CODING KNOWLEDGE AND SKILLS ASSESSMENT
Inpatient Coding Test

Section I: Please read the following questions carefully and select the best multiple choice or true/false answer.

1) A coding professional may assume a cause and effect relationship between hypertension and which of the following complications
   A. Heart disease.
   B. Renal Failure.
   C. Both heart disease and renal failure.
   D. No relationship can be assumed. The physician must document it.

2) Codes that contain the descriptive abbreviation NOS are to be used
   A. When the record itself is not available for review.
   B. When the coder lacks sufficient information to assign a more specific code.
   C. When the only outpatient diagnostic records are being coded.

3) If a patient is admitted to a 23-hour observation unit, has a minor procedure performed (such as the suture of an eyebrow laceration) and is subsequently admitted for additional conditions which need further workup, the record is combined to reflect one continuous stay. Codes, which are part of the observation record, may impact the DRG assignment. TRUE or FALSE

4) In a patient with a principal diagnosis of pneumonia, identification of the infecting organism via sputum or blood cultures may affect DRG assignment and reimbursement. TRUE or FALSE

5) When acute respiratory failure is present on admission along with aspiration or bacterial pneumonia and both conditions are equally treated either condition can be sequenced as the principal diagnosis. TRUE or FALSE

6) A diagnosis of seizure disorder or recurrent seizure is coded in the following way:
   A. 780.39
   B. 780.31
   C. 345.90
   D. 345.91

7) In a case where a patient is diagnosed as having both pneumococcal pneumonia and pneumococcal septicemia, coding guidelines require that both conditions be coded (481 + 038.2). TRUE or FALSE
8) When a patient is admitted to the hospital for treatment of a secondary malignancy, and the primary is still present, the principal diagnosis is the:

A. Primary Site.
B. Secondary Site.

9) Which of the following is not true about DRGs:

A. The principle diagnosis is always the determining factor.
B. Surgical ICD-9 codes affect it.
C. Age is a factor.
D. Sex is a factor.
E. Discharge status/ Place of disposition is a factor.

10) Which of the following is classified as a poisoning in ICD-9?

A. Syncope due to Benadryl Allergy pills and a three-martini lunch.
B. Digitalis intoxication.
C. Reaction to dye administered for a pyelogram.
D. Idiosyncratic reaction between various drugs.

Section II: Read each question carefully. Assign all applicable ICD-9-CM diagnoses and procedures. Assign the principal procedure FIRST. E codes and V codes should be assigned when applicable. Please note, indicate yes or no whether you feel there is a physician query opportunity from the following coding scenarios and if yes, describe briefly why you would submit a query.

1.) 59-year-old patient was scheduled for a right THA (total hip arthroplasty) for DJD (degenerative joint disease) of hip. The morning of admission, the patient was found to have an elevated temperature of 102 and the patient's urinalysis was found to have bacteria and a colony count of 100,000 E. coli with a final diagnosis of urosepsis. The hip replacement was cancelled and the patient was given IV Tetracycline. The patient was discharged the following day with plans to reschedule the THA.

Principal diagnosis:

Secondary diagnosis code(s):

ICD-9-CM procedure code(s):

Query: Yes or No / Provide Reason:

2.) A patient is seen in the ER with sever abdominal cramping, nausea and vomiting, and diarrhea. She states that she at a turkey salad several hours before the symptoms developed and they have lasted now for 20 hours. Lab tests show severe dehydration and she is admitted for IV therapy. Final Diagnoses are dehydration, salmonella gastroenteritis, nausea, vomiting, diarrhea and abdominal cramping. Assign the appropriate codes:
3.) A 53-year-old male was to be admitted to the hospital following a TURP (transurethral radical prostatectomy). The patient had been having urinary retention for the past 2 months and the Urologist stated the urinary retention was due to the BPH (benign prostatic hypertrophy) and it was necessary to have a TURP for BPH. The past medical history included hypertension, insulin dependent diabetes mellitus, CAD (coronary artery disease) with PTCA (percutaneous transluminal coronary angioplasty) in 2001. The home medications included Norvasc®, Sliding Scale Lente Insulin injections, and one 81 mg Aspirin a day.

The TURP was completed and the postoperative period was uneventful. The patient was to be discharged 48 hours following the TURP. The physician received the pathology report following the patient’s discharge and the findings were BPH and adenocarcinoma of the prostate.

Principal diagnosis:

Secondary diagnosis code(s):

ICD-9-CM procedure code(s):

Query: Yes or No / Provide Reason:

4.) A 37-year-old female was admitted for a scheduled C-section. This is the patient’s second pregnancy. The past history includes a previous cesarean section in 2002 for CPD (cephalopelvic disproportion). The patient was offered to deliver vaginally for this pregnancy, but declined and preferred to deliver by C-section.

A low transverse C-section was performed under epidural anesthetic and the patient delivered a 5 lb 4 oz female. There appeared to be no fetal abnormalities at the time of delivery. The patient developed a headache within the first 24 hours and Anesthesia was requested to see the patient for the headache. The Anesthesiologist recommended drinking lots of fluids and Tylenol. If this did not work they would consider doing a spinal blood patch.

The patient’s headache improved and the patient was discharged to home with instructions to call if her headache recurred or any other problems occurred.

Principal diagnosis:

Secondary diagnosis code(s):

ICD-9-CM procedure code(s):
5.) A 60-year-old female attempted suicide by taking an overdose of amitriptyline, hydrocodone and tramadol. She was initially seen in the emergency department at another facility in a coma and in acute respiratory failure, intubated, and placed on mechanical ventilation. The patient was then transferred to our hospital for continued toxicology management and for treatment of acute respiratory failure. The patient remained on the ventilator for three days.

Principal diagnosis:

Secondary diagnosis code(s):

ICD-9-CM procedure code(s):

Query: Yes or No / Provide Reason:

6.) A 67-year-old patient was admitted to the hospital with chest pain. In the final diagnostic statement, the provider documented chest pain, most likely of gastrointestinal (GI) origin. The patient has a history of hypertension (on current medication for this) with end stage renal failure on dialysis and long standing type II diabetes which is insulin requiring.

Principal diagnosis:

Secondary diagnosis code(s):

ICD-9-CM procedure code(s):

Query: Yes or No / Provide Reason:

7.) A 61 year old female presented to the emergency department with severe chest pain. The patient was admitted with a diagnosis of unstable angina and is to undergo a cardiac catheratization with possible PTCA. The patient is also morbidly obese with a physician documented BMI of 45. The patient has type II diabetes and is on Avandia and suffers from panic disorder, which she takes Xanax PRN. The patient goes to the cardiac cath lab and has a diagnostic left heart cath with a coronary arterioagrapy (Judkins Technique) and left ventriculography that reveals severe coronary artery disease of the native coronary artery. The patient undergoes a PTCA with successful placement of a single Cypher stent into the coronary artery. The patient is also given a platelet inhibitor tirofiban (IV infused) during the procedure. The patient tolerates the procedure well and the final dx is: Unstable Angina secondary to severe vessel CAD treated successfully.

Principal diagnosis:

Secondary diagnosis code(s):

ICD-9-CM procedure code(s):
8.) An 80 year old hypertensive patient was admitted to the hospital for cholecystectomy. The patient underwent an open cholecystectomy with exploration of the common duct and choledocholithotomy. Final diagnostic statement: Acute and chronic cholecystitis with choledocholithiasis and cholelithiasis.

Principal diagnosis:

Secondary diagnosis code(s):

ICD-9-CM procedure code(s):

Query: Yes or No / Provide Reason: