



श्री चित्रा तिरुनाल आयुर्विज्ञान और प्रौद्योगिकी संस्थान, त्रिवेंद्रम, तिरुवनन्तपुरम - 695 011, केरल, भारत
SREE CHITRA TIRUNAL INSTITUTE FOR MEDICAL SCIENCES AND TECHNOLOGY, TRIVANDRUM

THIRUVANANTHAPURAM - 695 011, KERALA, INDIA

(एक राष्ट्रीय महत्त्व का संस्थान, विज्ञान एवं प्रौद्योगिकी विभाग, भारत सरकार)

(An Institution of National Importance, Department of Science and Technology, Government of India)

टेलीफोन नं./Telephone No.: 0471-2443152 फैक्स/Fax: 0471-2446433, 2550728

ई-मेल/E-mail: sct@sctimst.ac.in वेबसाइट/Website: www.sctimst.ac.in

ROLL NUMBER

**WRITTEN TEST FOR THE POST OF
MEDICAL RECORDS ASSISTANT - A to B**

DATE: 24/09/2026

TIME: 10:00 AM to 11:00 AM

DURATION: 60 MINUTES

Total Marks: 50

INSTRUCTIONS TO THE CANDIDATES

1. Write your Roll Number on the top of the Question Booklet and in the answer sheet.
2. Each question carries 1 mark.
3. There will not be any Negative Marking.
4. Write legibly the alphabet of the most appropriate answer (A, B, C or D) in the separate answer sheet provided.
5. Over-writing is not permitted.
6. Candidate should sign in the question paper and answer sheet.
7. No clarifications will be given.
8. Candidate should hand over the answer sheet to the invigilator before leaving the examination hall.

Signature of the Candidate



श्री चित्रातिरुनालआयुर्विज्ञानऔरप्रौद्योगिकीसंस्थान, त्रिवेन्द्रम, केरल- 695 011
(एकराष्ट्रीयमहत्त्वकासंस्थान, विज्ञानएवंप्रौद्योगिकीविभाग, भारतसरकार)
SREE CHITRA TIRUNAL INSTITUTE FOR MEDICAL SCIENCES AND TECHNOLOGY, TRIVANDRUM
KERALA – 695 011

(An Institution of National Importance, Department of Science and Technology, Govt. of India)

ई-मेल/E-mail : sct@sctimst.ac.in वेबसाइट/ Website : www.sctimst.ac.in

1st MFCP September 2026 एमएफसीपी सितंबर 2026

Duration: 60 minutes

Post: Medical Records Assistant A to B

Max. Marks: 50

अवधि: 60 मिनट

Department: Medical Records

अधिकतम अंक: 50

Select the most appropriate answer. सबसे उपयुक्त उत्तर का चयन करें

(There are **no negative** marks for wrong answers) गलत उत्तरों के लिए कोई नकारात्मक अंक नहीं हैं

1	The Ayushman Bharat Digital Mission (ABDM) primarily aims to provide each citizen with a unique digital health identifier to:
a	Enable healthcare institutions to maintain a centralized record of all patients
b	Establish a single national database in which all clinical records are permanently stored
c	Enable a longitudinal, interoperable digital health record
d	Create a centralized repository containing the complete medical history of every citizen
2	The application of Artificial Intelligence/Natural Language Processing to automatically suggest ICD codes from free-text physician documentation is known as:
a	Computer-Assisted Clinical Documentation
b	Computer-Assisted Coding
c	Electronic Medical Record Indexing
d	Rule-Based Medical Record Abstraction
3	The ethical/legal principle that a MRD staff must not disclose patient information to unauthorized persons without consent is known as:
a	Non-maleficance
b	Confidentiality
c	Professional Autonomy
d	Information Governance
4	Maintaining a separate register/log to track scheme-wise (e.g., ESI, CGHS, PMJAY) patient beneficiaries and their claim status primarily supports:
a	Elimination of the Master Patient Index
b	Standardization of clinical treatment protocols
c	Effective monitoring & reconciliation
d	Standardization of statutory reporting
5	Under Ayushman Bharat-PMJAY, if a patient is eligible but the treating package selected does not match the actual procedure performed, the consequence most likely shall be:
a	The claim will be automatically approved because the beneficiary is eligible
b	The hospital may immediately report to State Anti-Fraud Unit (SAFU)
c	The hospital can retain the package amount if the procedure is clinically related
d	The claim may be queried, rejected, or subject to deduction
6	A medical record flagged as 'deficient' because the discharge summary is present but lacks the attending physician's signature would be identified through which type of review?
a	Quantitative analysis
b	Peer review analysis
c	Clinical audit review
d	Qualitative analysis

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7	A disaster recovery plan for an EDMS storing medical records should primarily ensure:	
	a	Continuous expansion of digital storage capacity
	b	Paper originals are destroyed immediately after scanning with no verification
	c	Replacement of paper records with electronic records within a defined period
	d	Redundant, geographically separated backups with recovery procedure
8	In an EDMS used for medical records, 'version control' primarily ensures that:	
	a	All users can modify the same document simultaneously without tracking changes
	b	Only the latest version of a document can ever be viewed, with prior versions permanently deleted
	c	A complete, auditable history of all document revisions is preserved
	d	Documents cannot be scanned more than once
9	A claim denied by an insurer specifically because the diagnosis code submitted does not support the medical necessity of the billed procedure reflects the importance of:	
	a	Accurate clinical documentation
	b	Coding the principal diagnosis regardless of the procedure performed
	c	Using the procedure code as the primary basis for determining the patient's diagnosis
	d	Patient identification and MPI management
10	A Centralized Admitting Department, as opposed to ward-level admission, is primarily designed to:	
	a	Allow each ward to independently assign its own patient numbers
	b	Standardize bed allocation, registration, and record initiation
	c	Eliminate the need for individual patient identification and medical record numbers
	d	Allow each clinical department to independently manage admission procedures
11	A patient transferred from the ICU to a general ward requires which specific documentation to ensure continuity of care during transfer?	
	a	Completed pre-induction and post-induction checklists
	b	No documentation is required for internal transfers
	c	A transfer note/summary detailing condition
	d	Only a change in the billing code
12	In ICD-10-PCS/CPT-style procedure coding, when a patient undergoes both a diagnostic and a subsequent definitive therapeutic procedure in the same encounter for the same condition, coding convention generally requires:	
	a	Coding the definitive therapeutic procedure when the diagnostic procedure is integral to or replaced by the definitive procedure.
	b	Coding only the diagnostic procedure because it was performed first
	c	Coding whichever procedure has the higher relative value or reimbursement
	d	Coding both procedures automatically, regardless of whether the diagnostic procedure is separately reportable.

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13	A Medical coder assigns a code for 'diabetes mellitus, unspecified' when the physician documentation clearly states 'Type 2 Diabetes Mellitus'. This is an example of:	
	a	Under-coding due to failure to use available clinical specificity
	b	Up-coding based on unsupported clinical documentation
	c	Appropriate use of an unspecified code when the diagnosis is documented
	d	Over-coding caused by assigning a code with excessive clinical specificity
14	Before destruction of medical records that have exceeded their retention period, the medical records department must FIRST ensure that:	
	a	The patient has been informed that all records are converted into electronic format.
	b	The physical records are destroyed immediately once the retention period expires.
	c	The records are removed from the hospital information system by the IT department.
	d	The records are reviewed and confirmed as eligible for destruction as per policy.
15	If a hospital or patient believes a subpoena seeking medical records is legally improper, the appropriate legal mechanism to challenge it is generally a —	
	a	Verbal refusal with no documentation
	b	Motion for protective order
	c	Petition for judicial review
	d	Motion to quash
16	“Semantic interoperability” refers to systems exchanging data such that —	
	a	Only the file transfers successfully, with no shared meaning
	b	Data is exchanged only in image format
	c	The meaning of the exchanged data is consistently understood by both systems
	d	Data are transferred automatically without requiring user authentication
17	SNOMED-CT differs fundamentally from ICD-10 in that SNOMED-CT is primarily a:	
	a	Billing and reimbursement classification
	b	Mortality and Morbidity classification
	c	Drug formulary Nomenclature
	d	Clinical reference terminology
18	When a discharge diagnosis states 'Type 2 Diabetes Mellitus with diabetic nephropathy', correct ICD-10 coding practice requires:	
	a	Assigning separate unrelated codes for diabetes mellitus and nephropathy without establishing their documented relationship.
	b	Assigning the appropriate combination diabetes with nephropathy code and an additional code to identify the specific renal manifestation.
	c	Assigning only the code for Type 2 Diabetes Mellitus because the nephropathy is a complication.
	d	Assigning only the code for diabetic nephropathy because it represents the more severe condition.
19	An access request is denied because the requested records include another patient's information mixed into the same chart entry. The MRD professional should —	
	a	Release the entire entry because the requesting patient has a right to access their own record
	b	Review the entry, segregate or redact the third-party information where feasible and release the requester's information
	c	Permanently withhold the entire medical record because the entry contains third-party information
	d	Release the entry after verbally informing the requester that another patient's information is included

20	A fetus after 28 weeks of gestation, born with no signs of life is correctly recorded in hospital statistics as a:	
	a	Live birth
	b	Maternal death
	c	Neonatal death
	d	Stillbirth
21	In a centralized Medical Records Department, the single most cited operational advantage over a decentralized model is:	
	a	Reduced need for trained medical record staff
	b	Faster access at each individual outpatient clinic
	c	Uniform record-keeping standards and a single complete patient record
	d	Lower initial capital cost of storage racks
22	Which document within the medical record is legally considered the physician's authorization for a specific surgical or invasive procedure after risks have been explained to the patient?	
	a	Informed consent form
	b	Pre-operative assessment sheet
	c	Surgical safety checklist
	d	Physician's progress note
23	An MRD audit reveals that several access requests were completed well beyond the policy-defined response window with no documented reason. The appropriate corrective action is to —	
	a	Close the audit finding because the requests were eventually completed
	b	Initiate corrective action by identifying the cause and documenting the findings
	c	Extend the response window retrospectively to accommodate the delays
	d	Require all future access requests to be approved by the HOD\ before processing
24	Under the DPDP Rules, 2025, a personal data breach must generally be reported to the Data Protection Board within —	
	a	72 hours
	b	7 days
	c	30 days
	d	90 days
25	A patient's request that specific information not be disclosed to a particular party or for a particular purpose relates to the right to —	
	a	Confidentiality
	b	Informed decision making
	c	Access medical records
	d	Privacy

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26	A minor patient requests that records related to a sensitive health matter not be shared with his parents, citing applicable confidentiality provisions, the MRD professional should :	
	a	Release the records to the parents as minors cannot exercise confidentiality rights as per the DPDP rules of 2025.
	b	Verify the applicable law, the minor's legal rights and the circumstances before deciding on disclosure.
	c	Release the records only after obtaining written consent from the treating physician.
	d	Withhold the records automatically because the minor has expressly objected to disclosure.
27	A patient with documented cognitive impairment approaches the Medical Records Department (MRD) and requests release of his/her medical records to a third party by signing an authorization form. What should the MRD do before processing the request?	
	a	Verify the patient's capacity to provide authorization for the specific disclosure by qualified clinical staff
	b	Decline the request because documented cognitive impairment establishes that the patient lacks capacity to authorize disclosure
	c	Obtain authorization from the patient's nearest family member rather than from the patient
	d	Process the request based solely on the patient's signature, since the patient has personally submitted the authorization
28	A Medical coding officer is asked whether reimbursement considerations should ever override official coding guidelines. The correct answer is —	
	a	Yes - Only for high-value claims, guidelines be set aside
	b	No - Official coding guidelines should always be followed
	c	Yes - When a higher-paying code is clinically reasonable
	d	No - When the insurer's reimbursement is otherwise inadequate
29	The etiology/manifestation coding convention generally requires that —	
	a	Only the underlying disease ever needs to be coded
	b	The manifestation be coded first, followed by the underlying disease
	c	The underlying disease be coded first, followed by the manifestation code
	d	The underlying condition and manifestation be coded independently
30	A researcher-clinician at the hospital asks whether standard clinical consent documentation is sufficient for a research study involving the same patients. The MRD professional should advise that —	
	a	Research consent is identical in every respect to routine treatment consent
	b	No additional consent is required if the researcher is the patient's treating physician
	c	No additional consent process is needed for research participation
	d	Research participation generally requires its own specific informed consent
31	Reviewing and resolving duplicate patient records in a Master Patient Index (MPI) is a common example of —	
	a	Data mining
	b	Data Fiduciary
	c	Data stewardship
	d	Data custodianship
32	When two conditions are, as per coding guidelines, equally responsible for occasioning an admission and either may be sequenced first, this reflects —	
	a	A specific tie-breaker rule addressed in the official coding guidelines
	b	A manifestation that must be sequenced before its underlying etiology
	c	A secondary diagnosis that affects the treatment plan but not the admission
	d	A principal diagnosis that must always be selected based on the higher resource utilization

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33	A persistently low BOR most directly suggests —	
	a	Excessive average length of stay among admitted patients
	b	Underutilization of available inpatient bed capacity
	c	Prolonged utilization of beds by fewer patients
	d	High turnover of occupied beds
34	A signed authorization is found to be missing the required expiration element, although everything else appears complete. The MRD professional's most defensible approach is to	
	a	Process the request because the authorization is signed and otherwise complete
	b	Assign an administrative expiration date based on the date of signature
	c	Process the request but document the missing element for future correction
	d	Withhold release until a valid authorization containing the required expiration element is obtained
35	By convention, a patient admitted and discharged on the same calendar day is typically counted, for length-of-stay purposes, as —	
	a	Zero inpatient days, because admission and discharge occurred on the same date
	b	One inpatient day, regardless of the number of hours the patient remained admitted
	c	The exact number of hours of stay converted into a fraction of an inpatient day
	d	Excluded from statistics entirely because of midnight census methodology
36	The standard "direct" formula for BTR is —	
	a	$\text{Total discharges (including deaths)} \div \text{Average bed complement}$
	b	$\text{Total patient days} \div \text{Available beds}$
	c	$\text{Total admissions (including births)} \div \text{Total available bed-days} \times 100$
	d	$\text{Average length of stay} \div \text{Bed occupancy rate} \times 100$
37	A patient wants to know exactly what categories of their personal data the hospital holds and for what purposes, without requesting any changes. This corresponds most closely to their DPDP Act; is —	
	a	Right to correction and erasure of personal data
	b	Right to grievance redressal
	c	Right to information about personal data
	d	Right to nominate
38	A very short or near-zero turnover interval generally indicates —	
	a	Prolonged inpatient stays resulting in delayed bed availability
	b	Beds are almost immediately reoccupied
	c	Excess inpatient capacity relative to the volume of admissions
	d	Low bed turnover caused by prolonged intervals between patient discharge and subsequent admission
39	A region records 10,000 live births and 50 neonatal deaths in a year. The NMR is —	
	a	500 per 1000 live births
	b	50 per 1000 live births
	c	0.5 per 1000 live births
	d	5 per 1000 live births
40	For a chronic disease with a long duration but a relatively low rate of new cases, prevalence tends to be —	
	a	Relatively high
	b	Equal to the incidence rate
	c	Very low, regardless of duration
	d	Always equal to incidence

41	A 72-year-old woman with long-standing hypertension suffers an acute ischemic stroke. She develops severe dysphagia, followed by aspiration pneumonia and respiratory failure. Despite treatment, she died in the hospital. Which condition should be mentioned as the <i>antecedent cause of death</i> while completing the MCCD form online as per mortality coding guidelines?	
	a	Acute ischemic stroke
	b	Respiratory failure
	c	Aspiration pneumonia
	d	Hypertension
42	From Medical records documentation point of view, the WHO Surgical Safety Checklist, including a "time-out" procedure before surgery, exists specifically to help prevent —	
	a	Wrong-site, wrong-patient, or wrong-procedure
	b	Postoperative wound infections and prolonged hospital stay
	c	Documenting postoperative recovery criteria
	d	Medication errors occurring after discharge
43	In hospital documentation, "STAT" in a clinical order generally means —	
	a	To be carried out at the next routine scheduled time
	b	To be carried out immediately or without delay
	c	To be performed only after approval from the department head
	d	To be repeated at regular intervals until discontinued
44	ICD-11 (the WHO's 11th revision of the International Classification of Diseases) was formally adopted by the World Health Assembly in —	
	a	2022
	b	2019
	c	2017
	d	2015
45	Unlike ICD-10, ICD-11 introduced a dedicated chapter for —	
	a	Health conditions associated with environmental and occupational exposures
	b	Disorders related to complementary and alternative healthcare interventions
	c	Symptoms and clinical findings associated with traditional therapeutic practices
	d	Conditions related to sexual health
46	India's national digital health record initiative, launched in September 2021, is known as the:	
	a	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
	b	National Digital Health Mission
	c	Ayushman Bharat Digital Mission
	d	Digital Personal Data Protection Act
47	Kerala's flagship state digital health initiative, e-Health Kerala, rolled out to provide citizens with a centralised, Aadhaar-based healthcare record system was officially launched in the year —	
	a	2017
	b	2018
	c	2019
	d	2020
48	Laterality coding in ICD-10-CM allows specification of —	
	a	The anatomical depth and severity of a condition
	b	The chronological stage and duration of a condition
	c	The side of the body affected

	d	The primary and secondary causes of a condition
49		CPT Category II codes typically end in the letter —
	a	X
	b	Z
	c	F
	d	T
50		In Current Procedure Terminology, Modifier -50 typically indicates —
	a	A procedure performed during a postoperative period
	b	A procedure performed more than once during the same encounter
	c	A procedure performed by an assistant surgeon
	d	A bilateral procedure performed on both sides of the body

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ANSWER KEY

Name of Post: Medical Record Assistant A to B
Department: Medical Records Department

Q No.	Choice	Q No.	Choice
1	C	26	B
2	B	27	A
3	B	28	B
4	C	29	C
5	D	30	D
6	A	31	C
7	D	32	A
8	C	33	B
9	A	34	D
10	B	35	B
11	C	36	A
12	A	37	C
13	A	38	B
14	D	39	D
15	D	40	A
16	C	41	C
17	D	42	A
18	B	43	B
19	B	44	B
20	D	45	D
21	C	46	C
22	A	47	A
23	B	48	C
24	A	49	C
25	D	50	D

