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ROLL NUMBER

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

DATE: 25/09/2024 **Time: 09.30 To 10.30 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. Darken only the bubble corresponding to the most appropriate answer.
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

25/9/24

MS.

MRA-A-B

01. Which classification of hospitals focuses primarily on a specific medical condition or population group?

A) General Hospitals.
B) Specialty Hospitals.
C) Community Hospitals.
D) Rural Hospitals.

02. What is the significant value of electronic medical records (EMRs) compared to paper records?

A) They reduce the risk of errors and allow quicker access to patient information.
B) They are easy to access for healthcare providers.
C) They reduce the cost of healthcare.
D) They can be used for financial purposes.

03. Which of the following is an important value of medical records for healthcare professionals?

A) Reducing the need for patient interaction.
B) Increasing patient visit frequency for revenue generation.
C) Eliminating the need for physical examination.
D) Supporting decision-making with detailed health information.

04. Which of the following is an essential use of medical record data in healthcare administration?

A) To track patients' travel history.
B) To record patients' social and lifestyle preferences.
C) To support in planning and resource allocation.
D) To advertise healthcare services to the public.

05. Which section of the medical record contains the doctor's observations and treatment plan?

A) Progress notes
B) Patient demographic information
C) Insurance and billing section
D) Patients family and Social history

06. Which technology has significantly improved the interoperability of electronic health records (EHRs) across different healthcare systems?

A) Blockchain
B) Artificial Intelligence (AI)
C) Health Information Exchange (HIE)
D) Internet of Things (IoT)

07. What does a "Physician Index" document?

A) The personal details of all doctors employed by the hospital.
B) A list of patients treated by each physician, categorized by diagnosis and treatment.
C) A financial record of patients treated by each physician.
D) A log of physician appointments, categorized by diagnosis and treatment.

08. Which of the following practices helps to maintain the confidentiality of medical records?

A) Sharing patient information only with family members.
B) Discussing patient details in public areas.
C) Allowing access to patient records for all doctors.
D) Storing medical records in a secure, access-controlled environment.

09. How would you describe the use of medical records by removing personal identifiers from health records before sharing them for research purposes?

A) Impersonal
B) Encryption
C) Anonymization
D) Personal use

10. Which recent advancement in medical records management involves the use of voice recognition for documentation?

A) Data Encryption
B) Natural Language Processing (NLP)
C) Optical Character Recognition (OCR)
D) Speech-to-Text Technology.

11. What is the purpose of having a "Death Register" in any hospital?

A) To track patient details for all autopsies that have been performed.
B) To record the details of all deaths that occur in the hospital.
C) To document patient details of those who are "Brought-Dead" to the hospital.
D) To keep financial records related to mortuary services.

12. Which of the following is an example of a breach of patient confidentiality?

A) Discussing a patient's case with their authorized representative.
B) Encrypting patient information for secure transmission.
C) Leaving medical records open and visible in a public area.
D) Requiring passwords to access electronic medical records.

13. Which method is commonly used for qualitative analysis of medical records?

A) Statistical sampling
B) Content analysis
C) Data mining
D) Trend analysis

14. Which type of data is typically analyzed in quantitative medical record reviews?

A) Patient satisfaction surveys.
B) Narrative descriptions of patient care.
C) The number of missing or incomplete records.
D) Clinical outcomes data.

15. What is a common tool used in qualitative analysis to evaluate the completeness of medical record documentation?

A) Systematized Nomenclature of Medicine.
B) International classification of health interventions.
C) Automated coding systems.
D) Checklists and guidelines.

16. What is required for a third party to access a patient's health information?

A) Verbal consent from the patient
B) A written request from any individual
C) A signed authorization form from the patient
D) Approval from the hospital administration only

17. **Which of the following acronym is used for section of a medical record used to document the patient's current medications, including dosage, route and frequencies?**

A) MAR
B) POMR
C) SOAP
D) HCPCS

18. What will be the timeframe for hospitals to notify the FRRO about the admission of foreign nationals for medical treatment?

A) Within 24 hours of admission
B) Within 7 days of discharge
C) After the patient's treatment is completed
D) At the end of each month

19. Which document is issued by the hospital to the Registrar of Birth and Death, after an institutional death has been reported; for official registration?

A) Form No: 2 only
B) Form No: 4 or 4A only
C) Form No: 2 & Form No: 4
D) Form No: 2 & Form No: 4A

20. The Death certificate will be issued by: _____?

A) Local self government department
B) Medical records department
C) Registrar
D) Treating doctor

21. Which of the following terms is related to the treatment of cancer using high-energy radiation?

A) Chemotherapy
B) Radiotherapy
C) Immunotherapy
D) Dialysis

22. Which medical term refers to the surgical repair or reconstruction of a joint?

A) Arthroplasty
B) Arthrotomy
C) Arthropathy
D) Arthrography

23. What is the primary ethical principle related to maintaining patient confidentiality?

A) Beneficence
B) Justice
C) Autonomy
D) Privacy

24. Under which circumstances can a healthcare provider officially share patient information without the patient's consent?

A) When the patient requests it.
B) For marketing purposes.
C) When required by law.
D) For personal use by healthcare staff.

25. Which ICD version is currently in use for medical coding?

A) ICD-8
B) ICD-9
C) ICD-10
D) ICD-11

26. In which of the following setting is ICD coding most commonly used?

A) Clinical decision support systems
B) Patient billing and insurance claims
C) Electronic health records for detailed patient history
D) Laboratory diagnostics

27. Which organization manages SNOMED CT?

A) International Health Terminology Standards Development Organisation (IHTSDO)
B) World Health Organization (WHO)
C) National Institutes of Health (NIH)
D) Centers for Medicare & Medicaid Services (CMS)

28. Which of the following is a key advantage of using Electronic Medical Records (EMRs)?

A) Increased physical storage requirements
B) Reduced patient confidentiality
C) Decreased data accuracy
D) Improved accessibility and sharing of patient information

29. Which feature of EMRs helps in ensuring compliance with healthcare regulations?

A) Clinical decision support
B) Integrated audit trails and security measures
C) Paper-based patient information
D) Limited data sharing capabilities

30. What does the term "cross-referencing" in medical records filing refer to?

A) The process of creating multiple copies of each record
B) The process of linking related records or files to facilitate easier retrieval
C) The process of filing records based on their creation date
D) The process of using multiple filing cabinets for a single patient

31. Which of the following is a key consideration for the efficient retrieval of medical records?

A) Using a filing system that does not require indexing
B) Ensuring that records are filed in random order
C) Regularly updating and maintaining the filing system for accuracy
D) Reducing the number of records stored in the system

32. Which factor primarily influences the retention period for medical records?

A) The size of the medical record
B) The frequency of patient visits
C) Legal and regulatory requirements
D) The type of medical record storage used

33. Why is it important to follow proper procedures for the destruction of medical records?

A) To avoid data breaches and protect patient confidentiality
B) To increase the physical space required for record storage
C) To simplify the medical record filing process
D) To increase the number of records available for audit

34. What is the purpose of presenting hospital statistics in a clear and understandable format?

A) To make the data visually appealing
B) To easily interpret and support informed decision making
C) To limit the number of data points shown
D) To comply with data protection regulations

35. Which organization is responsible for maintaining the ICD coding system?

A) American Medical Association (AMA)
B) Centers for Medicare & Medicaid Services (CMS)
C) American Health Information Management Association (AHIMA)
D) World Health Organization (WHO)

36. What is the primary purpose of a patient's flow sheet in medical records?

A) To document a summary of the discharge instructions
B) To track vital signs, laboratory results, and other key metrics over time
C) To provide a detailed account of a consultation
D) To record the patient's past medical history

37. Which type of document is essential for recording patient's informed decision making for a surgical procedure?

A) Progress note
B) History and Physical (H&P) record
C) Discharge summary
D) Consent form

38. In ICD-10, which convention is used to enclose supplementary words that may be present or absent in the statement of a disease or procedure?

A) Parentheses ()
B) Brackets []
C) Slash /
D) Hyphen -

39. What is the sequence for documenting cause of death according to ICD guidelines?

A) Antecedent cause first
B) Alphabetical order
C) Order of other significant conditions mentioned
D) Most immediate cause first

40. Which document is typically used to collect personal and demographic information from a patient during registration?

A) Discharge summary
B) History and Physical (H&P) record
C) Patient registration form
D) Consent form

41. What would you term "the surgical team's short pause, just before incision, to confirm that they are about to perform the correct procedure on the correct body part of the correct patient"?

A) Surgical Safety Check list
B) Time-Out
C) Informed Consent
D) Risk Assessment

42. Which technology might a medical records department use to improve the efficiency of record retrieval and management?

A) Barcode scanning systems
B) Manual paper sorting
C) Handwritten notes
D) Non-digital record storage

43. How do medical records departments ensure the accuracy of patient data?

A) By performing regular audits and validation checks
B) By increasing the number of data entry staff
C) By eliminating electronic record systems
D) By delaying the updating of patient records

44 As a prerequisite to implement Document Imaging system, what process should be considered by MRD, to facilitate automatic indexing?

A) Training Staff member
B) Modify hospital policies
C) Replace the Management Information Systems
D) Forms design by including barcodes

45. Which code set is commonly used for billing and coding medical procedures and services?

A) ICD-10
B) SNOMED CT
C) CPT (Current Procedural Terminology)
D) HCPCS (Healthcare Common Procedure Coding System)

46. Which statistical measure is commonly used to describe the average length of stay for patients in a hospital?

A) Standard deviation
B) Mean
C) Median
D) Mode

47. Which of the following is a common application of telemedicine?

A) Performing physical examinations
B) Providing in-person emergency care
C) Conducting remote consultations and follow-up visits
D) Handling medical billing and coding

48. What is the main purpose of using medical transcription services in healthcare settings?

A) To ensure accurate documentation of patient care and clinical findings
B) To perform coding as per International Classification of Diseases and procedures
C) To manage patient billing and insurance reimbursements
D) To provide emergency care services

49. Which document format is commonly supported by Electronic document management systems (EDMS) for storing digital files?

A) MP3
B) HTML
C) EXE
D) PDF

50. What would you term any adverse condition or illness that is inadvertently caused by medical treatment or intervention?

A) Prodrome
B) Comorbidity
C) Iatrogenic
D) Nosocomial

Name of category: I MFCP- MRA

ANSWER KEY

1	B	21	B	41	B
2	A	22	A	42	A
3	D	23	D	43	B
4	C	24	C	44	D
5	A	25	D	45	C
6	C	26	B	46	B
7	B	27	A	47	C
8	D	28	D	48	A
9	A	29	B	49	D
10	D	30	B	50	C
11	B	31	C		
12	C	32	C		
13	B	33	A		
14	C	34	B		
15	D	35	D		
16	C	36	B		
17	A	37	D		
18	A	38	A		
19	C	39	D		
20	A	40	C		

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