative Value Unit (RVU) order. For example, if a provider excises a malignant lesion from the forehead with an excised diameter of 1.5 cm and performs an intermediate repair measuring 1.8 cm, the correct codes are 11642 (8.05 RVUs) and 12051 (8.43 RVUs). Because 12051 has the higher RVU value, it is reported first. Modifier 51 is then appended to 11642 to indicate that a multiple procedure was performed. A RVU calculator will be provided as a resource in the online CFPC™ exam.

2. **Venipuncture:** When venipuncture is performed in the office and the labs are sent to an outside lab, report 36415. Although most payers bundle 36415 with the E/M service, for purposes of the CFPC™ certification exam, you should report the code.

3. **Parenthetical Instructions:** Refer to the parenthetical instructions in the CPT® code book for reporting codes 69209 and 69210. To report these codes the cerumen needs to be impacted. If the cerumen is not documented as impacted, you report an E/M service code.

4. When coding **adverse reactions** to a correct substance properly administered, you will first report any manifestations caused by the drug, and then a code from the Adverse Effect column in the Table of Drugs and Chemicals. An adverse effect is not considered a poisoning; do not report a poison code from the Poisoning column in the Table of Drugs. For example, a patient is prescribed with an antibiotic to treat a UTI. She takes the medication as directed and becomes nauseous and can't stop vomiting. The correct code sequence is: R11.2, T36.95XA.

5. **Split/Shared Visits:** A shared/split visit occurs when an NPP and physician are involved in the same patient case in a facility setting. Shared/split visits does not apply in the office setting. If performed in the office setting, refer to incident-to requirements. In the facility setting, if the physician and NPP in the same group performs a face-to-face encounter or non-face-to-face time, the service is billed by either physician or the NPP depending on which one performs the substantive portion (more than half) of the visit. CPT® defines substantive portion when code selection is based on time will need to be more than half of the total time or two out of three elements when the level is based on MDM.

6. **Incident-to Guidelines:** To bill services as incident-to under the physician, the services must be a result of the physician's treatment plan for an established patient and the physician must be in the office suite to provide supervision (physician does not need to be in the room with the patient, but must be somewhere in the office). For example, if an established patient comes for a follow up as part of the physician's treatment plan and is seen by the physician assistant, this qualifies as incident-to and the service is billed under the physician. If the physician is out of the office seeing patients at the hospital, the services cannot be billed under the physician, because the physician is not in the office to provide supervision. Incident-to is not recognized in a facility setting.

7. **New versus established patient determination:** If the patient sees a provider in the same group practice but of a different specialty for the first time, the encounter is coded as a new patient.

8. **Consultation rules according to CPT® and CMS:** Consultations, according to CPT® coding guidelines, require: 1. A request by a physician or other qualified source; 2. That the service is to recommend care for a specific condition or problem, or to determine whether to accept responsibility for ongoing management of the patient's entire care or specific condition; and 3. A written report back to the requesting provider. If all three conditions are not met (for example, there is no documentation of a written report back to the referring provider), a consultation cannot be coded. CMS no longer reimburses consultations; you are directed to code office and outpatient E/M codes or hospital care codes when the case note indicates the patient is a Medicare beneficiary. Do not assume based on the patient's age that the patient is covered by Medicare. On the exam, if Medicare covers the patient, the information is provided in the case note or the question.

9. **AMA E/M Guidelines for Selecting the Level for the Amount and/or Complexity of Data to be Reviewed:** For Amount and/or Complexity of Data, whether a test counts toward data depends on whether the test is separately reportable. Ordering, performing, or interpreting diagnostic tests during the encounter does not count toward the E/M data element when the

physician separately bills for the test's professional interpretation with a CPT® code.When a provider orders a test that includes a separate interpretation (X-ray, ECG) and it is performed in the office it is presumed that the provider will bill for the test and therefore ordering of a unique test is not counted. Tests that do not require separate interpretation (such as lab tests that are results only – e.g. rapid strep test) can be counted as ordered or reviewed when they are analyzed as part of the MDM. During a follow-up visit, review of test results ordered at a prior encounter is not counted, because the review was already included with the original order.

10. **AMA E/M Guidelines for Selecting the Level for Number and Complexity of Problems Addressed at the Encounter:** An acute, uncomplicated illness or injury is a recent or newly developed short-term condition that carries a low risk of morbidity. These conditions have little to no risk of mortality with appropriate care, and patients are expected to make a full recovery without lasting functional impairment. An example can be a contusion on the leg or an acute ankle sprain which recommends rest, ice, compression, elevation, and over-the-counter pain medication for treatment.

AAPC continuously evaluates and enhances our certification exams throughout the year. As AAPC continues to enhance the certification exams, we are beta testing the inclusion of a fill-in-the-blank item type on our certification exams. To prepare you for both item types (multiple choice and fill-in-the-blank), we have provided two versions of this practice exam. The same questions are on both versions of the Test Your Knowledge practice exam; however, the last three cases on this version of the practice exam are fill-in-the-blank. If you prefer to test using the multiple-choice item type for all the cases, use practice exam B.

The following questions will test your comprehension of the information covered in this study guide. The answer key is used for both versions of the Test Your Knowledge practice exams.

Version A

CASE 1

Reason for Visit

- Adolescent WCE
- Concerns or Questions: None
- Family Members Present: Mother, Father
- Immunizations Requirements: Hepatitis A

HPI

12-year-old male with behavioral problems that include ADHD. He has run out of his medications for the past 2 months and according to mother this was not making any difference. He was on Concerta prescribed from the guidance clinic and this was not helping at all. When he was about 5 years of age he had Adderall and parents think that the medication worked very well then. He punched a classmate in the face after he kept hitting him repeatedly, and he was suspended from school for a few days. His mother has not noted him pulling any hairs off himself. He does have a very big appetite and has been screened for Prader-Willi syndrome but everything has been negative.

Vital Signs

BP: 115/40, LUE, Sitting

HR: 65 b/min Apical

Resp: 20 r/min

Temp: 97.9 F, Oral

Height: 173.4 cm; Weight: 81.1 kg; BMI: 27 kg/m2

Pain Scale: 0

Weight Percentile: 99

Height Percentile: 99

BMI Percentile: 97

Immunizations

Varicella

Hepatitis B: 13 Sept. 1995

OPV: 01 Oct. 1995

DtaP: 01 Oct. 1995
Hepatitis B: 13 Oct. 1995
MMR: 01 Oct. 1997
OPV: 01 Oct. 1997
DtaP: 01 Oct. 1997
Hepatitis B: 13 Oct. 1997
OPV: 01 June 1999
DtaP: 01 June 1999
DtaP: 01 June 2000
OPV: 01 June 2000
MMR: 01 June 2000
DtaP: 01 Sept. 2001
Tdap (Boostrix): 11 Sept. 2006
Meningo (Menactra): 05 June 2007
Hepatitis A: 05 June 2007

History

Diet: Appetite: Good. Four Food Groups: Yes
Brushes teeth: Yes. Has seen Dentist: No
PPD Screening: No
Hemoglobin Screening: Yes
Present during exam: Mother, Father

Developmental

Grade: 7th in a special class
Performance: Does very, very well, gets mostly As and Bs and thinks that most of the work in class except reading is easy
Activities/Sports: No activities
Family/Emotional Stresses: None
Drug Use: No
Alcohol Use: No
Tobacco Use: No
Sexual Orientation: Male
Sexual Activity: No
Birth Control Method: NA
STD Prevention: NA

Physical Exam

GENERAL APPEARANCE: Well-nourished. Well-developed. Obese. NAD.
HEAD: Normal shape, no signs of trauma.
EYES: PERRLA. EOM intact. Normal fundoscopic exam.
EARS: TM pearly with good landmarks. TM mobile. Canals clear.
NOSE: Normal, no runny nose
MOUTH: Normal oral mucosa
TEETH: Normal, gums healthy

After reviewing the answers and rationales, if you have further questions, please send them to: mct@aapc.com

CASE 1

Reason For Visit

- Adolescent WCE [1]
- Concerns or Questions: None
- Family Members Present: Mother, Father
- Immunizations Requirements: Hepatitis A

HPI

12-year-old [2] male with behavioral problems that include ADHD. He has run out of his medications for the past 2 months and according to mother this was not making any difference. He was on Concerta, prescribed from the guidance clinic, and this was not helping at all. When he was about 5 years of age he had Adderall and parents think that the medication worked very well then. He punched a classmate in the face, after he kept hitting him repeatedly, and he was suspended from school for a few days. His mother has not noted him pulling any hairs off himself. He does have a very big appetite and has been screened for Prader-Willi syndrome but everything has been negative.

Vital Signs

BP: 115/40, LUE, Sitting

HR: 65 b/min Apical

Resp: 20 r/min

Temp: 97.9 F, Oral

Height: 173.4 cm; Weight: 81.1 kg; BMI: 27 kg/m2

Pain Scale: 0

Weight Percentile: 99

Height Percentile: 99

BMI Percentile: 97 [3]

Immunizations

Varicella

Hepatitis B: 13 Sept. 1995

OPV: 01 Oct. 1995

DtaP: 01 Oct. 1995

Hepatitis B: 13 Oct. 1995

MMR: 01 Oct. 1997

OPV: 01 Oct. 1997

DtaP: 01 Oct. 1997

Hepatitis B: 13 Oct. 1997

OPV: 01 June 1999

DtaP: 01 June 1999
DtaP: 01 June 2000
OPV: 01 June 2000
MMR: 01 June 2000
DtaP: 01 Sept. 2001
Tdap (Boostrix): 11 Sept. 2006
Meningo (Menactra): 05 June 2007
Hepatitis A: 05 June 2007

History

Diet: Appetite: Good. Four Food Groups: Yes
Brushes teeth: Yes. Has seen Dentist: No
PPD Screening: No
Hemoglobin Screening: Yes
Present during exam: Mother, Father

Developmental

Grade: 7th in a special class
Performance: Does very, very well, gets mostly As and Bs and thinks that most of the work in class except reading is easy
Activities/Sports: No activities
Family/Emotional Stresses: None
Drug Use: No
Alcohol Use: No
Tobacco Use: No
Sexual Orientation: Male
Sexual Activity: No
Birth Control Method: NA
STD Prevention: NA

Physical Exam

GENERAL APPEARANCE: Well-nourished. Well-developed. Obese. NAD.
HEAD: Normal shape, no signs of trauma.
EYES: PERRLA. EOM intact. Normal fundoscopic exam.
EARS: TM pearly with good landmarks. TM mobile. Canals clear.
NOSE: Normal, no runny nose
MOUTH: Normal oral mucosa
TEETH: Normal, gums healthy
NECK: Supple, no masses or lymphadenopathy
LUNGS: Clear to auscultation. Normal chest expansion.
HEART: Regular rate and rhythm. No murmurs.
ABDOMEN: Soft and non-tender. Bowel sounds present. No palpable masses or hepatosplenomegaly.
BACK: Straight
Tanner Stage: Patient would not allow me to do an examination of his external genitalia.

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