SREE CHITRA TIRUNAL INSTITUTE FOR MEDICAL SCIENCES & TECHNOLOGY
THIRUVANANTHAPURAM—695 011, INDIA.
(An Institute of National Importance under Govt.of India)
Phone—(91)0471—2443152 Fax—(91)0471—2446433, 2550728
Email-sct@sctimst.ac.in Web site—www.sctimst.ac.in

ROLL NUMBER

WRITTEN TEST FOR THE POST OF MEDICAL RECORDS ASSISTANT – A TO B

DATE: 25.03.2026 **Time: 10 To 11 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

1st MFCP- Medical Records Assistant A to B

1	'Outguide' in a physical medical records filing system is used to:	
	a	Guide new patients to the registration counter
	b	Mark the location of a record that has been removed from the file shelves
	c	Separate active from inactive (purged) records on the shelf
	d	Index the contents of a voluminous record exceeding 100 pages
2	The 'Master Patient Index' (MPI) is best defined as:	
	a	A list of all admitted patients currently in the hospital
	b	A register maintained by the MRD for bed management
	c	A financial record of all patient billing transactions
	d	A permanent database of every patient registered
3	'Bed Turnover Rate' as a hospital statistic is calculated using the formula:	
	a	Number of admissions ÷ Number of beds × 100
	b	Total discharges (including deaths) ÷ Average beds available during the period
	c	Average length of stay × Bed occupancy rate
	d	Total discharges (including deaths) ÷ Average beds available during the period
4	In hospital admission records, the term 'Transfer In' specifically refers to:	
	a	A patient transferred from the emergency department to a ward within the same hospital
	b	A patient moving from one ward to another within the same hospital
	c	A patient admitted from another hospital or healthcare facility to the current hospital
	d	Readmission of a patient within 30 days of previous discharge
5	Under the Pre-conception and Pre-natal Diagnostic Techniques (PC-PNDT) Act 1994, a genetic counselling centre/ultrasound clinic must maintain Form F (record of pregnant women) for a minimum period of:	

	a	1 year			c	3 years
	b	2 years			d	5 years

6	Which of the following is an example of secondary data?			
	a	Discharge summary	c	Cancer registry
	b	Surgical Sign In and Sign Out forms	d	Procedure report
7	Under the 'Unit Numbering System' in medical records, a patient who has been admitted three times to the same hospital will have:			
	a	One record number with all admissions filed together		
	b	Three separate record numbers — one per admission		
	c	A new MRD number assigned to each admissions - with a separate series		
	d	Separate numbers for OPD and IPD visits		

8	The Ayushman Bharat Health Account (ABHA) number issued under ABDM is a:	
	a	10-digit number linked to the patient's Aadhaar
	b	12-digit number same as the Aadhaar number
	c	14-digit unique health identifier
	d	Hospital-specific number assigned at first registration
9	In a large 500-bed tertiary care hospital, which filing system is most commonly recommended for efficient retrieval of a large volume of active medical records?	
	a	Alphabetical filing by patient surname
	b	Straight numerical (serial) filing
	c	Terminal Digit Filing
	d	Soundex phonetic filing
10	The 'Discharge Register' maintained in hospital's MRD primarily serves as:	
	a	A register for recording patients who left against medical advice (LAMA)
	b	A record of bed availability for admission planning purposes
	c	A register for discharge medication prescriptions given to patients
	d	A summary statistical tool recording diagnosis, procedures, length of stay, and outcome for each discharge.
11	A 'Mortality Review' committee mandated under NABH standards should ideally review the medical record of a hospital death within:	
	a	6 months of discharge
	b	30 days of the patient's death
	c	The next annual audit cycle
	d	Only when a legal complaint is filed
12	What is the primary goal of documenting the patient's activities of daily living (ADLs) in long-term care records?	
	a	To assess the need for assistance
	b	To assess the skin tone
	c	To track cognitive status
	d	To identify social history
13	A 'Concurrent Medical Audit' differs from a 'Retrospective Audit' in a hospital setting as it:	
	a	Is conducted by an external accreditation body only
	b	Is mandatory only for NABH-accredited hospitals above 100 beds
	c	Only audits billing records, not clinical documentation
	d	Enables real-time correction of documentation gaps
14	For a medical record to be legally defensible in Indian courts, which of the following is LEAST acceptable?	
	a	Use of correction fluid to obliterate original entries
	b	Corrections made by drawing a single line through the error with the corrector's initials and date
	c	Late entries documented with the actual date/time of recording and reason for delay
	d	Verbal orders countersigned by the ordering physician within 24 hours
15	Under the Indian Evidence Act 1872, medical records maintained in the regular course of hospital business are admissible as evidence under which section?	
	a	Section 32 (dying declaration)
	b	Section 34 (entries in books of account)
	c	Section 35 (relevancy of entry in public record)
	d	Section 65B (admissibility of electronic records)

16	Under the Right to Information (RTI) Act 2005, can a patient obtain their medical records from a government hospital in India?			
	a	No, medical records are exempt from RTI as personal information		
	b	Yes, a patient can obtain their own medical records using RTI as it relates to personal information of the applicant		
	c	Only if the patient has paid at least 50% of their treatment cost		
	d	Only aggregate statistical data, not individual records, can be obtained via RTI		
17	For Release of Information to a third party, the 'Authorization for Release' form must mandatorily include:			
	a	Patient's Aadhaar number and PAN card details		
	b	Hospital's registration number and the treating doctor's accreditation		
	c	Purpose of disclosure and specific information to be released		
	d	Billing summary and itemized invoice		
18	In a hospital using an Electronic Medical Record (EMR) system, which of the following constitutes a violation of access control policy?			
	a	A treating physician accessing the complete record of a patient who is currently admitted in Intensive Care Unit (ICU)		
	b	A medical coder accessing the discharge summary for coding purposes		
	c	A ward nurse sharing login credentials with a physician to access patient records		
	d	An MRD technician retrieving a record for a court-ordered subpoena		
19	What is the primary benefit of Interoperability in health records?			
	a	Increase efficiency in medical coding enabling better continuity and quality of patient care.		
	b	All staff can view all patient records for seamless care coordination		
	c	Secure exchange of patient health information across different health care systems		
	d	Keeping medical records as brief as possible to use patient data effectively.		
20	In health informatics, SNOMED-CT is primarily used for:			
	a	Statistical classification of diseases for mortality reporting		
	b	Billing and reimbursement coding		
	c	Drug formulary management		
	d	Clinical terminology and concept representation in EHR systems		
21	Under CGHS (Central Government Health Scheme), which document serves as the primary authorization for cashless treatment at empanelled hospitals?			
	a	Pre-authorization (PA) approval letter	c	CGHS Card only
	b	Essentiality and Emergency Certificate	d	Referral from CMO
22	'Upcoding' in medical coding refers to:			
	a	Correcting previously undercoded claims		
	b	Adding supplementary codes to a primary diagnosis		
	c	Updating old codes to newer ICD versions		
	d	Assigning a higher-value code than the documented service		

23	In ICD-10, the 'dagger and asterisk' (†/*) convention is used to indicate:	
	a	Provisional and confirmed diagnoses respectively
	b	The etiology code and the manifestation code
	c	Primary and secondary diagnoses
	d	Communicable and non-communicable conditions
24	Under the IT Act 2000 and DPDP Act 2023 in India, electronic health records (EHRs) are classified as:	
	a	Public records freely accessible under RTI
	b	Non-regulated data under state jurisdiction only
	c	Government property exempt from privacy protections
	d	Sensitive personal data requiring explicit consent for processing and sharing
25	Which chapter in ICD-10 covers 'Pregnancy, childbirth and the puerperium'?	
	a	Chapter XIV
	b	Chapter XV
	c	Chapter XVI
	d	Chapter XVII
26	'Gross Death Rate' in hospital statistics includes which category of deaths that 'Net Death Rate' excludes?	
	a	Deaths occurring within 48 hours of admission
	b	Deaths occurring in the ICU
	c	Deaths of patients who are "brought dead" (dead on arrival)
	d	Deaths due to surgical complications
27	'Post-operative Death Rate' as a hospital quality indicator is defined as:	
	a	Deaths occurring in the operation theatre during any surgical procedure
	b	Deaths within 48 hours of Intensive Care Unit admission following surgery
	c	All anesthesia-related deaths per 1000 surgical cases performed during the period
	d	Deaths within ten days of a surgical procedure to the total surgeries performed
28	Under the MoHFW Electronic Health Record (EHR) Standards for India (2016), which technical standard is recommended for document imaging and digitization of paper medical records?	
	a	PDF/A format with a minimum resolution of 300 DPI
	b	JPEG 2000 at 72 DPI for all clinical documents
	c	MP4 video format for surgical records
	d	DICOM standard for all paper-based records including OPD notes
29	The DICOM (Digital Imaging and Communications in Medicine) standard in hospitals are primarily used for:	
	a	Standardized electronic exchange of imaging data
	b	Digitizing handwritten discharge summaries
	c	Encrypting patient demographic data in the MPI
	d	Transmitting billing and insurance claim data
30	In ICD-10 morbidity coding for an inpatient record, when two conditions are documented as equally responsible for admission (neither one clearly the principal diagnosis), the coder should	
	a	Code the condition appearing first in the discharge summary as principal
	b	Query the attending physician to determine which condition was chiefly responsible
	c	Code both conditions as additional diagnoses and leave the principal diagnosis field blank
	d	Assign a combination code that represents both conditions

31	In India, the Medical Certificate of Cause of Death (MCCD/Form 4A) is governed by which Act for compulsory registration?	
	a	Indian Medical Council Act 1956
	b	Births, Deaths and Marriages Registration Act, 1886
	c	Clinical Establishments Act 2010
	d	Registration of Births and Deaths Act 1969
32	In MCCD Form 4/4A, where should the conditions that contributed to the death; but were not part of the direct sequence leading to death be recorded?	
	a	Part I
	b	Part II
	c	Either Part I or II
	d	Not required as per the LSGD Act of 2023
33	In ICD-10 coding, the use of 'combination codes' is preferred when:	
	a	A single code fully describes two diagnoses
	b	The coder cannot find individual codes for both conditions
	c	The patient has more than three diagnoses requiring coding
	d	The conditions occurred in different admissions are documented in the latest discharge summary
34	In ICD-10, the abbreviation 'NEC' (Not Elsewhere Classified) means:	
	a	The code requires a 5th character for specificity
	b	The coder does not have sufficient information to assign a more specific code
	c	The condition is not classified anywhere in ICD-10
	d	The code is only used when no other specific code exists for the condition
35	When a patient is admitted for chemotherapy for malignant neoplasm, ICD-10 guidelines instruct the medical records coder to sequence the principal diagnosis as:	
	a	The malignant neoplasm code (C-category) as principal diagnosis
	b	The chemotherapy complication/side effect code along with (C-category) as principal diagnosis
	c	The encounter for antineoplastic chemotherapy as principal diagnosis, with the neoplasm coded additionally
	d	The metastatic site code if metastasis is present as principal diagnosis, with benign neoplasm code (C-category) coded additionally
36	Under ICD-10 coding conventions, the instruction 'Code First' indicates:	
	a	The code with 'Code First' is always sequenced as the principal diagnosis
	b	Only the first-listed diagnosis in the discharge summary should be coded
	c	The underlying condition must be coded first when an etiology/manifestation convention applies
	d	The chronologically first condition diagnosed during the admission must be coded first followed by etiology/manifestation conventions
37	The medical term 'Cholecystolithiasis' correctly breaks down into which components?	
	a	Cholecysto (bile duct) + lith (stone) + iasis (condition)
	b	Cholecysto (gallbladder) + lith (stone) + iasis (condition)
	c	Chole (bile) + cysto (bladder) + litho (crushing) + iasis (surgical removal)
	d	Cholecysto (liver) + lith (calcification) + iasis (inflammation)

38	In medical terminology, the suffix '-plasty' denotes:			
	a	Surgical repair or reconstruction of a body part		
	b	Surgical removal of an organ or structure		
	c	Incision into a body part for exploration		
	d	Visual examination of an internal structure using an endoscope		
39	Which of the following medical terms correctly describes 'inflammation of the inner lining of the heart'?			
	a	Pericarditis	c	Pancarditis
	b	Myocarditis	d	Endocarditis
40	If a hospital has a low bed occupancy rate and high average length of stay, it indicates:			
	a	High efficiency	c	High patient satisfaction
	b	Poor utilization	d	High turnover rate
41	'Microfilming' of medical records as a preservation method offers which primary advantage over simple paper storage?			
	a	Microfilmed records are directly searchable by keyword using standard hospital HIS software		
	b	Microfilm significantly reduces physical storage space while providing a legally admissible, long-lasting archival format		
	c	Microfilming allows real-time access by multiple users simultaneously across hospital departments		
	d	Microfilmed records do not require any indexing system as images are self-organizing		
42	In an MRD equipped with an Electronic Document Management System (EDMS), the 'Optical Character Recognition (OCR)' function is primarily used for:			
	a	Encrypting patient health information stored on hospital servers		
	b	Automatically assigning ICD-10 codes from scanned discharge summaries		
	c	Indexing scanned documents with minimum human intervention		
	d	Generating digital signatures for authentication of electronic medical records		
43	A 'Care Plan' in a long-term care or rehabilitation facility medical record is best described as:			
	a	A discharge planning document prepared only when the patient is ready to leave the facility		
	b	A financial plan detailing expected costs of long-term care for the patient's family		
	c	A nursing assignment sheet allocating care tasks to ward staff by shift		
	d	A dynamic, multidisciplinary document identifying patient problems and measurable goals		
44	The 'Problem-Oriented Medical Record (POMR)' system, introduced by Dr. Lawrence Weed, is structured around which four components?			
	a	Subjective, Objective, Assessment and Plan (SOAP)		
	b	Database, Problem List, Initial Plans, and Progress Notes		
	c	Chief complaint, history, examination findings, and discharge instructions		
	d	Admission note, daily progress notes, operative reports, and discharge summary		
45	In designing an electronic health record (EHR) data entry form, 'field validation rules' are programmed primarily to:			
	a	Automatically prevent the entry of clinically or technically invalid data		
	b	Restrict access to sensitive fields based on user role permissions		
	c	Encrypt data entered into mandatory fields for HIPAA/DPDP compliance		
	d	Format the printed output of the form for A4 paper with standard margins		

46	During qualitative analysis of a medical record, a Medical record analyst identifies that a patient's discharge summary lists 'Type 2 Diabetes Mellitus' but no blood glucose values, HbA1c, insulin orders, or anti-diabetic medications appear anywhere in the record. The MOST appropriate action is to:	
	a	Accept the diagnosis as documented since the physician has clinical authority to document any diagnosis
	b	Delete the DM diagnosis from the record as it is unsupported
	c	Issue a physician query requesting clinical support for the documented DM diagnosis
	d	Assign the ICD code for 'Suspected DM' and note the discrepancy in the coding worksheet only
47	The 'Reliability' of a qualitative medical record review process is best ensured by:	
	a	Having a senior officer assess all records to maintain one consistent standard
	b	Conducting reviews only when triggered by a patient complaint or insurance denial
	c	Limiting the review to only discharge summaries to keep the process manageable and consistent
	d	Establishing standardised review criteria and structured data collection tools
48	'Qualitative Analysis' of a medical record, as distinct from Quantitative Analysis, evaluates:	
	a	The clinical adequacy, consistency, accuracy, and completeness of the content documented
	b	Whether all mandatory forms are physically present and all required signatures are obtained
	c	The number of pages in the record against a benchmark for the patient's diagnosis-related group
	d	Whether the record's physical condition (paper quality, legibility) meets archival standards
49	The MRD's role in NABH's 'Quality Improvement' (QI) programme specifically involves:	
	a	MRD has no role in QI — quality improvement is exclusively a clinical or nursing function
	b	Generating data-driven quality indicators from patient records
	c	Conducting monthly satisfaction surveys among patients
	d	Submitting monthly reports to NABH based on the number of records processed
50	'Workload measurement' in MRD staffing plan uses which primary metric to determine the number of coding staff required?	
	a	Number of hospital beds as the sole staffing determinant
	b	Total number of outpatient registrations per day divided by eight working hours
	c	Coding productivity standard adjusted with record complexity and specialty mix
	d	The standard ratio of one coder per 50 licensed beds regardless of discharge volume

MFCP- Medical Records Asst- A to B

Answer Key

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