Corrections

RHIT Exam Preparation, Fifth Edition

AHIMA Product #AB105014

Exam 2

129. Physician orders for DNR and DNI should be consistent with:
   a. Patient’s advance directive
   b. Patient’s bill of rights
   c. Notice of privacy practices
   d. Authorization for release of information

   A second type of advance directive, a living will, describes what types of care the patient does or does not desire if he or she is not capable of communicating the information or of making decisions. Physician orders for do not resuscitate (DNR) and do not attempt intubation (DNI) should be consistent with the patient's advance directives (Sayles, 2013, 104).

Practice Questions

135. When reporting an encounter for a patient who is HIV positive but has never had any symptoms, the following code is assigned:
   a. B20, Human immunodeficiency virus [HIV] disease
   b. Z21, Asymptomatic HIV infection status
   c. R75 Inconclusive laboratory evidence of human immunodeficiency virus
   d. Z20.6, Contact with and (suspected) exposure to human immunodeficiency virus [HIV]

157. Unbundling refers to:
   a. Use of a comprehensive code to appropriately maximize reimbursement
b. Use of multiple procedure codes when a comprehensive code is available

c. Combined billing for pre- and postsurgery physician services

d. Using the incorrect DRG code

Unbundling refers to a billing practice in which providers use multiple procedure codes for a group of procedures instead of the appropriate combination code (Brodnik et al. 2012, 443).

364. The Medical Staff Executive Committee has requested a report that identifies all medical staff members who have been suspended in the last six months due to delinquent health records. This is an example of what type of report?

a. Ad hoc or demand
b. Annual report
c. Exception
d. Periodic scheduled

As opposed to periodic and exception reports, demand reports, also known as ad hoc reports, are produced as needed, whenever a manager demands or asks for it. Usually, demand reports are produced through report generators or database query languages and are customized by the manager (Sayles, 2013, 923).

429. Fifty percent of our HIM staff members have a nationally recognized credential. This is an example of what type of indicator:

a. Structured
b. Process
c. Outcome
d. Internal

Structure indicators measure the attributes of the setting, such as number and qualifications of the staff, adequacy of equipment and facilities, and adequacy of organizational policies and procedures (Sayles, 2013, 568).

465. Which of the following statements is false?

a. A notice of privacy practices must be written in plain language.
b. A notice of privacy practices must have a statement that other uses and disclosures will be made only with the individual’s written authorization and that the individual may revoke such authorization.
c. An authorization **must be** obtained for uses and disclosures for treatment, payment, and operations.

d. A notice of privacy practices must give an example of a use or disclosure for healthcare operations.

c. C should read that an authorization **MUST** be obtained or IS required for uses and disclosures for treatment, payment, and operations.

Under the Privacy Rule, healthcare providers are not required to obtain patient consent to use or disclose personal identifiable information for treatment, payment, and healthcare operations (Sayles 2013, 799).
RHI T Exam Preparation 5th Edition Updates

Exam 1

33. Which of the following statements does not apply to ICD-9-CM?
   a. It can be used as the basis for epidemiological research.
   b. It can be used in the evaluation of medical care planning for healthcare delivery systems.
   c. It can be used to facilitate data storage and retrieval.
   d. It can be used to collect data about nursing care.

   According to the American Hospital Association’s Central Office on ICD-9-CM, ICD-9-CM has a number of uses. Some of these uses are conducting epidemiological and clinical research, storing and retrieving data, and reporting and compiling healthcare data to assist in the evaluation of medical care planning for healthcare delivery systems. Collecting data about nursing care is not a use of ICD-9-CM (Sayles, 2013, 183–184).

37. The APC payment system is based on what coding system?
   a. CPT/HCPCS codes
   b. ICD-9-CM diagnosis and procedure codes
   c. CPT and ICD-9-CM procedure codes
   d. Only CPT codes

   The calculation of payment for services under the outpatient prospective payment system (OPPS) is based on the categorization of outpatient services into APC groups according to CPT/HCPCS codes (Sayles 2013, 275).

38. When reporting an encounter for a patient who is HIV positive but has never had any symptoms, the following code is assigned:
   a. 042, Human immunodeficiency virus [HIV] disease
   b. V08, Asymptomatic HIV infection status
   c. 795.71, Nonspecific serologic evidence of Human Immunodeficiency Virus [HIV]
   d. V01.79, Contact with or exposure to communicable diseases

   V08, Asymptomatic HIV infection status is to be used when the patient without any documentation of symptoms is listed as being “HIV positive,” “known HIV,” “HIV test positive,” or similar terminology. Do not use this code if the term “AIDS” is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from HIV positive status; use 042 in these cases (Schraffenberger 2012, 82–83).

39. A patient was seen in the emergency department for chest pain. It was suspected that the patient may have gastroesophageal reflux disease (GERD). The final diagnosis was “Rule out GERD.” The correct ICD-9-CM diagnosis code is:
   a. V71.7, Observation for suspected cardiovascular disease
b. 789.01, Abdominal pain, right upper quadrant
c. 530.81, Esophageal reflux
d. 786.50, Unspecified chest pain

Because this patient was seen only in the emergency department, they would be classified as an outpatient. Diagnoses documented as “probable,” “suspected,” “questionable,” “rule out,” “working diagnosis,” or other similar terms in the outpatient setting indicate uncertainty, and would not be coded as if existing. Rather, code the condition to the highest degree of certainty for that encounter or visit, such as signs, symptoms, abnormal test results, or other reason for the visit. In this case, unspecified chest pain would be coded (Schraffenberger 2012, Appendix I, 81).

44. When coding a benign neoplasm of skin of the eyelid, which of the following codes should be used?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>216</td>
<td>Benign neoplasm of skin</td>
</tr>
<tr>
<td></td>
<td><em>Includes:</em></td>
</tr>
<tr>
<td></td>
<td>Blue nevus</td>
</tr>
<tr>
<td></td>
<td>Dermatofibroma</td>
</tr>
<tr>
<td></td>
<td>Hydrocystoma</td>
</tr>
<tr>
<td></td>
<td>Pigmented nevus</td>
</tr>
<tr>
<td></td>
<td>Syringoadenoma</td>
</tr>
<tr>
<td></td>
<td>Syringoma</td>
</tr>
<tr>
<td></td>
<td><em>Excludes:</em></td>
</tr>
<tr>
<td></td>
<td>Skin of genital organs (221.0–222.9)</td>
</tr>
<tr>
<td>216.0</td>
<td>Skin of lip</td>
</tr>
<tr>
<td></td>
<td><em>Excludes:</em></td>
</tr>
<tr>
<td></td>
<td>Vermilion border of lip (210.0)</td>
</tr>
<tr>
<td>216.1</td>
<td>Eyelid, including canthus</td>
</tr>
<tr>
<td></td>
<td><em>Excludes:</em></td>
</tr>
<tr>
<td></td>
<td>Cartilage of eyelid (215.0)</td>
</tr>
</tbody>
</table>

a. 216
b. 210.0
c. 215.0
d. 216.1

When subcategory codes are provided, they must be used. Code 216.1 is a subcategory code that is most specific to the diagnosis provided (Schraffenberger 2012, 3).

54. An inpatient, acute-care coder must follow official ICD-9-CM coding guidelines established by the:

a. American Health Information Management Association
b. American Medical Association
c. Centers for Medicare and Medicaid Services
d. Cooperating Parties
Coding professionals shall adhere to the ICD coding conventions, official coding guidelines approved by the Cooperating Parties, the CPT rules established by the American Medical Association, and any other official coding rules and guidelines established for use with mandated standard code sets (Schraffenberger and Kuehn 2011, 339).

57. A patient was admitted to the hospital on September 15, 2014 and discharged on October 5, 2014. In order to code this record correctly, the coder must use the version of ICD-9-CM updated on:
   a. January 1, 2014
   b. April 1, 2014
   c. October 1, 2014
   d. October 1, 2013

Biannual changes to ICD-9-CM codes become effective for discharges after October 1 and April 1, respectively, coinciding with the beginning and middles of the US government’s fiscal year. For a patient discharged on October 5, 2014, the October 1, 2014 version of ICD-9-CM would be used to code the record correctly (Schraffenberger and Kuehn 2011, 9).

63. In developing a monitoring program for coding compliance, which of the following should be regularly audited?
   a. ICD-9-CM and CPT coding
   b. CPT/HCPCS and LOINC coding
   c. ICD-9-CM and SNOMED coding
   d. CPT/HCPCS and SNOMED coding

The corporate compliance program addresses the coding function. Because the accuracy and completeness of ICD-9-CM and CPT code assignment determine the provider payment, the coding compliance program should regularly audit these codes. It is important that healthcare organizations have a strong coding compliance program (Sayles 2013, 305–306).
Exam 2

32. Volume 1 of ICD-9-CM contains which one of the following?
   a. Numerical listing of disease codes ranging from 001–999.9
   b. Numerical listing of procedure codes ranging from 01–99.9
   c. Morphology codes
   d. Alphabetic Index to Diseases

   a Volume 1 of ICD-9-CM contains 17 chapters that classify conditions according to etiology or by specific anatomical system. These categories are from 001–999.9 (Schräfberger 2012, 2–3).

36. Which of the following is not one of the purposes of ICD-9-CM?
   a. Classification of morbidity for statistical purposes
   b. Classification of mortality for statistical purposes
   c. Reporting of diagnoses by physicians
   d. Identification of the supplies, products, and services provided to patients

   d According to the American Hospital Association’s Central Office on ICD-9-CM, ICD-9-CM is used for classification of morbidity and mortality for statistical purposes, reporting of diagnoses by physicians and many more users. But, ICD-9-CM is not used to identify supplies, products, and services provided to patients (Sayles 2013, 183–184).

39. The patient was discharged with the following diagnoses: Cerebral occlusion, hemiparesis, asphasia, and hypertension. Which of the following code assignments would be appropriate for this case?

   342.90 Hemiparesis affecting unspecified side
   342.91 Hemiparesis affecting dominant side
   342.92 Hemiparesis affecting nondominant side
   434.90 Cerebral artery occlusion unspecified
   434.91 Cerebral artery occlusion with infarction
   401.0 Malignant hypertension
   401.1 Benign hypertension
   401.9 Unspecified hypertension
   428.0 Congestive heart failure
   784.3 Aphasia

   a. 434.91, 342.92, 784.3, 401.1
b. 434.90, 342.90, 784.3, 401.9

c. 434.90, 342.91, 784.3, 401.9

d. 434.90, 342.90, 784.3, 401.0

434.90 is used because the type of cerebral artery occlusion is unspecified; 342.90 is used because the side affected by the hemiparesis in not indicated in the diagnosis; 784.3 codes the aphasia; 401.9 is used because the hypertension is unspecified as to whether it is malignant or benign (Schraffenberger 2012, 35, 198).

41. A 65-year-old patient is admitted with pain and loosening of a previous total hip arthroplasty. The acetabular component has loosened and become painful. The patient was admitted for revision of the hip replacement. The acetabular component uses a metal-on-metal bearing surface. Which of the following codes would be the appropriate coding for the admission?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>996.41</td>
<td>Mechanical loosening of prosthetic joint</td>
</tr>
<tr>
<td>996.66</td>
<td>Infection and inflammatory reaction due to internal joint prosthesis</td>
</tr>
<tr>
<td>V43.64</td>
<td>Organ or tissue replaced by other means, hip</td>
</tr>
<tr>
<td>00.71</td>
<td>Revision hip replacement, acetabular component</td>
</tr>
<tr>
<td>00.74</td>
<td>Revision hip replacement bearing surface, metal on polyethylene</td>
</tr>
<tr>
<td>00.75</td>
<td>Revision hip replacement bearing surface, metal on metal</td>
</tr>
</tbody>
</table>

a. 996.41, V43.64, 00.71, 00.75
b. 996.96, 00.75
c. 996.41, V43.64, 00.71, 00.74
d. 996.96, V43.64, 00.71, 00.75

Assign code 996.41, Mechanical loosening of prosthetic joint, for the loosening of the acetabular component. Assign code V43.64, Organ or tissue replaced by other means, joint, hip, to identify the prosthetic joint associated with the mechanical complication. Assign code 00.71, Revision of hip replacement, acetabular component of the hip prosthesis. Code 00.75, hip replacement bearing surface, metal-on-metal, should be assigned as an additional procedure to identify the specific type of bearing surface (Schraffenberger 2012, 35).

Practice Questions

111. When coding a hydrocystoma of the eyelid, which of the following codes should be used?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>216</td>
<td>Benign neoplasm of skin</td>
</tr>
</tbody>
</table>

Includes:
### Blue nevus
### Dermatofibroma
### Hydrocystoma
### Pigmented nevus
### Syringoadenoma
### Syringoma

**Excludes:**
- Skin of genital organs (221.0–222.9)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Excludes</th>
</tr>
</thead>
<tbody>
<tr>
<td>216.0</td>
<td>Skin of lip</td>
<td>Vermilion border of lip (210.0)</td>
</tr>
<tr>
<td>216.1</td>
<td>Eyelid, including canthus</td>
<td>Cartilage of eyelid (215.0)</td>
</tr>
</tbody>
</table>

**d** A fourth digit code must be used when present. Diagnosis is of eyelid, 216.1, is the correct code (Schraffenberger 2012, 29).

112. When coding a benign neoplasm of skin of the vermilion border of the lip, which of the following codes should be used?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Excludes</th>
</tr>
</thead>
<tbody>
<tr>
<td>216</td>
<td>Benign neoplasm of skin</td>
<td>Skin of genital organs (221.0–222.9)</td>
</tr>
<tr>
<td>216.0</td>
<td>Skin of lip</td>
<td>Vermilion border of lip (210.0)</td>
</tr>
<tr>
<td>216.2</td>
<td>Eyelid, including canthus</td>
<td>Cartilage of eyelid (215.0)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Excludes</th>
</tr>
</thead>
<tbody>
<tr>
<td>216</td>
<td>Benign neoplasm of skin</td>
<td>Skin of genital organs (221.0–222.9)</td>
</tr>
<tr>
<td>216.0</td>
<td>Skin of lip</td>
<td>Vermilion border of lip (210.0)</td>
</tr>
<tr>
<td>216.2</td>
<td>Eyelid, including canthus</td>
<td>Cartilage of eyelid (215.0)</td>
</tr>
</tbody>
</table>

a. 216  

b. 210.0
The excludes notes found in the Tabular List are hard to miss because the word excludes appears in italicized print with a box around it. The exclusion note indicates that code 210.0, rather than code 216.0, should be assigned if the skin of the lip is the vermilion border of the lip (Schraffenberger 2012, 18).

130. A 65-year-old woman was admitted to the hospital. She was diagnosed with septicemia secondary to methicillin susceptible *Staphylococcus aureus* and abdominal pain secondary to diverticulitis of the colon. What is the correct code assignment?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>038.11</td>
<td>Methicillin susceptible staphylococcus aureus septicemia</td>
</tr>
<tr>
<td>038.8</td>
<td>Other specified septicemia</td>
</tr>
<tr>
<td>038.9</td>
<td>Unspecified septicemia</td>
</tr>
<tr>
<td>041.11</td>
<td>Methicillin susceptible staphylococcus aureus</td>
</tr>
<tr>
<td>562.11</td>
<td>Diverticulitis of colon (without mention of hemorrhage)</td>
</tr>
<tr>
<td>789.00</td>
<td>Abdominal pain, unspecified site</td>
</tr>
</tbody>
</table>

a. 038.8, 562.11, 789.00  
b. 038.11, 562.11  
c. 038.8, 562.11, 041.11  
d. 038.9, 562.11

Septicemia generally refers to a systemic disease associated with the presence of pathological microorganisms or toxins in the blood, which can include bacteria, viruses, fungi or other organisms. Code 038.11 is for septicemia with *Staphylococcus aureus*. Because abdominal pain is a symptom of diverticulitis, only the diverticulitis of the colon is coded (Schraffenberger 2012, 80–81).

131. Which of the following provides the most comprehensive, controlled vocabulary for coding the content of a patient record?

a. CPT  
b. HCPCS  
c. ICD-9-CM  
d. SNOMED CT

In the field of medicine, two physicians may use two different terms for the same medical condition. This makes it difficult to gather and retrieve information. Standardized vocabulary is needed to facilitate the indexing, storage, and retrieval of patient information in an EHR. SNOMED CT creates a standardized vocabulary (Sayles 2013, 207).

132. A patient was admitted to the hospital and diagnosed with diabetic gangrene. What is the correct code assignment?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.00</td>
<td>Diabetes mellitus without mention of complication, type II or unspecified</td>
</tr>
</tbody>
</table>
type, not stated as uncontrolled

250.70 Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled

250.71 Diabetes with peripheral circulatory disorders, type I [juvenile type], not stated as uncontrolled

785.4 Gangrene

a. 250.71, 785.4
b. 785.4, 250.70
c. 250.70, 250.00, 785.4
d. 250.70, 785.4

to assign these codes, documentation in the health record must support a causal relationship. When a causal relationship exists, the principal diagnosis code assigned is a diabetic code from category 250, followed by the code for the manifestation or complication. The diabetes codes and the secondary codes that correspond to them are paired codes that follow the etiology or manifestation convention of the classification. Without documentation as to the type of diabetes, the default is Type 2, with the fifth digit of ‘0’ (Schraffenberger 2012, 123–124).

134. A 45-year-old male is seen for Hb-SS sickle-cell disease with crisis. How would this be coded?
   a. 282.60 Sickle-cell disease, unspecified
   b. 282.5 Sickle-cell trait
   c. 282.61 Hb-SS disease without crisis
   d. 282.62 Hb-SS disease with crisis

d Main term: Disease, sickle-cell, Hb-S, with crisis 282.62 is the most specific code and should be assigned for this condition (Schraffenberger 2012, 29).

135. A patient was diagnosed with L4-5 lumbar neuropathy and discogenic pain. The patient underwent an intradiscal electrothermal annuloplasty (IDET) in the radiology suite. What ICD-9-CM procedure code is used?
   a. 721.42, Spondylosis with myelopathy, lumbar region
   b. 722.10, Displacement of lumbar intervertebral disc without myelopathy
   c. 80.59, Other destruction of intervertebral disc
   d. 338.22 Chronic post-thoracotomy pain

c Option “c” is the only procedure code listed (Sayles 2013, 187–188).

138. What are four-digit ICD-9-CM diagnosis codes referred to as?
   a. Category codes
b. Section codes

c. Subcategory codes

d. Subclassification codes

c. Categories are further divided into subcategories. At this level, four-digit code numbers are used and the four-digit codes are referred to as subcategory codes (Sayles 2013, 186).

140. Which of the following ICD-9-CM codes classify environmental events and circumstances as the cause of an injury, poisoning, or other adverse effect?

a. Category codes

b. E codes

c. Subcategory codes

d. V codes

b. **E codes or external cause of injury codes**, provide a means to classify environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effect. These codes are used in addition to codes from the main chapters of ICD-9-CM. E codes begin with the alpha character **E** and are followed by numerical characters (Sayles 2013, 186).

176. A patient with known AIDS is admitted to the hospital for treatment of Pneumocystis carinii pneumonia. Assign the principal diagnosis for this patient:

a. 042, Human immunodeficiency virus [HIV disease]

b. 486, Pneumonia, organism unspecified

c. 136.3, Pneumocytosis due to pneumocystis carinii

d. V08, Asymptomatic human immunodeficiency virus [HIV] infection

a. AIDS stands for acquired immunodeficiency syndrome, frequently called human immunodeficiency infection. When a patient is treated for a complication associated with HIV infection, the 042 code is assigned as the principal diagnosis, followed by the code for the complication. Patients who are admitted for an HIV-related illness should be assigned a minimum of two codes in the following order: 042 to identify the HIV disease and additional codes to identify other diagnoses (Schraffenberger 2012, 83–84).

184. A patient is seen as an outpatient to receive radiation and chemotherapy for distal esophageal carcinoma. What is the appropriate first-listed diagnosis?

a. V58.42, Aftercare following surgery for a neoplasm

b. V58.11, Encounter for antineoplastic chemotherapy

c. 150.5, Malignant neoplasm of esophagus, lower third of esophagus

d. 150.3, Malignant neoplasm of esophagus, upper third of esophagus

b. If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis. The only exception to
This guideline is if a patient admission or encounter is for the purpose of radiotherapy, immunotherapy, or chemotherapy. When the purpose of the encounter or hospital admission is for radiotherapy, or for antineoplastic chemotherapy, use the V code as the principal diagnosis (Schraffenberger 2012, 97–98).

186. A 30-year-old female has a vaginal delivery with single liveborn female with episiotomy and repair.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>650</td>
<td>Normal delivery</td>
</tr>
<tr>
<td>664.41</td>
<td>Unspecified perineal laceration, delivered, with or without mention of antepartum condition</td>
</tr>
<tr>
<td>665.40</td>
<td>High-vaginal laceration, unspecified as to episode of care or not applicable</td>
</tr>
<tr>
<td>V27.0</td>
<td>Single liveborn</td>
</tr>
<tr>
<td>73.6</td>
<td>Episiotomy (with subsequent repair)</td>
</tr>
<tr>
<td>75.69</td>
<td>Repair of other current obstetric laceration</td>
</tr>
</tbody>
</table>

a. 664.41, V27.0, 73.6, 75.69  
b. 650, V27.0, 73.6; 75.69  
c. 650, V27.0, 73.6  
d. 665.40, 73.6

c. The patient had a normal delivery, full-term, single, healthy live born infant with an episiotomy. No other procedures or manipulation needed to aide in delivery (Schraffenberger 2012, 272–273).

189. Which of the following would be classified in ICD-9-CM with an external cause code?

a. Echocardiogram  
b. Fall from curb  
c. Adenocarcinoma  
d. Admission for plastic surgery

b. **E codes or external cause of injury codes**, provide a means to classify environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effect. These codes must be used in addition to codes from the main chapters of ICD-9-CM. E codes begin with the alpha character $E$ and are followed by numerical characters (Sayles 2013, 186).

196. The main purpose of Correct Coding Initiative edits is to prohibit:

a. ICD-9-CM procedure code errors  
b. DRG assignment errors  
c. Unbundling of procedures  
d. Incorrect POA assignment

c. The National Correct Coding Initiative (NCCI or CCI) edits also apply to the APC system. The main purpose of CCI edits is to prohibit unbundling of procedures. CCI edits are updated quarterly.
206. A patient was seen and diagnosed with pneumonia. The patient was also treated and managed for her congestive heart failure angina pectoris. What codes would be assigned for this patient?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>413.9</td>
<td>Other and unspecified angina pectoris</td>
</tr>
<tr>
<td>428.0</td>
<td>Congestive heart failure, unspecified</td>
</tr>
<tr>
<td>428.9</td>
<td>Heart failure, unspecified</td>
</tr>
<tr>
<td>481</td>
<td>Pneumococcal pneumonia</td>
</tr>
<tr>
<td>486</td>
<td>Pneumonia, organism unspecified</td>
</tr>
</tbody>
</table>

- a. 481, 428.0, 413.9
- b. 486, 428.0, 413.9
- c. 486, 428.9, 413.9
- d. 481, 428.9, 413.9

Category 486, Pneumonia, organism unspecified, is a three-digit code that should be assigned only when the physician does not identify the causative organism. In this case, 486 should be assigned as the organism was not identified in the documentation. The term heart failure is not synonymous with congestive heart failure, so 428.0 should be assigned for the diagnosis of CHF, and then the angina pectoris 413.9 should also be assigned (Schraffenberger 2012, 194, 220).

208. Code the following scenario: Patient with flank pain was admitted and found to have a calculus of the kidney. Ureteroscopy with placement of ureteral stents was performed. What codes would be assigned for this patient?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>592.0</td>
<td>Calculus of kidney</td>
</tr>
<tr>
<td>592.9</td>
<td>Urinary calculus, unspecified</td>
</tr>
<tr>
<td>788.0</td>
<td>Renal colic</td>
</tr>
<tr>
<td>56.0</td>
<td>Transurethral removal of obstruction from ureter and renal pelvis</td>
</tr>
<tr>
<td>59.8</td>
<td>Ureteral catheterization</td>
</tr>
</tbody>
</table>

- a. 592.0, 788.0, 59.8
- b. 788.0, 592.0, 56.0
- c. 592.9, 59.8
- d. 592.0, 59.8

Codes for symptoms, signs, and ill-defined conditions are not to be used as the principal diagnosis when a related definitive diagnosis has been established. The flank pain would not be coded because it is a symptom of the calculus (Schraffenberger 2012, 338–339).
210. Patient admitted with chronic cystitis. A cystoscopy and biopsy of the bladder were performed. What diagnosis and procedure codes would be assigned for this patient?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>595.1</td>
<td>Chronic interstitial cystitis</td>
</tr>
<tr>
<td>595.2</td>
<td>Other chronic cystitis</td>
</tr>
<tr>
<td>595.3</td>
<td>Trigonitis</td>
</tr>
<tr>
<td>599.0</td>
<td>Urinary tract infection, site not specified</td>
</tr>
<tr>
<td>57.32</td>
<td>Diagnostic procedure on bladder, other cystoscopy</td>
</tr>
<tr>
<td>57.33</td>
<td>Closed [transurethral] biopsy of bladder</td>
</tr>
</tbody>
</table>

- a. 595.3, 57.33
- b. 595.1, 57.33, 57.32
- c. 595.3, 57.33
- d. 599.0, 57.32

c Main term for diagnosis: Cystitis; subterm: chronic. Main term for procedure: Cystoscopy; subterm: with biopsy (Schraffenberger 2012, 10–11, 40–41).

211. According to the UHDDS, a procedure that is surgical in nature, carries a procedural or anaesthetic risk, or requires special training is defined as a ______________ and must be coded.

- a. principal procedure
- b. operating room procedure
- c. significant procedure
- d. therapeutic procedure

c A procedure is identified as a significant procedure when it: is surgical in nature, carries a procedural risk, carries an anesthetic risk, or requires specialized training. All significant procedures are to be coded and reported (Schraffenberger, 2012, 65).

213. Code the following scenario: A patient was admitted to the hospital with an admitting diagnosis of acute hip pain. There was no history of trauma; she stated that she had simply stood up from her chair and immediately experienced acute pain in the left leg. She is a known diabetic and has severe osteoporosis. An x-ray revealed a fracture of the lower third of the shaft of the femur and the fracture was diagnosed as spontaneous. A routine preoperative chest x-ray showed a few strands of atelectasis and a small cloudy area that may have represented mild pleural effusion. A cast was applied to the leg to immobilize the fracture.
Pathologic fractures are classified to subcategory 733.1, with the fifth-digit subclassification identifying the specific site. These types of fractures occur in existing diseases such as osteoporosis or bone metastasis, both of which are capable of weakening the bone. Often, pathologic fractures are spontaneous in nature. The osteoporosis and diabetes should also be coded as other diagnoses (Schraffenberger, 2012, 306).

391. A report that lists the ICD-9-CM codes associated with each physician in a healthcare facility can be used to assess the quality of the physician’s services before he or she is:
  a. Scheduled for a coding audit
  b. Subjected to corrective action
  c. Recommended for staff reappointment
  d. Involved in an in-house training program
The medical staff department is particularly interested in the ICD-9-CM codes associated with each physician. Because diagnostic codes can identify untoward events that occur during hospitalization, the quality of a physician’s services can be identified through reports called physician reappointment summaries. These summaries outline the number of cases by diagnosis and procedure type, LOS, and infection and mortality statistics. At reappointment to a facility’s medical staff, code-based reports are required. The medical staff department accumulates these reports and works with the elected or appointed medical staff leadership to ensure that a thorough analysis of each physician’s activities takes place before he or she is reappointed to the staff (Schraffenberger and Kuehn 2011, 443).

538. The codes used in a charge description master are:
   a. ICD-9-CM
   b. CPT-4
   c. HCPCS Levels I and II
   d. SNOMED CT

For Medicare and most other third-party payer reporting, Levels I and II of HCPCS codes are used to report supplies and services for the CDM (Schraffenberger and Kuehn 2011, 226).