Clinical Coder interview questions

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What to expect

Clinical Coder interviews are usually a mix of a practical coding assessment and a conversation with the coding manager or health information manager. They are testing whether your coding judgement is sound, how you handle unclear documentation, and whether you can work with clinicians without turning a query into a confrontation. Familiarity with the classification system and the standards behind it matters, but so does the way you explain your decisions.

- **Technical coding knowledge:** Questions on ICD-10-AM conventions, principal diagnosis selection and how the Australian Coding Standards apply to a specific scenario. They often use a short de-identified case to see your reasoning.
- **Process and workflow:** Questions that walk through how you manage a record from receipt to submission, including how you prioritise a backlog and reconcile against discharge lists.
- **Scenario and judgement:** A record with incomplete, uncertain or contradictory documentation, where the interviewer wants to see whether you query, escalate or code on the basis of what is documented.
- **Behavioural:** Past examples of querying a clinician, picking up your own error or handling a heavy casemix period, usually explored with STAR follow-ups.
- **Team and stakeholder:** How you work with clinicians, ward clerks, health information managers and auditors, including when a clinician disagrees with your query.
- **Practical assessment:** A timed coding exercise or accuracy test on sample records, sometimes followed by a discussion of your code assignment and rationale.

A typical process starts with a short phone or video screen covering your background and availability, then a practical coding assessment on de-identified records, often done on site or via a secure system. The final stage is usually a panel with the coding manager and sometimes a health information manager or clinical liaison, covering your coding approach, query habits and how you keep current with standards changes. Some employers include a short tour of the health information service or a sit-in with the coding team before an offer.

1. Walk us through how you code an inpatient episode, from the moment the record reaches you to the point it is submitted.

Why they ask

This is the core process question for a coder. It shows whether your workflow is deliberate or ad hoc, and where you build in checks before a record leaves your hands.

How to structure your answer

Use a chronological walk-through. Name each decision point in order, say what you look at first, where you stop and query, and what you check before submitting. Keep it to the record itself, not a tour of your whole career.

Example answer

“I start with the discharge summary to get the shape of the admission, then work back through the progress notes, operation report, pathology and imaging results, and medication chart. I code the principal diagnosis first, checking it against the definition in the Australian Coding Standards rather than just taking the discharge summary at face value. Then I work through additional diagnoses and procedures, and if something is documented as uncertain or the wording does not support a code, I raise a query before I abstract anything. Once the codes are in, I re-read the record against my code list as a final check, because that is where I tend to catch an omitted procedure or a diagnosis I have

coded from a summary rather than the notes."

2. Tell me about a time you had to query a clinician because the documentation did not support a code.

Why they ask

Querying is a daily part of the job, and employers want to see that you do it early, specifically and without friction.

How to structure your answer

Use STAR, but keep the result focused on what changed in the record or the relationship, not just on the code you eventually assigned.

Example answer

"On a surgical ward we had a run of records where the discharge summary listed a post-operative complication that was not described anywhere in the progress notes. The situation was that I could not code it from the summary alone, and the episodes were closing before I could sort it out. I drafted a specific query through our usual process, quoting the exact line in the summary and asking the treating team to confirm whether the condition was documented and treated during the admission. More often than not the answer came back within a day, and where it did not, I escalated to the coding manager rather than guessing. The result was that our specialty picked up a short education note at the next ward meeting about documenting complications in the progress notes, and the number of these queries dropped over the following months."

3. You are coding a record where the discharge summary lists a condition as possible, and the treating team has already closed the episode. What do you do?

Why they ask

This tests coding judgement under pressure. Interviewers are watching for whether you code what is documented or code what you think probably happened.

How to structure your answer

Show your reasoning in stages: what the standard says, what you can and cannot code, what you try next, and when you escalate. Be explicit that you do not guess.

Example answer

"I would go back to the standards first. A condition documented as possible does not meet the criteria for code assignment, so I cannot code it as confirmed. Before I move on, I would check the rest of the record to see whether the condition was actually investigated or treated, because there may be a documented diagnosis elsewhere that supports a code. If the record is genuinely unclear, I would raise a query through the usual channel even though the episode has closed, since many services accept retrospective queries for a set period. If the clinician confirms it, I code it; if they cannot confirm it, I leave it uncoded and note the reason so the auditor can see my rationale. I would rather defend a record I did not code than one I coded on a guess."

4. A patient has several significant conditions documented. How do you decide which one is the principal diagnosis?

Why they ask

Principal diagnosis selection drives the DRG and the funding, so interviewers use this to check you understand the definition rather than applying rules of thumb.

How to structure your answer

Lead with the definition, then apply it to a short worked example. Definition first, example second is the cleanest way to answer.

Example answer

“The principal diagnosis is the condition established after study to be chiefly responsible for the episode of care, so it is not necessarily the one that was known first or the one the patient was referred for. I look at what the admission was actually for, what was investigated and treated, and what the discharge summary says about the reason for the stay. Say a patient is admitted with chest pain but is found to have a respiratory infection that is treated during the admission, the infection is likely to be the principal diagnosis if that is what the episode was chiefly about. I check the standard and any relevant advice for the specific condition before I finalise it, because specialty rules do change how that definition is applied.”

5. How do you keep up with changes to ICD-10-AM and the Australian Coding Standards?

Why they ask

Coding rules change regularly, and employers want someone who stays current without being chased.

How to structure your answer

Give a short, specific answer naming the sources you actually use and how you apply them on the floor. Avoid vague statements about lifelong learning.

Example answer

“I work through the standards updates when they come out, focusing first on the sections that affect my specialties, since those are the changes I will hit in the next caseload. I use the national coding advice and HIMAA resources to check anything I am unsure about, and I keep a running note of the changes that have caused confusion in our team. We also run a short coding meeting where we work through tricky records together, which is where most of the practical learning happens. If I am still unsure after that, I ask the coding manager rather than coding something I cannot explain.”

6. Describe a time you picked up one of your own coding errors.

Why they ask

This reveals whether you treat accuracy as your own responsibility and whether you learn from audit feedback or get defensive about it.

How to structure your answer

Use STAR, then add a short reflective closing line about what you changed afterwards. The follow-up is what interviewers remember.

Example answer

“During an internal audit I found I had coded a procedure from the operation report without picking up that it had been abandoned partway through, so the code did not reflect what actually happened. I raised it myself as soon as I spotted it, corrected the record and told the coding manager so we could check whether I had made the same mistake elsewhere. There were two other records with the same issue, and we fixed those too. After that I changed my habit of reading the operation report in isolation and started reading it alongside the anaesthetic and recovery notes, which usually makes it obvious when a procedure did not go to plan. I would rather find my own errors in audit than have someone else find them downstream.”