FY 2017 ICD-10-CM Guideline Updates

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How to Review Guideline Changes

1. Download the FY 2017 ICD-10-CM Guidelines from the NCHS website
2. Narrative changes appear in **bold** text
3. Items that have been moved within the guidelines since the FY 2016 version are **underlined**
4. Revisions to heading changes are shown in *italics*
5. Take this time to re-review all of the guidelines

- **Excludes1**
  - A type 1 Excludes note is a pure excludes note. It means “NOT CODED HERE!” An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

  - An exception to the Excludes1 definition is the circumstance when the two conditions are unrelated to each other. If it is not clear whether the two conditions involving an Excludes1 note are related or not, query the provider. For example, code F45.8, Other somatoform disorders, has an Excludes1 note for "sleep related teeth grinding (G47.63)," because "teeth grinding" is an inclusion term under F45.8. Only one of these two codes should be assigned for teeth grinding. However psychogenic dysmenorrhea is also an inclusion term under F45.8, and a patient could have both this condition and sleep related teeth grinding. In this case, the two conditions are clearly unrelated to each other, and so it would be appropriate to report F45.8 and G47.63 together.
Etiology/manifestation convention ("code first", "use additional code" and "in diseases classified elsewhere" notes)

- Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, if applicable, followed by the manifestation. Wherever such a combination exists, there is a "use additional code" note at the etiology code, and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.

- Paragraphs 2-6 (no changes)
• “With”
  - The word “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related.
  - The word “with” in the Alphabetic Index is sequenced immediately following the main term, not in alphabetical order.

• Code assignment and Clinical Criteria
  – The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

• Laterality

  – Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side.

  – When a patient has a bilateral condition and each side is treated during separate encounters, assign the "bilateral" code (as the condition still exists on both sides), including for the encounter to treat the first side. For the second encounter for treatment after one side has previously been treated and the condition no longer exists on that side, assign the appropriate unilateral code for the side where the condition still exists (e.g., cataract surgery performed on each eye in separate encounters). The bilateral code would not be assigned for the subsequent encounter, as the patient no longer has the condition in the previously-treated site. If the treatment on the first side did not completely resolve the condition, then the bilateral code would still be appropriate.

- Documentation for BMI, Depth of Non-pressure ulcers, Pressure Ulcer Stages, Coma Scale, and NIH Stroke Scale
  - For the Body Mass Index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stage, coma scale, and NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke, or pressure ulcer) must be documented by the patient’s provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient’s attending provider should be queried for clarification.
  - The BMI, coma scale, and NIHSS codes should only be reported as secondary diagnoses.

ICD-10-CM Official Guidelines for Coding and Reporting FY 2017, Page 17
ICD-10-CM Guideline I.B.16.

• Documentation of Complications of Care
  – Code assignment is based on the provider’s documentation of the relationship between the condition and the care or procedure, unless otherwise instructed by the classification. The guideline extends to any complications of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications. There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication. Query the provider for clarification, if the complication is not clearly documented.
ICD-10-CM Guideline I.C.1.f.

• Zika virus infections
  1. Code only confirmed cases
     – Code only a confirmed diagnosis of Zika virus (A92.5, Zika virus disease) as documented by the provider. This is an exception to the hospital inpatient guideline Section II, H.
     – In this context, “confirmation” does not require documentation of the type of test performed; the physician’s diagnostic statement that the condition is confirmed is sufficient. This code should be assigned regardless of the stated mode of transmission.
     – If the provider documents "suspected", "possible" or "probable" Zika, do not assign code A92.5. Assign a code(s) explaining the reason for encounter (such as fever, rash, or joint pain) or Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.
ICD-10-CM Guideline I.C.4.a.3

• Diabetes mellitus and the use of insulin and oral hypoglycemics
  – If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, code E11, Type 2 diabetes mellitus, should be assigned. Code Z79.4, Long-term (current) use of insulin, or Z79.84, Long term (current) use of oral hypoglycemic drugs, should also be assigned to indicate that the patient uses insulin or hypoglycemic drugs. Code Z79.4 should not be assigned if insulin is given temporarily to bring a type 2 patient’s blood sugar under control during an encounter.

• Secondary diabetes mellitus and the use of insulin or hypoglycemic drugs
  – For patients who routinely use insulin or hypoglycemic drugs, code Z79.4, Long-term (current) use of insulin, or Z79.84, Long term (current) use of oral hypoglycemic drugs should also be assigned. Code Z79.4 should not be assigned if insulin is given temporarily to bring a patient’s blood sugar under control during an encounter.

• **Hypertension**
  – The classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term “with” in the Alphabetic Index. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.
  – For hypertension and conditions not specifically linked by relational terms such as “with,” “associated with” or “due to” in the classification, provider documentation must link the conditions in order to code them as related.

• Hypertension with Heart Disease
  – Hypertension with heart conditions classified to I50.- or I51.4-I51.9, are assigned to a code from category I11, Hypertensive heart disease. Use an additional code from category I50, Heart failure, to identify the type of heart failure in those patients with heart failure.
  – The same heart conditions (I50.-, I51.4-I51.9) with hypertension are coded separately if the provider has specifically documented a different cause. Sequence according to the circumstances of the admission/encounter.

• **Hypertensive Chronic Kidney Disease**
  – Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present. **CKD should not be coded as hypertensive if the physician has specifically documented a different cause.**
  – The appropriate code from category N18 should be used as a secondary code with a code from category I12 to identify the stage of chronic kidney disease.
  – If a patient has hypertensive chronic kidney disease and acute renal failure, an additional code for the acute renal failure is required.
**Hypertensive Heart and Chronic Kidney Disease**

- Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when **there is hypertension with both heart and kidney involvement**. If heart failure is present, assign an additional code from category I50 to identify the type of heart failure.

- The appropriate code from category N18 should be used as a secondary code with a code from category I12 to identify the stage of chronic kidney disease.


- The codes in category I13, Hypertensive heart and chronic kidney disease, are combination codes that include hypertension, heart disease and chronic kidney disease. The Includes note at I13 specifies that the conditions included at I11 and I12 are included together in I13. If a patient has hypertension, heart disease and chronic kidney disease, then a code from I13 should be used, not individual codes for hypertension, heart disease and chronic kidney disease, or codes from I11 or I12.

- For patients with both acute renal failure and chronic kidney disease, an additional code for acute renal failure is required.

*ICD-10-CM Official Guidelines for Coding and Reporting FY 2017, Pages 43-44*
• Hypertensive Crisis
  – Assign a code from category I16, Hypertensive crisis, for documented hypertensive urgency, hypertensive emergency or unspecified hypertensive crisis. Code also any identified hypertensive disease (I10-I15). The sequencing is based on the reason for the encounter.

• **ST elevation myocardial infarction (STEMI) and non ST elevation myocardial infarction (NSTEMI)**
  
  – The ICD-10-CM codes for acute myocardial infarction (AMI) identify the site, such as anterolateral wall or true posterior wall. Subcategories I21.0-I21.2 and code I21.3 are used for ST elevation myocardial infarction (STEMI). Code I21.4, Non-ST elevation (NSTEMI) myocardial infarction, is used for non ST elevation myocardial infarction (NSTEMI) and nontransmural MIs.
  
  – If NSTEMI evolves to STEMI, assign the STEMI code. If STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI.
  
  – For encounters occurring while the myocardial infarction is equal to, or less than, four weeks old, including transfers to another acute setting or a postacute setting, and the myocardial infarction meets the definition for “other diagnoses” (see Section III, Reporting Additional Diagnoses), codes from category I21 may continue to be reported. For encounters after the 4 week time frame and the patient is still receiving care related to the myocardial infarction, the appropriate aftercare code should be assigned, rather than a code from category I21. For old or healed myocardial infarctions not requiring further care, code I25.2, Old myocardial infarction, may be assigned.

ICD-10-CM Official Guidelines for Coding and Reporting FY 2017, Pages 46-47
ICD-10-CM Guideline I.C.12.a.5.

- Patients admitted with pressure ulcers documented as healing
  - Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record. If the documentation does not provide information about the stage of the healing pressure ulcer, assign the appropriate code for unspecified stage.
  - If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider.
  - For ulcers that were present on admission but healed at the time of discharge, assign the code for the site and stage of the pressure ulcer at the time of admission.

- Patients admitted with pressure ulcer evolving into another stage during the admission
  - If a patient is admitted with a pressure ulcer at one stage and it progresses to a higher stage, **two separate codes should be assigned**: one code for the site and stage of the ulcer on admission and a second code for the same ulcer site and the highest stage reported during the stay.

- **Coding of Pathologic Fractures**
  - 7th character A is for use as long as the patient is receiving active treatment for the fracture. While the patient may be seen by a new or different provider over the course of treatment for a pathological fracture, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.
  - 7th character D is to be used for encounters after the patient has completed active treatment. The other 7th characters, listed under each subcategory in the Tabular List, are to be used for subsequent encounters for *routine care of fractures during the healing and recovery phase as well as* treatment of problems associated with the healing, such as malunions, nonunions, and sequelae.
  - Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes.

ICD-10-CM Official Guidelines for Coding and Reporting FY 2017, Page 52
• **Supervision of High-Risk Pregnancy**
  
  - Codes from category O09, Supervision of high-risk pregnancy, are intended for use only during the prenatal period. For complications during the labor or delivery episode as a result of a high-risk pregnancy, assign the applicable complication codes from Chapter 15. If there are no complications during the labor or delivery episode, assign code O80, Encounter for full-term uncomplicated delivery.
  
  - For routine prenatal outpatient visits for patients with high-risk pregnancies, a code from category O09, Supervision of high-risk pregnancy, should be used as the first-listed diagnosis. Secondary chapter 15 codes may be used in conjunction with these codes if appropriate.

*ICD-10-CM Official Guidelines for Coding and Reporting FY 2017, Page 56*
ICD-10-CM Guideline I.C.15.b.4.

• When a delivery occurs
  – When an obstetric patient is admitted and delivers during that admission, the condition that prompted the admission should be sequenced as the principal diagnosis. If multiple conditions prompted the admission, sequence the one most related to the delivery as the principal diagnosis. A code for any complication of the delivery should be assigned as an additional diagnosis. In cases of cesarean delivery, if the patient was admitted with a condition that resulted in the performance of a cesarean procedure, that condition should be selected as the principal diagnosis. If the reason for the admission was unrelated to the condition resulting in the cesarean delivery, the condition related to the reason for the admission should be selected as the principal diagnosis.

ICD-10-CM Official Guidelines for Coding and Reporting FY 2017, Page 56
ICD-10-CM Guideline I.C.15.h.

• Long term use of insulin and oral hypoglycemics
  – Code Z79.4, Long-term (current) use of insulin, or code Z79.84, Long-term (current) use of oral hypoglycemic drugs, should also be assigned if the diabetes mellitus is being treated with insulin or oral medications. If the patient is treated with both oral medications and insulin, only the code for insulin-controlled should be assigned.
ICD-10-CM Guideline I.C.15.i.

- **Gestational (pregnancy induced) diabetes**
  - Gestational (pregnancy induced) diabetes can occur during the second and third trimester of pregnancy in women who were not diabetic prior to pregnancy. Gestational diabetes can cause complications in the pregnancy similar to those of pre-existing diabetes mellitus. It also puts the woman at greater risk of developing diabetes after the pregnancy. Codes for gestational diabetes are in subcategory O24.4, Gestational diabetes mellitus. No other code from category O24, Diabetes mellitus in pregnancy, childbirth, and the puerperium, should be used with a code from O24.4.
  - The codes under subcategory O24.4 include diet controlled, insulin controlled, and controlled by oral hypoglycemic drugs. If a patient with gestational diabetes is treated with both diet and insulin, only the code for insulin-controlled is required. **If a patient with gestational diabetes is treated with both diet and oral hypoglycemic medications, only the code for "controlled by oral hypoglycemic drugs" is required.** Code Z79.4, Long-term (current) use of insulin or code Z79.84, Long-term (current) use of oral hypoglycemic drugs, should not be assigned with codes from subcategory O24.4.
  - An abnormal glucose tolerance in pregnancy is assigned a code from subcategory O99.81, Abnormal glucose complicating pregnancy, childbirth, and the puerperium.

*ICD-10-CM Official Guidelines for Coding and Reporting FY 2017, Pages 58-59*
• Observation and Evaluation of Newborns for Suspected Conditions not Found

1) Assign a code from category Z05, Observation and evaluation of newborns and infants for suspected conditions ruled out, to identify those instances when a healthy newborn is evaluated for a suspected condition that is determined after study not to be present. Do not use a code from category Z05 when the patient has identified signs or symptoms of a suspected problem; in such cases code the sign or symptom.

2) A code from category Z05 may also be assigned as a principal or first-listed code for readmissions or encounters when the code from category Z38 code no longer applies. Codes from category Z05 are for use only for healthy newborns and infants for which no condition after study is found to be present.

3) Z05 on a birth record
A code from category Z05 is to be used as a secondary code after the code from category Z38, Liveborn infants according to place of birth and type of delivery.
• **Coma scale**

  – The coma scale codes (R40.2-) can be used in conjunction with traumatic brain injury codes, *acute cerebrovascular disease or sequelae of cerebrovascular disease codes*. These codes are primarily for use by trauma registries, but they may be used in any setting where this information is collected. The coma scale may also be used to assess the status of the central nervous system for other non-trauma conditions, such as monitoring patients in the intensive care unit regardless of medical condition. The coma scale codes should be sequenced after the diagnosis code(s).

  – These codes, one from each subcategory, are needed to complete the scale. The 7th character indicates when the scale was recorded. The 7th character should match for all three codes.

  – At a minimum, report the initial score documented on presentation at your facility. This may be a score from the emergency medicine technician (EMT) or in the emergency department. If desired, a facility may choose to capture multiple coma scale scores.

  – Assign code R40.24, Glasgow coma scale, total score, when only the total score is documented in the medical record and not the individual score(s).
• NIHSS Stroke Scale
  – The NIH stroke scale (NIHSS) codes (R29.7--) can be used in conjunction with acute stroke codes (I63) to identify the patient's neurological status and the severity of the stroke. The stroke scale codes should be sequenced after the acute stroke diagnosis code(s).
  – At a minimum, report the initial score documented. If desired, a facility may choose to capture multiple stroke scale scores.
  – See Section I.B.14. for information concerning the medical record documentation that may be used for assignment of the NIHSS codes.

• Application of 7th Characters in Chapter 19
  – Paragraphs 1 & 2 (no changes)
  – 7th character “A”, initial encounter is used for each encounter where the patient is receiving active treatment for the condition.
  – 7th character “D” subsequent encounter is used for encounters after the patient has completed active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.
  – Paragraphs 5 & 6 (no changes)

ICD-10-CM Official Guidelines for Coding and Reporting FY 2017, Pages 69-70

• Initial vs. Subsequent Encounter for Fractures
  – Traumatic fractures are coded using the appropriate 7th character for initial encounter (A, B, C) for each encounter where the patient is receiving active treatment for the fracture. The appropriate 7th character for initial encounter should also be assigned for a patient who delayed seeking treatment for the fracture or nonunion.
  – Paragraphs 2-5 (no changes)
  – The open fracture designations in the assignment of the 7th character for fractures of the forearm, femur and lower leg, including ankle are based on the Gustilo open fracture classification. When the Gustilo classification type is not specified for an open fracture, the 7th character for open fracture type I or II should be assigned (B, E, H, M, Q).
  – Paragraph 7 (no changes)
• Poisoning
  – When coding a poisoning or reaction to the improper use of a medication (e.g., overdose, wrong substance given or taken in error, wrong route of administration), first assign the appropriate code from categories T36-T50. The poisoning codes have an associated intent as their 5th or 6th character (accidental, intentional self-harm, assault and undetermined. If the intent of the poisoning is unknown or unspecified, code the intent as accidental intent. The undetermined intent is only for use if the documentation in the record specifies that the intent cannot be determined. Use additional code(s) for all manifestations of poisonings.
  – If there is also a diagnosis of abuse or dependence of the substance, the abuse or dependence is assigned as an additional code.

• Adult and child abuse, neglect and other maltreatment
  – Paragraphs 1 & 2 (no changes)
  – For cases of confirmed abuse or neglect an external cause code from the assault section (X92-Y09) should be added to identify the cause of any physical injuries. A perpetrator code (Y07) should be added when the perpetrator of the abuse is known. For suspected cases of abuse or neglect, do not report external cause or perpetrator code.
  – Paragraph 4 (no changes)
  – If a suspected case of alleged rape or sexual abuse is ruled out during an encounter code Z04.41, Encounter for examination and observation following alleged adult rape or code Z04.42, Encounter for examination and observation following alleged child rape, should be used, not a code from T76.

• Observation

  – There are **three** observation Z code categories. They are for use in very limited circumstances when a person is being observed for a suspected condition that is ruled out. The observation codes are not for use if an injury or illness or any signs or symptoms related to the suspected condition are present. In such cases the diagnosis/symptom code is used with the corresponding external cause code.

  – The observation codes are to be used as principal diagnosis only. **The only exception to this is when the principal diagnosis is required to be a code from category Z38, Liveborn infants according to place of birth and type of delivery. Then a code from category Z05, Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out, is sequenced after the Z38 code.** Additional codes may be used in addition to the observation code, but only if they are unrelated to the suspected condition being observed.

  – *Paragraphs 3-6 (no changes)*

  – The observation Z code categories:

    Z03 Encounter for medical observation for suspected diseases and conditions ruled out
    Z04 Encounter for examination and observation for other reasons
    Except: Z04.9, Encounter for examination and observation for unspecified reason
    Z05 Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out

*ICD-10-CM Official Guidelines for Coding and Reporting FY 2017, Pages 91-92*
• **Encounters for Obstetrical and Reproductive Services**
  - Z codes for pregnancy are for use in those circumstances when none of the problems or complications included in the codes from the Obstetrics chapter exist (a routine prenatal visit or postpartum care). Codes in category Z34, Encounter for supervision of normal pregnancy, are always first-listed and are not to be used with any other code from the OB chapter.
  - Codes in category Z3A, Weeks of gestation, may be assigned to provide additional information about the pregnancy. **Category Z3A codes should not be assigned for pregnancies with abortive outcomes (categories O00-O08), elective termination of pregnancy (code Z33.32), nor for postpartum conditions, as category Z3A is not applicable to these conditions.** The date of the admission should be used to determine weeks of gestation for inpatient admissions that encompass more than one gestational week.
  - Paragraphs 3-5 (no changes)
ICD-10-CM Guideline Section II.

• **Selection of Principal Diagnosis**
  
  – *Paragraphs 1 & 2 (no changes)*
  
  – Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc). **The UHDDS definitions also apply to hospice services (all levels of care).**

  – *Paragraphs 4 & 5 (no changes)*
ICD-10-CM Guideline Section III.

• Reporting Additional Diagnoses
  – *Paragraphs 1 & 2 (no changes)*
  – Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc). *The UHDDS definitions also apply to hospice services (all levels of care).*
  – *Paragraph 4 (no changes)*
ICD-10-CM Guideline Section IV.

• Diagnostic Coding and Reporting Guidelines for Outpatient Services
  – These coding guidelines for outpatient diagnoses have been approved for use by hospitals/providers in coding and reporting hospital-based outpatient services and provider-based office visits. Guidelines in Section I, Conventions, general coding guidelines and chapter-specific guidelines, should also be applied for outpatient services and office visits.
  – Paragraphs 2 & 3 (no changes)
  – Though the conventions and general guidelines apply to all settings, coding guidelines for outpatient and provider reporting of diagnoses will vary in a number of instances from those for inpatient diagnoses, recognizing that:
    • The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis does not apply to hospital-based outpatient services and provider-based office visits.
    • Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.
• Encounters for general medical examinations with abnormal findings
  – The subcategories for encounters for general medical examinations, Z00.0-, provide codes for with and without abnormal findings. Should a general medical examination result in an abnormal finding, the code for general medical examination with abnormal finding should be assigned as the first-listed diagnosis. An examination with abnormal findings refers to a condition/diagnosis that is newly identified or a change in severity of a chronic condition (such as uncontrolled hypertension, or an acute exacerbation of chronic obstructive pulmonary disease) during a routine physical examination. A secondary code for the abnormal finding should also be coded.
References

• National Center for Health Statistics. ICD-10-CM FY 2017 Guidelines.
  http://www.cdc.gov/nchs/icd/icd10cm.htm
1. The word “with” should be interpreted to mean _______________ when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.
   a. “associated with”
   b. “due to”
   c. Either a. or b.
   d. None of the above

2. True or False? Code assignment is based on clinical criteria used by the provider to establish the diagnosis.
   a. True
   b. False

3. Which of the following may be based on medical record documentation from clinicians who are not the patient’s provider, such as a nurse, emergency medical technician or dietician?
   a. NIH stroke scale (NIHSS)
   b. Depth of non-pressure ulcers
   c. Coma scale
   d. All of the above

4. What code is assigned for an inpatient diagnosis of “probable Zika”?
   a. A92.5, Zika virus disease
   b. A98.8, Other specified viral hemorrhagic fevers
   c. B34.8, Other viral infections of unspecified site
   d. Assign a code(s) explaining the reason for encounter (such as fever, rash, or joint pain) or Z20.828, Contact with and (suspected) exposure to other viral communicable diseases

5. True or False? A code for hypertensive crisis would also be assigned as the principal diagnosis.
   a. True
   b. False

6. If a patient is admitted with a pressure ulcer at stage 1 that progresses to a stage 2 during admission, what code(s) is/are assigned?
   a. Stage 1 code only
   b. Stage 2 code only
   c. Two separate codes – stage 1 and stage 2
   d. Query the physician

7. Which of the following statements is true regarding Z05 category codes?
   a. A code from category Z05 may be assigned as a principal or first-listed code for readmissions or encounters when the code from category Z38 no longer applies
   b. Codes from category Z05 are for use only for healthy newborns and infants for which no condition after study is found to be present
c. Do not use a code from category Z05 when the patient has identified signs or symptoms of a suspected problem; in such cases code the sign or symptom
d. All of the above are true statements

8. UHDDS definitions apply to which of the following healthcare settings?
   a. Nursing homes
   b. Hospice services
   c. Home health agencies
   d. All of the above

9. True or False? When an obstetric patient is admitted and delivers during that admission, the condition that prompted the admission should be sequenced as the principal diagnosis.
   a. True
   b. False

10. If the intent of a poisoning is unknown or unspecified, code the intent as ____________.
    a. Accidental
    b. Uncertain
    c. Undetermined
    d. Assault