

Certified Inpatient Coding (CIC) Practice Exam (Sample)

Study Guide



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Questions

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- 1. Why is interdisciplinary collaboration important in inpatient coding?**
 - A. It reduces communication within the healthcare team**
 - B. It fosters comprehensive patient care documentation**
 - C. It limits the amount of information shared**
 - D. It streamlines billing processes**
- 2. Why is precise documentation important in inpatient psychiatric coding?**
 - A. It reduces paperwork**
 - B. It ensures accurate coding of mental health conditions**
 - C. It saves time for staff**
 - D. It acts as a legal safeguard**
- 3. Based on the principal diagnosis of *Clostridium difficile* enterocolitis, what is the appropriate MS-DRG for the patient?**
 - A. 371: Major gastrointestinal disorders w MCC**
 - B. 372: Major gastrointestinal disorders w CC**
 - C. 373: Major gastrointestinal disorders w/o CC/MCC**
 - D. 391: Esophagitis and miscellaneous digestive disorders w MCC**
- 4. Under APCs, what does status indicator C indicate?**
 - A. Ancillary service**
 - B. Inpatient only procedure**
 - C. Significant procedure, discounted**
 - D. Significant procedure, non-discounted**
- 5. What type of cancer originates from connective tissues like bone and muscles?**
 - A. Adenoma**
 - B. Sarcoma**
 - C. Lipoma**
 - D. Carcinoma**

- 6. Under the OPPS, which term refers to an item that will not receive separate payment because it is considered an integral part of another service?**
- A. Combining**
 - B. Packaging/Bundling**
 - C. Status Indicator**
 - D. Non-covered service**
- 7. In a person suffering from alcohol abuse, which molecules accumulate in the liver?**
- A. Water**
 - B. Lipids**
 - C. Protein**
 - D. Iron**
- 8. What is a requirement when coding significant procedures under the APC system?**
- A. All procedures must be performed in a hospital**
 - B. Only procedures with a discount are coded**
 - C. Procedures must align with the principal diagnosis**
 - D. Procedures unrelated to the patient's condition are included**
- 9. What specialized principle applies to coding patients treated in specific facilities?**
- A. General coding conventions apply to all cases.**
 - B. Specialized coding guidelines must be adhered to.**
 - C. Patients should not be coded for unique services.**
 - D. Coding is uniform across all healthcare settings.**
- 10. What is a key purpose of the health assessment provided by the Minimum Data Set?**
- A. To prepare for insurance claims**
 - B. To identify financial resources**
 - C. To assist in identifying health problems across multiple dimensions**
 - D. To comply with state regulations**

Answers

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

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Explanations

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1. Why is interdisciplinary collaboration important in inpatient coding?

- A. It reduces communication within the healthcare team**
- B. It fosters comprehensive patient care documentation**
- C. It limits the amount of information shared**
- D. It streamlines billing processes**

Interdisciplinary collaboration is crucial in inpatient coding because it fosters comprehensive patient care documentation. When professionals from various disciplines, such as nursing, physicians, and coding specialists, work together, they can share relevant information that contributes to a holistic view of the patient's care. This collaboration ensures that all aspects of patient treatment are accurately documented, which is essential for correct coding, billing, and compliance with regulatory standards. Accurate and thorough documentation is vital for reflecting the level of care provided and justifying the services billed. When information is gathered and communicated effectively among team members, it enhances the quality of the data used for coding, ultimately improving the accuracy of the coding process. Additionally, comprehensive documentation helps in many other aspects, including quality reporting and performance measures, which are increasingly important in the healthcare environment.

2. Why is precise documentation important in inpatient psychiatric coding?

- A. It reduces paperwork**
- B. It ensures accurate coding of mental health conditions**
- C. It saves time for staff**
- D. It acts as a legal safeguard**

Precise documentation is crucial in inpatient psychiatric coding because it ensures accurate coding of mental health conditions. Accurate coding is essential for several reasons: it allows for appropriate reimbursement from payers, ensures compliance with regulatory requirements, and provides valuable data for healthcare statistics and quality improvement. Mental health conditions can be complex and often involve co-morbid conditions that require detailed documentation to capture the full clinical picture. When documentation is clear and precise, it helps coders select the correct codes that reflect the patient's diagnosis and treatment, which is vital for proper billing and consistent patient care. In the context of the other options, while reducing paperwork, saving time for staff, and acting as a legal safeguard are all relevant benefits of good documentation practices, the most direct and critical impact of precise documentation is seen in the accuracy of coding mental health conditions. This accuracy directly influences patient care, reimbursement, and the effective management of healthcare resources.

3. Based on the principal diagnosis of Clostridium difficile enterocolitis, what is the appropriate MS-DRG for the patient?

- A. 371: Major gastrointestinal disorders w MCC**
- B. 372: Major gastrointestinal disorders w CC**
- C. 373: Major gastrointestinal disorders w/o CC/MCC**
- D. 391: Esophagitis and miscellaneous digestive disorders w MCC**

The principal diagnosis of Clostridium difficile enterocolitis is significant in determining the appropriate MS-DRG because it relates to a major gastrointestinal condition. MS-DRG assignment takes into account not only the type of diagnosis but also the presence or absence of major complications or comorbidities (MCC) and complications or comorbidities (CC). In this case, the principal diagnosis falls under the category of major gastrointestinal disorders. When determining the correct MS-DRG, it is important to note that Clostridium difficile enterocolitis is not classified as a condition that typically results in a major complication or comorbidity. Therefore, the assignment of the MS-DRG would not benefit from the inclusion of MCC or possibly even CC. Thus, the appropriate assignment would be for major gastrointestinal disorders without complications or major complications, which aligns with the characteristics of the diagnosis at hand. Option C accurately reflects this situation, as it pertains to major gastrointestinal disorders without the presence of CC or MCC, fitting the clinical scenario described.

4. Under APCs, what does status indicator C indicate?

- A. Ancillary service**
- B. Inpatient only procedure**
- C. Significant procedure, discounted**
- D. Significant procedure, non-discounted**

Status indicator C under the Ambulatory Payment Classification (APC) system is used to designate procedures that are classified as "Inpatient only." This means that the procedure is not typically provided in an outpatient setting, and it requires hospitalization for its performance. Understanding this status is crucial for accurate coding and billing, as it helps identify which procedures cannot be billed or performed on an outpatient basis. This classification impacts how health care facilities plan and manage their services, ensuring that inpatient and outpatient resources are allocated appropriately. Procedures marked with status indicator C must meet specific clinical criteria that necessitate inpatient care, making it essential for coders to recognize these designations during the coding process. The other options, while related to the classification of services and procedures, do not apply to the definition of status indicator C as it strictly pertains to procedures that are reserved for inpatient care only.

5. What type of cancer originates from connective tissues like bone and muscles?

- A. Adenoma**
- B. Sarcoma**
- C. Lipoma**
- D. Carcinoma**

Sarcoma is the correct choice because it specifically refers to a type of cancer that arises from connective tissues, such as bone, cartilage, fat, muscle, and blood vessels. This classification is critical in understanding cancer types, as sarcomas differ from other forms of cancer, namely carcinomas, which originate from epithelial tissues. To provide some context, adenomas are benign tumors that arise from epithelial tissue, and while they can develop in glandular structures, they are not classified as cancers, as they are typically not malignant. Lipomas are benign tumors specifically made up of adipose (fat) tissue and are also not malignant, thus further distinguishing them from sarcomas. Lastly, carcinomas are a broader category that includes cancers derived from epithelial cells, including those of the skin and lining of organs, which do not originate from the connective tissues that sarcomas do. Understanding these distinctions is crucial for accurate coding and classification of different cancer types within the field of medical coding.

6. Under the OPPS, which term refers to an item that will not receive separate payment because it is considered an integral part of another service?

- A. Combining**
- B. Packaging/Bundling**
- C. Status Indicator**
- D. Non-covered service**

The term that indicates an item not receiving separate payment because it is regarded as an integral part of another service is packaging or bundling. In the context of the Outpatient Prospective Payment System (OPPS), services and items that are clinically related may be grouped together, and payment is made for the entire package rather than for each individual component. This approach is designed to streamline billing and ensure that providers are compensated fairly for comprehensive care, rather than for each individual service rendered. Bundling promotes efficiency in healthcare delivery by encouraging providers to deliver more integrated services, which can lead to better patient outcomes. It also helps to minimize unnecessary procedures and assessments that might arise if each component was billed separately. This concept also serves to simplify the reimbursement process, aligning it with the overall goal of cost containment in the healthcare system. Options like combining, status indicator, and non-covered service do not encapsulate this specific concept. Combining suggests a different aspect of integration that doesn't directly refer to payment methodologies. Status indicators are used to define payment rules and impact how services are billed, while non-covered services refer to items that are not eligible for reimbursement at all, rather than those bundled with covered services.

7. In a person suffering from alcohol abuse, which molecules accumulate in the liver?

- A. Water**
- B. Lipids**
- C. Protein**
- D. Iron**

In individuals suffering from alcohol abuse, the liver frequently experiences lipid accumulation, a condition known as fatty liver disease or hepatic steatosis. This occurs because excessive alcohol consumption disrupts the normal metabolism of lipids in the liver. When alcohol is metabolized, it leads to the production of acetaldehyde and other byproducts that affect mitochondrial function, which in turn impairs the oxidation of fatty acids. Concurrently, alcohol increases the synthesis of fatty acids and triglycerides while simultaneously inhibiting their export from the liver. As a result, triglycerides build up within the liver cells, leading to an accumulation of lipids. This condition can have significant implications for liver health, potentially leading to more severe forms of liver disease such as alcoholic hepatitis or cirrhosis if the alcohol abuse continues. The presence of excess water, protein accumulation, or iron does not typically correlate directly with the biological processes induced by alcohol consumption in the same way that lipid accumulation does. In this context, lipid accumulation is the most relevant and accurate response to the question regarding what accumulates in the liver due to alcohol abuse.

8. What is a requirement when coding significant procedures under the APC system?

- A. All procedures must be performed in a hospital**
- B. Only procedures with a discount are coded**
- C. Procedures must align with the principal diagnosis**
- D. Procedures unrelated to the patient's condition are included**

When coding significant procedures under the Ambulatory Payment Classification (APC) system, it is essential that procedures align with the principal diagnosis. This means that the procedures performed should be directly related to the primary reason for the patient's admission or treatment. Proper alignment ensures that the coding accurately reflects the medical necessity of the services provided, which is crucial for compliance and appropriate reimbursement under Medicare and other payers. This alignment helps in capturing the complexity and severity of the patient's condition accurately, allowing healthcare providers to demonstrate the need for the services rendered. When coding, it's vital to have clear documentation linking the procedures to the diagnosis, as this will support the claim during audits or reviews. Other choices do not reflect the core requirement when coding under the APC system. For example, while procedures must be performed in a clinical setting, not all significant procedures require a hospital setting, nor are discounts a determining factor for coding. Additionally, unrelated procedures wouldn't be considered for coding if they do not connect to the principal diagnosis, as this would undermine the intent of coding for medical necessity.

9. What specialized principle applies to coding patients treated in specific facilities?

- A. General coding conventions apply to all cases.**
- B. Specialized coding guidelines must be adhered to.**
- C. Patients should not be coded for unique services.**
- D. Coding is uniform across all healthcare settings.**

Specialized coding guidelines are critical in accurately coding patients treated in specific facilities, such as hospitals, outpatient centers, or specialty clinics. These specialized guidelines account for the unique services and procedures offered in these environments, which often differ from general healthcare practices. For instance, a procedure performed in a hospital may have specific coding requirements that reflect the complexity and nature of care provided, including any unique diagnostic or treatment protocols that are not applicable in other settings. Adhering to these specialized guidelines ensures compliance with coding standards for reimbursement and reporting purposes, while also capturing the full complexity and variety of services rendered to each patient. The unique characteristics of each setting, including the types of patients treated and the resources utilized, necessitate these distinct coding rules to maintain accuracy in clinical documentation and facilitate proper billing processes. In contrast, the notion that general coding conventions apply to all cases, or that coding is uniform across all healthcare settings, overlooks the nuances that specialized facilities have, which are vital for effective and accurate patient care documentation.

10. What is a key purpose of the health assessment provided by the Minimum Data Set?

- A. To prepare for insurance claims**
- B. To identify financial resources**
- C. To assist in identifying health problems across multiple dimensions**
- D. To comply with state regulations**

The key purpose of the health assessment provided by the Minimum Data Set (MDS) is to assist in identifying health problems across multiple dimensions. The MDS is a comprehensive assessment tool used primarily in long-term care settings, and it enables healthcare providers to evaluate residents' medical, psychological, and social functioning. This multidimensional assessment captures a wide range of information about a patient's health status, which is critical for developing individualized care plans. By utilizing this comprehensive approach, healthcare teams can identify specific health issues that may require intervention, monitor changes in health over time, and facilitate the planning of appropriate care strategies. Recognizing health problems across various dimensions allows for a holistic view of the patient's needs and supports better clinical outcomes. While aspects such as preparing for insurance claims, identifying financial resources, and complying with state regulations can be related to the MDS in various ways, the primary focus is on health assessments and their role in enhancing patient care.