Medical Coder Competency Assessment

Testing Your Knowledge of Coding Rules, Accuracy, and Compliance

Instructions: This assessment tests whether a medical coder has the skills needed to code accurately and follow the rules. There are four sections: Multiple Choice, Coding Practice, Scenario Questions, and a Performance Scorecard. A passing score is **80% or higher**. The coder must complete this assessment alone, without notes, within **90 minutes**.

Coder Information

Coder Name: _____ Date: _____

Credential (CPC, CCS, etc.): _____ Specialty / Department: _____

Years of Experience: _____ Supervisor: _____

Section 1 — Multiple Choice (25 Points)

Circle the letter of the best answer. Each correct answer is worth 1 point.

1. Which coding system is used to describe medical diagnoses in the United States?

A. CPT
B. ICD-10-CM
C. HCPCS Level II
D. DRG

2. What does CPT stand for?

A. Current Procedural Terminology
B. Clinical Patient Terms
C. Coded Provider Transactions
D. Complete Physician Terminology

3. A modifier is used to:

A. Replace a diagnosis code
B. Add extra information to a procedure code without changing its meaning
C. Deny a claim automatically
D. Change the patient's insurance plan

4. Which code set is used for durable medical equipment (DME) and supplies?

A. ICD-10-PCS
B. CPT Category III
C. HCPCS Level II
D. DSM-5

5. What is 'upcoding'?

A. Updating a patient's insurance information
B. Billing for a more expensive service than what was actually provided — this is fraud
C. Adding a modifier to a code
D. Submitting a claim electronically

6. What does 'bundling' mean in medical coding?

A. Sending multiple claims at once
B. Including a minor service inside a major service code instead of billing both separately
C. Grouping patients by diagnosis
D. Combining two insurance companies on one claim

7. When must a diagnosis code be coded to the highest level of specificity?

A. Only for Medicare patients
B. Always, for every claim
C. Only when a specialist requests it
D. Only for inpatient coding

8. What is a query in the context of medical coding?

A. A complaint from a patient about their bill
B. A formal question a coder sends to a physician to clarify documentation before coding
C. A denial letter from the insurance company
D. A billing error report

9. Which of the following is an example of a place of service code?

A. 99213
B. 11 — Office
C. Z00.00
D. 25

10. Coding an office visit as a higher level E/M code than is supported by the documentation is called:

A. Downcoding
B. Unbundling
C. Upcoding
D. Crosswalking

Continue for remaining 15 multiple choice questions. Questions 11–25 cover: ICD-10-PCS structure, E/M documentation requirements, code sequencing rules, Medicare NCCI edits, and compliance standards.

Section 2 — Coding Practice (40 Points)

Read each clinical note below and write the correct codes in the spaces provided. Include all necessary CPT codes, ICD-10-CM codes, and modifiers. Each scenario is worth 8 points.

Scenario 1

Clinical Note: A 45-year-old established patient comes in for an office visit for type 2 diabetes that is not well controlled. The physician does a detailed history, a detailed examination, and moderate medical decision making. The physician also administers a flu shot at the same visit.

CPT Code(s): _____

ICD-10 Code(s): _____

Modifier(s) if any: _____

Scenario 2

Clinical Note: A new patient is seen in the emergency department for an acute asthma attack. The physician performs a comprehensive history and exam with high complexity medical decision making. The patient is given a nebulizer treatment in the ED and discharged home.

CPT Code(s): _____

ICD-10 Code(s): _____

Modifier(s) if any: _____

Scenario 3

Clinical Note: A surgeon performs a laparoscopic appendectomy on a 22-year-old for acute appendicitis without mention of peritonitis. The procedure goes smoothly and the patient is discharged the next day.

CPT Code(s): _____

ICD-10 Code(s): _____

Modifier(s) if any: _____

Scenario 4

Clinical Note: A radiologist interprets a bilateral screening mammogram for a 52-year-old woman with no symptoms and no personal history of breast cancer. The results are normal.

CPT Code(s): _____

ICD-10 Code(s): _____

Modifier(s) if any: _____

Scenario 5

Clinical Note: An orthopedic surgeon sees an established patient for a follow-up after a right knee replacement done 3 weeks ago. The visit is a low-complexity straightforward check-up. The patient is healing well. This visit is within the global period of the surgery.

CPT Code(s): _____

ICD-10 Code(s): _____

Modifier(s) if any: _____

Section 3 — Scenario Questions (20 Points)

Answer each question in 2–4 sentences. Be clear and specific. Each question is worth 5 points.

Q1. A physician documents 'patient has chest pain.' As a coder, what would you do before assigning a diagnosis code, and why?

Q2. You notice that a claim was submitted with a code for a procedure that is not supported by the medical record. What steps do you take?

Q3. What is the difference between a primary diagnosis and a secondary diagnosis? Give an example.

Q4. A claim is denied because the diagnosis code is 'not specific enough.' What does this mean and how do you fix it?

Section 4 — Competency Scorecard (Assessor Use Only)

Section	Maximum Points	Points Earned	Notes
Section 1 — Multiple Choice	25		
Section 2 — Coding Practice	40		
Section 3 — Scenario Questions	20		

Coding Accuracy Rate (chart audit)	15		Reviewed __ charts; __ coded correctly
TOTAL	**100**		

Score 80–100:	PASS — Coder is competent and cleared to work independently
Score 70–79:	CONDITIONAL PASS — Coder needs targeted remediation in weak areas and reassessment within 30 days
Score Below 70:	FAIL — Coder requires full retraining and must retake assessment before working independently

Assessor Name: _____ Result (Pass/Fail): _____

Assessor Signature: _____ Date: _____

Coder Signature: _____ Reassessment Date (if applicable): _____