

# CERTIFIED MEDICAL CODER

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## CANDIDATE PREPARATION HANDBOOK

### ABOUT THE EXAM:

The **Certified Medical Coder** examination is designed to test a well-defined body of knowledge representative of professional practice in the discipline of medical procedure and diagnosis coding. Successful completion of this certification examination verifies that the candidate has met competency standards set forth by the **PMI Certification Board** for this specific specialty area.

**FORMAT:** Fill-in-the-blank, matching

**TIME ALLOWED:** 360 Minutes (6 Hours)

**NUMBER OF  
REQUIRED  
ANSWERS:** 142

**AVERAGE TIME  
PER ANSWER:** Approximately 2 Minutes, 30 Seconds

**COMPETENCY:** Candidates must compile an **aggregate score of 70%** in order to meet the minimal certification standards set forth by the **PMI Certification Board**.

**SCORE:** Scores are determined by totaling the number of **incorrect answers** selected in each section. This total is then multiplied by a predetermined point value and then subtracted from 100 to determine the overall percentage value. Each answer blank is of equal value.

**RESULTS:** Results are usually determined within a 6-week period and are reported to the home address the candidate provides on the exam cover sheet. **Candidates are asked not to inquire about results until this period has expired. PMI exam results are provided in writing only, and will not be obtained over the phone.**

**BYLAWS:** Candidates are encouraged to access the PMI Website, [www.PMI.md.com](http://www.PMI.md.com), for questions regarding the **PMI Certification**. This includes inquiries regarding appeals, re-testing and re-certification.

**WHAT TO BRING ON THE DATE OF THE EXAM:**

1. Picture Identification
2. Three #2 Pencils and/or Blue/Black ballpoint pens
3. Current ICD-9-CM Volumes 1 & 2 Manual
4. Current CPT-4 Manual
5. Current HCPCS Manual
6. Medical Dictionary
7. Confirmation of Payment for Exam

**EXAM Tips and Instructions:**

- (I) Allot adequate time for nourishment, rest, and relaxation on the day before and day of the exam.
- (II) Arrive at least 15 minutes prior to the start time.
- (III) Have all materials listed above available and ready for use upon arrival to exam site (i.e., pens, pencils, reference materials).
- (IV) Do not communicate with anyone other than the proctor/instructor during the exam. Cell phones/pagers must be turned off and stowed away.
- (V) No other paper may be used during the exam. All work must be turned in upon completion of the examination.
- (VI) Listen carefully to all exam instructions. Do not start the exam until instructed to do so.
- (VII) Be sure to complete the contact information sections on the exam, recording your name on each section. PMI will be unable to notify you if the information is incomplete or illegible.

- (VIII) Read each question carefully.
- (IX) Clearly and legibly document answers
- (X) Attempt to answer each question even if you are not certain of the correct answer. However, as this is a timed test, it may be advisable to skip a question if you are unsure of the answer and then return to it after completing the rest of the exam.
- (XI) Completely erase mistakes or indicate mistakes with one line drawn through the incorrect answer.
- (XII) Upon completion, review the exam to ensure all questions were answered and that all personal contact information has been completed correctly and is legible.
- (XIII) Leave the exam site immediately after turning in your exam.
- (XIV) Good Luck!

**STUDY LIST:**

***Section I: Medical Terminology***

**NO RESOURCE MATERIALS MAY BE USED FOR THIS PORTION OF THE EXAM.**

***Section II: ICD-9 Coding***

**YOU MAY USE YOUR ICD-9/CPT-4/HCPCS CODE BOOKS and MEDICAL DICTIONARY FOR SECTION II, III, and IV OF THE EXAM.**

Review and understand the following:

1. Understand and review general ICD-9 coding principles and methodology including correct use of current ICD-9 Manual.
2. Review principles of ICD-9 Coding and proper use of the following sections / areas:
  - A. Volumes I and II – correct use
  - B. Signs, Symptoms and Ill-Defined Conditions
  - C. “V” and “E” Codes
  - D. Hypertension
  - E. Neoplasms
  - F. Table of Drugs and Chemicals
  - G. Adverse Reactions
  - H. Poisoning
  - I. HIV / AIDS
  - J. Septicemia, SIRS, Septic Shock

- K. MRSA/MSSA
- L. Circulatory System. Diabetes, and Systemic Manifestations
- M. Diseases of the Nervous and Respiratory Systems
- N. Diseases of the Skin and Subcutaneous Tissue
- O. Classification of Injuries
- P. Burns
- Q. Fractures
- R. Contusions, Sprains, and Dislocations
- S. Open Wounds / Complicated Wounds
- T. Late Effects
- U. Pregnancy, Childbirth and the Puerperium
- V. Ectopic and Molar Pregnancy
- W. Spontaneous Abortions

### ***Section III: CPT Coding***

Review and understand the following:

1. Understand and review general CPT/E&M coding principles and methodology including correct use of current CPT Manual.
2. Review principles of CPT/E&M Coding and proper use of the following sections / areas:
  - A. HCPCS Coding
  - B. Therapeutic Injections
  - C. Evaluation and Management (E/M) Coding Principles
    1. Anatomy of E/M Codes
    2. Categories and Sub-Categories
    3. Correct Selection of Level
    4. Contributing Factors
  - D. Documentation Guidelines
    1. E/M Coding Guidelines
    2. General Principles of Record Documentation
  - E. CPT Modifiers, Use and Application
  - F. Maternity and Delivery Services
  - G. Radiology Services
  - H. Pathology and Laboratory Services

### ***Section IV: Coding Scenarios***

Apply coding principles in reviewing case studies and selecting correct code set(s) based on presenting documentation.