ICD-10 Competency Assessment for Coders

ICD-10-CM & ICD-10-PCS

Lolita M. Jones, RHIA, CCS

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About the Author

Lolita M. Jones, RHIA, CCS

Lolita M. Jones, an American Health Information Management Association (AHIMA)–approved ICD-10-CM/PCS trainer, is sole principal of Lolita M. Jones Consulting Services, founded in October 1998 in Fort Washington, MD.

Jones, who has more than 25 years of coding and consulting experience, began preparing for ICD-10 by returning to school. She completed University of Phoenix online courses in anatomy, physiology, and pathophysiology. These biomedical courses are essential for successful understanding and application of ICD-10 diagnosis and procedure codes. She also attended the Third Annual ICD-10-CM Summit in Baltimore and the ICD-10-CM Academy in Boston.

Jones is the author of *The ICD-10-CM/PCS Implementation Action Plan*, a comprehensive management tool that identifies facilitywide action items and operational processes that are necessary for timely and successful management of ICD-10-CM/PCS.

About the Reviewers

Margi Brown, RHIA, CCS, CCS-P, CPC, CCDS

Margi Brown, currently an independent consultant in Orlando, is an ICD-10-CM/PCS trainer certified by AHIMA.

Brown's more than 30 years of experience provides expertise across a broad continuum in the healthcare industry, including hospitals, physician offices/clinics, insurance carriers, surgery centers, the Veterans Administration, software/equipment companies, law firms, and consulting companies.

Brown's focus has been coding, beginning with ICD-8-CM. She specializes in clinical documentation integrity; audits involving all levels in inpatient, outpatient, and physician settings; denial management, including Recovery Audit Contractors; education and training; computer-assisted coding; health information management operations; revenue cycle; and compliance. The ultimate goal of her work is complete documentation to support the most accurate codes, sustainable through time as the healthcare industry transitions to an increasingly electronic world and prepares for ICD-10.

A frequent speaker, Brown has addressed diverse audiences, including specialty associations, national organizations such as AHIMA and the Association of Clinical Documentation Specialists, and several state and regional AHIMA and AAPC chapters.

Brown entered the health information management field as an accredited record technician. She attended Moraine Valley Community College in Palos Hills, IL, and holds a bachelor's degree in health information management from the University of Central Florida in Orlando.

Paul L. Dickson, MD, CCS, CPC

Paul L. Dickson of Cornelia, GA, has provided independent coding and billing compliance consulting services to a variety of organizations since 1999. He specializes in ICD-9-CM and CPT® coding for inpatient and outpatient services.

Since 2003, his focus has been clinical documentation improvement training programs and audits. Dickson has provided education programs and coding compliance audits for hospitals (inpatient) and physicians (E/M). His services as a consultant have included risk opportunity coding assessment; compliance audits; and clinical education for physicians and office and hospital staff.

Dickson has provided consulting services for a variety of organizations, including DCBA, Inc., in Atlanta and numerous healthcare facilities. A graduate of the Medical College of Georgia in Augusta, Dickson completed his surgical internship and residency at the Medical College of Georgia Hospital and Clinics and later practiced in Demorest, GA. He is a frequent contributor to professional publications that address various coding topics.

Chapter 1

ICD-10-CM: 35 Questions

Editor's note: Answers to the questions in this chapter include explanations that rely on and provide information from the following online sources.

Access the *ICD-10-CM Official Guidelines for Coding and Reporting 2011* at *www.cdc.gov/nchs/data/icd9/10cmguidelines2011_FINAL.pdf.*

Access the *ICD-10 Table of Neoplasms* at *www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp#TopOfPage.*
Next, download the 2011 Code Tables and Index file.
Then, select icd10cm_neoplasm_2011.

Access the *ICD-10-CM Tabular List of Diseases and Injuries* at *www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp#TopOfPage.*
Next, download the 2011 Code Tables and Index file.
Then, select icd10cm_Tabular.

1. Official coding guidelines instruct coders to code only confirmed cases of HIV infection/illness. Which of the following statements is true with respect to the "confirmed" reference in this guideline?

a. An infectious disease specialist must document that the patient is HIV-positive.

b. An infectious disease specialist must document that the patient has an HIV-related illness.

c. Confirmation does not require documentation of positive serology or culture for HIV.

d. Confirmation does require documentation of positive serology or culture for HIV.

2. Complete the following sentence.

The introduction to the *ICD-10-CM Table of Neoplasms* states that codes listed with a dash after them have a required _____.

3. How should the encounter be coded when an outpatient is seen for a pathological fracture due to neoplasm and the focus of the treatment is the neoplasm?

a. A code from subcategory M84.5-, Pathological fracture in neoplastic disease, should be sequenced first, followed by the code for the neoplasm.

b. A neoplasm code should be sequenced first, followed by a code from M84.5- for the pathological fracture.

c. A code from subcategory M84.5-, Pathological fracture in neoplastic disease, is the only code required.

d. A code from subcategory M84.5-, Pathological fracture in neoplastic disease, should be sequenced first, followed by a personal history of neoplasm code.

4. Which Excludes note appears in the *ICD-10-CM Tabular List of Diseases and Injuries* at code D63.0, Anemia in neoplastic disease?

_____

5. Refer to the "Use additional code" note that appears in the *ICD-10-CM Tabular List of Diseases and Injuries* for code E10.621. Which of the following is not a valid code combination for type 1 diabetes mellitus with right foot ulcer?

a. E10.621 and L97.409

b. E10.621 and L97.419

c. E10.621 and L97.511

d. E10.621 and L97.519

6. Is the following statement true or false?

The *ICD-10-CM Tabular List of Diseases and Injuries* includes a note that explains the difference between mild, moderate, and severe nonproliferative diabetic retinopathy.

True
False

7. When provider documentation refers to use, abuse, and dependence of the same substance (e.g., alcohol, opioid, cannabis), only one code should be assigned to identify the pattern of use based on the following hierarchy. List this hierarchy.

_____

_____

_____

_____

_____

8. Which Excludes note applies to all codes in ICD-10-CM Chapter 5, Mental and Behavioral Disorders?

_____

9. How many sequelae codes does the *ICD-10-CM Tabular List of Diseases and Injuries* for Chapter 6, Diseases of the Nervous System, include?

a. One

b. Two

c. Three

d. Four

10. Which disease is classified as "with early onset" and "with late onset" in Chapter 6, Diseases of the Nervous System?

_____

11. Which of the following is not a subcategory heading in the *ICD-10-CM Tabular List of Diseases and Injuries* for Chapter 7, Diseases of the Eye and Adnexa, in the H59 coding range?

a. Disorders of the eye following cataract surgery

b. Disorders of the eye following glaucoma surgery

c. Intraoperative hemorrhage and hematoma of eye and adnexa complicating a procedure

d. Accidental puncture and laceration of eye and adnexa during a procedure

12. Which of the following complications would be reported with ICD-10-CM code H95.88 and an additional code to further specify the disorder?

a. Postmastoidectomy chronic inflammation

b. Postmastoidectomy granulation

c. Postmastoidectomy mucosal cyst

d. Postmastoidectomy pneumocephalus

13. Assign the appropriate code(s) for hypertensive heart and chronic kidney disease, with acute on chronic combined systolic congestive and diastolic congestive heart failure, and stage 4 chronic kidney disease.

_____

14. Which of the following guidelines is not correct for ICD-10-CM myocardial infarction (MI) coding?

a. A code from category I22 must be used in conjunction with a code from category I21.

b. Code I22 should be sequenced first, if it is the reason for encounter.

c. Code I22 should be sequenced after the I21 code if the subsequent MI occurs during the encounter for the initial MI.

d. Code I22 should not be used if the subsequent MI occurs intraoperatively during cardiac surgery; use only code I97.790.

15. How many cardiac arrest codes are there in the *ICD-10-CM Tabular List of Diseases and Injuries* for Chapter 9, Diseases of the Circulatory System?

a. Five

b. Six

c. Seven

d. Eight

16. Which of the following conditions is classified as "mild intermittent," "mild persistent," "moderate persistent," and "severe persistent" in ICD-10-CM?

a. Sinusitis

b. Pharyngitis

c. Asthma

d. Tonsillitis

Chapter 2

ICD-10-CM: 15 Case Studies

Case Study 1

Assign all applicable ICD-10-CM diagnosis codes (including all appropriate external cause of injury codes) for the following case.

URGENT CARE CENTER

VISIT NOTE

Subjective: This is a 78-year-old female here for a lacerated leg and arm. She is visiting from Texas; while she was at the local airport, she fell down several stairs on the escalator. She lacerated her left shin and left elbow. She had no loss of consciousness, and no other injuries were sustained. She was attended by a paramedic, but then declined treatment and was brought here by her family to be seen. She denies any headache. She denies any numbing or tingling. No other injuries were sustained. She complains of left elbow pain and left lower-leg pain.

Past medical history/operations: Abdominal hernia, cholecystectomy, ganglion cyst—left wrist, bladder suspension

Illnesses: Hypothyroidism, atrial fibrillation, rheumatoid arthritis, incontinence, gastroesophageal reflux disease (GERD)

Medications: Ditropan®, prednisone and Ultram®, Elavil®, Rythmol®, Protonix®, calcium, Zestril®, Levoxyl®

Primary care physician: Texas

Allergies: None known

Objective:
Vital signs: Temperature: 98.6°F; respirations: 12; pulse oximetry: 94; blood pressure: 151/81.
General: This is an alert, elderly female. She is in no acute distress.
Skin: Examination of her left elbow reveals two 1-cm lacerations noted, not actively bleeding, just at the olecranon. There is no tenderness to palpation around the elbow. She has full range of motion. Her left lower extremity reveals a significant 5cm × 7cm area of avulsion of the skin, lateral aspect of her lower leg, superior to the lateral malleolus. It is down to the fatty tissue. It is tender to palpation. It is not actively bleeding. She has no tenderness to palpation around her ankle or leg. She has good range of motion. Her neurovascular is intact.

Diagnostics: X-ray of the left elbow and the right lower extremity tibia, fibula, and ankle all appear negative. No evidence of a fracture. Radiologist is to overread.

Assessment:

1. Lacerated elbow times two
2. Avulsion laceration, left lower extremity

Plan: I placed lidocaine, epinephrine, and tetracaine, and subsequently infiltrated a total of 6 cc of 1% plain xylocaine in the left elbow lacerations and around the left lower-extremity laceration. The left elbow lacerations were sutured with a total of five 4-0 Prolene™ sutures with good wound edge approximation. The left lower extremity was then sutured with multiple sutures to approximate the skin edges. There was a fairly large area, approximately the size of a quarter, of the skin that had been avulsed and was not able to be approximated. The skin that was remaining was approximated with multiple 4-0 Prolene® sutures. On the remainder of that area, Dermabond® was placed. It was dressed with Vaseline® gauze. An IV was started prior to the procedure. She was given Demerol® 50 mg and Phenergan® 25 mg with adequate analgesia. She was also given Ancef® 1 g IV times

one, as well as an adult DT. The wounds were then dressed, as noted previously. She was given Keflex® 500 mg t.i.d., #40, Lortab® 5/500, 1–2 q. 4 hours p.r.n. pain, #20, with one refill, and Silvadene® 1% to be applied to the lower extremity for dressing changes twice daily. She is to follow up with her relative's primary care physician (PCP) or return here in two to three days for a recheck/reassessment. The sutures are to be removed in seven to 10 days. Her current medications were reviewed, and she is to continue them as prescribed. Wound care instructions were given. She is to follow up sooner if worsening symptoms occur. She understands and agrees with the treatment plan. She was dismissed in stable condition. There were no complications during her urgent care stay.

Case Study 2

Assign all applicable ICD-10-CM diagnosis codes (including all appropriate external cause of injury codes) for the following case.

MEDICAL CLINIC

VISIT NOTE

Reason for visit: Burning with urination and hematuria

History of present illness: The patient is a 74-year-old white male who presents to clinic with a two-day history of hematuria and dysuria.

Past medical history: Transurethral prostatectomy in February as well as placement of a penile prosthesis. The patient also had a GreenLight™ laser surgery of the urethra performed July 17. The patient has had intermittent hematuria since that time.

Allergies: No known allergies

Current medications: Zocor®; the patient also took one tablet of ciprofloxacin approximately four hours ago.

Review of systems:
Constitutional: The patient had no fever or chills.
Musculoskeletal: The patient complains of some left low-back pain; however, he had a deep tissue massage approximately three days ago and believes his back pain may be related to this.

Physical examination:

Vital signs: Blood pressure: 142/92; pulse: 51; temperature: 97.8°F; respirations: 16; pulse oximetry on room air: 97%; weight: 210 pounds

General: The patient is in no acute distress. On examination of his back, the patient has some tenderness of paraspinous muscles on left lower back.

Laboratory: The patient's urinalysis reveals a large amount of blood and a small amount of leukocytes.

Assessment:

1. Urinary tract infection complicated by hematuria secondary to laser transurethral procedure
2. Low back pain, musculoskeletal

Plan:

1. The patient is placed on ciprofloxacin 500 mg, one p.o. b.i.d. for seven days, #14
2. The patient is given instruction in use of heat, ibuprofen, and rest

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Lolita M. Jones, RHIA, CCS

The ***ICD-10 Competency Assessment for Coders: ICD-10-CM & ICD-10-PCS*** features 70 questions and answers and 30 case studies with answers and explanations developed to help you kick off your training program and see where your coding and HIM staff need focused training efforts. You'll identify key areas of your staff members' understanding of ICD-10 that your training program will need to address. Each package includes five workbooks and one answer key.

The author includes correct answers to the questions and appropriate code selections for the case studies along with the rationale for each.

The ***ICD-10 Training Toolkit*** provides the building blocks for your training programs for physicians, as well as coding, HIM, documentation, and billing professionals in both inpatient and outpatient settings.

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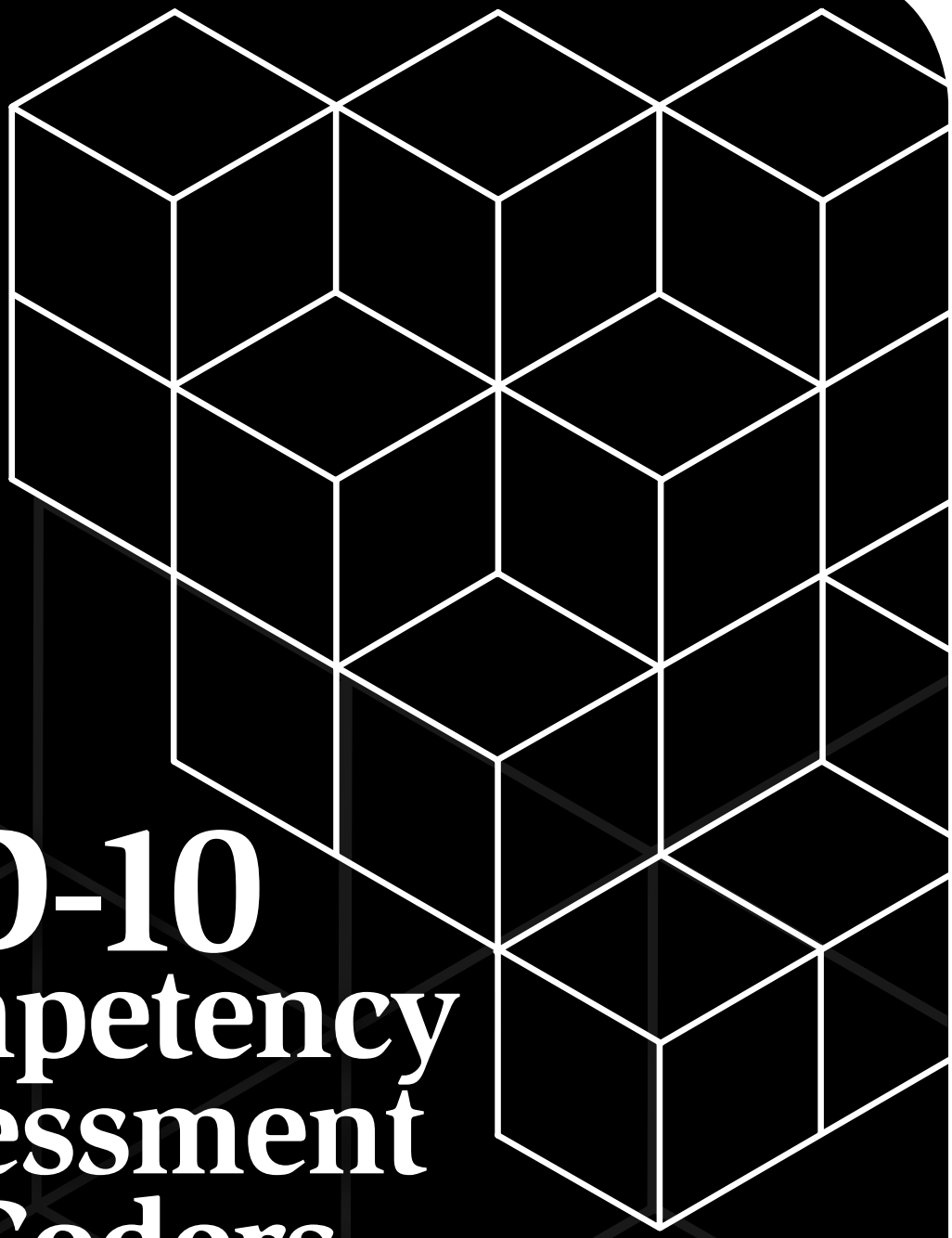

ICD-10 Competency Assessment for Coders

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ANSWER KEY

Contents

Chapter 1

Answer Key

Question 1

Correct answer:

c. Confirmation does not require documentation of positive serology or culture for HIV.

Rationale:

ICD-10-CM Official Guidelines for Coding and Reporting 2011, p. 16, at *www.cdc.gov/nchs/data/icd9/10cmguidelines2011_FINAL.pdf*, state:

> *Code only confirmed cases of HIV infection/illness. This is an exception to the hospital inpatient guideline Section II, H. In this context, "confirmation" does not require documentation of positive serology or culture for HIV; the provider's diagnostic statement that the patient is HIV positive, or has an HIV-related illness is sufficient.*

Question 2

Correct answer:

Fifth character for laterality

Rationale:

Refer to the following note at the beginning of the *ICD-10-CM Table of Neoplasms*:

> *Codes listed with a dash -, following the code have a required 5th character for laterality. The tabular list must be reviewed for the complete code.*

Access the *ICD-10 Table of Neoplasms* at *www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp#TopOfPage.*

Download the 2011 Code Tables and Index file.

Select icd10cm_neoplasm_2011.

Question 3

Correct answer:

b. A neoplasm code should be sequenced first, followed by a code from M84.5- for the pathological fracture.

Rationale:

ICD-10-CM Official Guidelines for Coding and Reporting 2011, p. 27, state:

> *If the focus of treatment is the neoplasm with an associated pathological fracture, the neoplasm code should be sequenced first, followed by a code from M84.5- for the pathological fracture.*

Question 4

Correct answer:

Excludes1

anemia due to antineoplastic chemotherapy (D64.81)

aplastic anemia due to antineoplastic chemotherapy (D61.1)

Rationale:

In the *2011 ICD-10-CM Tabular List of Diseases and Injuries*, this Excludes1 note appears below code D63.0.

Question 5

Correct answer:

a. E10.621 and L97.409

Rationale:

The following note appears in the *ICD-10-CM Tabular List of Diseases and Injuries*:

E10.621 Type 1 diabetes mellitus with foot ulcer

Use additional code to identify site of ulcer (L97.4-, L97.5-)

The additional code notes include "an unspecified" heel. Code L97.409 does not specify right or left laterality: Non-pressure chronic ulcer of unspecified heel and midfoot with unspecified severity. The other codes in the range specify the right foot, as the following descriptions indicate:

L97.419	*Non-pressure chronic ulcer of right heel and midfoot with unspecified severity*
L97.511	*Non-pressure chronic ulcer of other part of right foot limited to breakdown of skin*
L97.519	*Non-pressure chronic ulcer of other part of right foot with unspecified severity*

Access the *ICD-10-CM Tabular List of Diseases and Injuries* at *www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp#TopOfPage.*

Download the 2011 Code Tables and Index file.

Select icd10cm_Tabular.

Refer to Chapter 12, Diseases of the Skin and Subcutaneous Tissue (L00–L99).

Question 6

Correct answer:

False

Rationale:

This information does not exist in the *ICD-10-CM Tabular List of Diseases and Injuries* nor in the *ICD-10-CM Official Guidelines for Coding and Reporting 2011*. Attending physicians will need to document the severity of nonproliferative diabetic retinopathy to facilitate assignment of the most specific code.

Question 7

Correct answer:

- If both use and abuse are documented, assign only the code for abuse
- If both abuse and dependence are documented, assign only the code for dependence
- If use, abuse, and dependence are all documented, assign only the code for dependence
- If both use and dependence are documented, assign only the code for dependence

Rationale:

ICD-10-CM Official Guidelines for Coding and Reporting 2011, p. 31, state:

> *When the provider documentation refers to use, abuse and dependence of the same substance (e.g. alcohol, opioid, cannabis, etc.), only one code should be assigned to identify the pattern of use based on the following hierarchy:*
>
> - *If both use and abuse are documented, assign only the code for abuse*
> - *If both abuse and dependence are documented, assign only the code for dependence*
> - *If use, abuse and dependence are all documented, assign only the code for dependence*
> - *If both use and dependence are documented, assign only the code for dependence.*

Question 8

Correct answer:

Excludes2: symptoms, signs, and abnormal clinical laboratory findings, not elsewhere classified (R00–R99)

Rationale:

The following note appears at the beginning of Chapter 5. Therefore, it applies to all codes in the F01–F99 code range, which is the entire listing of codes in the chapter.

> *Chapter 5*
> *Mental and behavioral disorders (F01–F99)*
>
> *Excludes2: symptoms, signs and abnormal clinical laboratory findings, not elsewhere classified (R00–R99)*

ICD10CMPCS

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