# Certified Inpatient Coding (CIC) Practice Exam (Sample)

## Study Guide



BY EXAMZIFY

**Everything you need from our exam experts!**

# Table of Contents

# 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. **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.

2. **Which of the following activities is NOT part of the OIG's functions in healthcare?**

   A. Excluding individuals from Medicare participation

   B. Monitoring Corporate Integrity Agreements

   C. Suing facilities for malpractice

   D. Assessing civil monetary penalties

3. **What is the role of the coding professional regarding medical necessity?**

   A. To question the treatment options provided to the patient

   B. To ensure the coded diagnoses and procedures reflect care that is medically necessary

   C. To focus solely on administrative tasks and billing

   D. To document patient complaints without regard to coding

4. **What is a key benefit of conducting audits on coding practices?**

   A. Audits reduce the number of coded records.

   B. Audits help identify coding inaccuracies.

   C. Audits ensure quicker payment processing.

   D. Audits eliminate the need for coding guidelines.

5. **Which POA indicator would be assigned for an allergic reaction that develops during outpatient surgery?**

   A. Y

   B. N

   C. W

   D. U

6. What should be done if a coder identifies incomplete documentation?

   A. Proceed to code based on assumptions

   B. Consult with clinical staff to obtain clarification

   C. Ignore the missing information

   D. Wait until the case is reviewed

7. In terms of coding, what does MS-DRG stand for?

   A. Medical Surgical Diagnosis Review Group

   B. Medicare Severity-Diagnosis Related Group

   C. Medical Services-Disease Reference Group

   D. Management and Surgical Diagnosis Review Group

8. How often should a thorough chargemaster review be conducted?

   A. Daily

   B. Every 10 years

   C. Never

   D. Annually

9. How do accurate clinical pathways impact reimbursement for healthcare services?

   A. They have no effect on reimbursement.

   B. They ensure correct coding for services provided.

   C. They can delay payment processing.

   D. They primarily benefit administrative staff.

10. How many Major Diagnostic Categories (MDCs) are recognized in the MS-DRG system?

    A. 40

    B. 17

    C. 20

    D. 25

# Answers

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

# **Explanations**

1. **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.

2. **Which of the following activities is NOT part of the OIG's functions in healthcare?**

   A. Excluding individuals from Medicare participation

   B. Monitoring Corporate Integrity Agreements

   **C. Suing facilities for malpractice**

   D. Assessing civil monetary penalties

The correct answer is based on the primary responsibilities of the Office of Inspector General (OIG) within the healthcare sector. OIG's functions are designed to protect the integrity of federal healthcare programs, promote efficiency, and deter fraud and abuse. Excluding individuals from Medicare participation, monitoring Corporate Integrity Agreements, and assessing civil monetary penalties are all actions aligned with the mission of the OIG. For instance, the OIG has the authority to exclude individuals or entities from participating in Medicare due to various offenses, aligning with their mission to protect the integrity of the healthcare system. Monitoring Corporate Integrity Agreements ensures that organizations comply with applicable laws and regulations following identified violations or misconduct. Additionally, the OIG can impose civil monetary penalties on entities that violate healthcare laws, further emphasizing their role in maintaining compliance and accountability in healthcare practices. In contrast, suing facilities for malpractice does not fall under the OIG's responsibilities. Malpractice suits are generally matters for private legal action or state regulatory bodies rather than being within the scope of OIG's enforcement functions. Therefore, the activity of suing facilities for malpractice is clearly separate from the OIG's designated roles, which focus more on regulatory oversight and enforcement against fraud and abuse in federal healthcare programs.

## 3. What is the role of the coding professional regarding medical necessity?

**A. To question the treatment options provided to the patient**

**B. To ensure the coded diagnoses and procedures reflect care that is medically necessary**

**C. To focus solely on administrative tasks and billing**

**D. To document patient complaints without regard to coding**

The role of the coding professional regarding medical necessity is centered on ensuring that the coded diagnoses and procedures accurately represent the care that is medically necessary for the patient. Medical necessity is a key concept in healthcare that determines whether services are appropriate and necessary for the diagnosis or treatment of a condition. Coding professionals must have a thorough understanding of clinical documentation and guidelines related to medical necessity to ensure compliance with payer policies. This ensures that claims are supported by adequate documentation that reflects the rationale behind the medical services provided. By focusing on this responsibility, coding professionals help to prevent errors in coding that could lead to claim denials or issues with reimbursement, while also supporting the overall quality of care delivered to patients. They bridge the gap between healthcare services rendered and proper representation in the medical record, ensuring that the information used for billing and reporting purposes is both accurate and justifiable based on clinical necessity. This role is vital in maintaining the integrity of healthcare documentation and ensuring that healthcare providers receive appropriate compensation for their services.

## 4. What is a key benefit of conducting audits on coding practices?

**A. Audits reduce the number of coded records.**

**B. Audits help identify coding inaccuracies.**

**C. Audits ensure quicker payment processing.**

**D. Audits eliminate the need for coding guidelines.**

Conducting audits on coding practices serves the essential function of identifying coding inaccuracies. This process involves a thorough review of coded records to ensure that codes are correctly applied according to established guidelines. By highlighting errors or discrepancies, audits facilitate the opportunity for education and improvement among coding staff, which can lead to more accurate documentation and coding in the future. Moreover, identifying inaccuracies can significantly impact overall patient care, reimbursement processes, and compliance with regulations. Effective audits not only enhance the quality of coding but also help health facilities maintain their integrity and financial viability by reducing the risk of denials or penalties arising from incorrect coding practices.

## 5. Which POA indicator would be assigned for an allergic reaction that develops during outpatient surgery?

**A. Y**

B. N

C. W

D. U

The correct POA (Present on Admission) indicator for an allergic reaction that develops during outpatient surgery is denoted by the indicator 'Y'. This designation specifically indicates that the condition was present at the time of admission to a healthcare facility. In the context of outpatient surgery, even though the procedure is not performed in an inpatient setting, the allergic reaction occurs during the period of surgical care, effectively classifying it as a condition that emerged while the patient was under medical supervision. Using the 'Y' indicator communicates that the allergic reaction was not pre-existing before the surgery but rather arose as a direct result of the intervention. This distinction is crucial for accurate coding and for understanding the administrative implications regarding healthcare quality and patient care. The other indicators—such as 'N,' which indicates that the condition was not present at the time of admission, or 'W' and 'U,' which pertain to specific exceptions or unclear cases—would not be appropriate in this scenario, as they do not accurately capture the timing and context of the allergic reaction's onset related to the outpatient surgical event.

## 6. What should be done if a coder identifies incomplete documentation?

A. Proceed to code based on assumptions

**B. Consult with clinical staff to obtain clarification**

C. Ignore the missing information

D. Wait until the case is reviewed

When a coder encounters incomplete documentation, the most appropriate course of action is to consult with clinical staff to obtain clarification. This approach ensures that the coder gathers accurate, complete, and reliable information to ensure proper coding. Incomplete documentation can lead to misunderstandings about the patient's condition, the course of treatment, and the services rendered, which can ultimately affect reimbursement and compliance. By seeking clarification from clinical staff, the coder can make informed decisions based on accurate information, reducing the risk of errors that could arise from coding based on assumptions or incomplete documentation. This not only enhances the quality of the coding process but also contributes to better patient records and reporting. In contrast, proceeding to code based on assumptions could lead to inaccurately coded data, which may have significant financial and legal implications. Ignoring the missing information is not advisable, as it would compromise the integrity of the coding, potentially leading to audits or compliance issues. Waiting until the case is reviewed may delay the coding process unnecessarily and may not address the underlying issue of incomplete documentation. Therefore, seeking clarification is the best proactive approach to ensure accuracy in coding.

## 7. In terms of coding, what does MS-DRG stand for?

A. Medical Surgical Diagnosis Review Group

**B. Medicare Severity-Diagnosis Related Group**

C. Medical Services-Disease Reference Group

D. Management and Surgical Diagnosis Review Group

The correct answer, Medicare Severity-Diagnosis Related Group, refers to a classification system used in healthcare for inpatient hospital reimbursement. It categorizes hospital cases into groups expected to have similar hospital resource use, which helps in determining the amount of reimbursement a hospital will receive for the services provided to patients.   This classification is essential for quality control, healthcare planning, and ensuring that hospitals are adequately compensated for their services. The inclusion of "Medicare Severity" indicates that it takes into account the severity of a patient's condition, improving the accuracy of the reimbursement process by reflecting differences in hospital resource utilization based on the severity level of the diagnosis. The other options presented do not accurately describe the MS-DRG system. They either mislabel the structure or focus on aspects not recognized in the official terminology used by Medicare for inpatient hospital payment policy.

## 8. How often should a thorough chargemaster review be conducted?

A. Daily

B. Every 10 years

C. Never

**D. Annually**

Conducting a thorough chargemaster review on an annual basis is essential for several reasons. Chargemasters are comprehensive lists of items billable to a hospital or healthcare facility's customers, and they play a critical role in the revenue cycle. Regular reviews help ensure compliance with regulations, accurate coding and billing, and the incorporation of any changes in pricing or services.  By performing an annual review, healthcare facilities can assess the chargemaster for updates necessary due to changes in healthcare regulations, coding guidelines, technological advancements, or shifts in operational practices. This frequency not only helps maintain accuracy in billing and coding, reducing the risk of revenue loss or compliance issues, but also enhances the facility's overall financial health and operational efficiency. Frequent updates also facilitate adaptation to the evolving landscape of healthcare services, ensuring the chargemaster mirrors current practices and pricing models.   In contrast, options such as conducting reviews daily, every 10 years, or never would not provide the necessary balance of oversight and adaptability that is vital in effectively managing a chargemaster. Daily reviews could overwhelm staff and lead to decreased efficiency, while infrequent reviews could result in significant compliance risks and inaccuracies in billing.

## 9. How do accurate clinical pathways impact reimbursement for healthcare services?

A. They have no effect on reimbursement.

**B. They ensure correct coding for services provided.**

C. They can delay payment processing.

D. They primarily benefit administrative staff.

Accurate clinical pathways play a critical role in ensuring correct coding for services provided, which directly influences reimbursement for healthcare services. Clinical pathways outline standardized protocols for patient care, detailing procedures, diagnoses, and treatment plans. When these pathways are followed accurately, they help coders assign the appropriate codes for diagnoses and procedures in alignment with established clinical guidelines. This leads to precise documentation, which is essential for justifying claims submitted to payers. In addition to enhancing coding accuracy, clinical pathways promote consistent and efficient documentation practices. This ensures that all required information is readily available for billing purposes, reducing the likelihood of claim denials or delays that can arise from improperly coded services. As a result, healthcare providers can secure timely reimbursement based on the services rendered, reflecting the true nature of the care provided. While the other options touch upon relevant topics, they do not accurately capture the significant impact of clinical pathways on the coding process and subsequent reimbursement. The idea that clinical pathways have no effect on reimbursement overlooks their vital role in coding accuracy. Suggesting they delay payment processing misrepresents their purpose, which is to streamline and support accuracy in billing. The notion that they primarily benefit administrative staff disregards the broader implications for patient care and financial sustainability for healthcare organizations.

## 10. How many Major Diagnostic Categories (MDCs) are recognized in the MS-DRG system?

A. 40

B. 17

C. 20

**D. 25**

The Major Diagnostic Categories (MDCs) in the Medicare Severity Diagnosis Related Group (MS-DRG) system serve as a method for classifying inpatient hospital cases into groups that are expected to have similar hospital resource use. There are a total of 25 recognized MDCs in this classification system. Each MDC encompasses a variety of related conditions and guidelines to facilitate appropriate reimbursement and management of patient care, aiding in determining payment rates that correlate with the type of treatment provided. Understanding the number of MDCs is crucial for healthcare professionals as it directly influences coding accuracy, billing, and the overall financial operations within healthcare facilities. As coders and healthcare providers navigate the intricacies of patient care documentation and DRG assignment, they need to be aware of how these categories are structured and the implications they have on their healthcare practice.

# 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://certifiedinpatientcoding.examzify.com

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