Coding Cases

Case 1

Subjective: The patient is a 66-year-old female who presents to the clinic today for a five-month recheck on her type II diabetes mellitus, as well as mixed hyperlipidemia. As far as her diabetes she states that she only checks her blood sugars in the morning and those have all been ranging less than 100. She has not been checking any two hours after meals. Her blood pressures when she does check them have been running normal as well but she does not have any record of these present with her. No other issues or concerns.

Medications: She is on Hyzaar 50/12.5 one-half p.o. daily, coated aspirin daily, lovastatin 40 mg one-half tab p.o. daily, multivitamin daily, metformin 500 mg one tab p.o. b.i.d.; however, she has been skipping her second dose during the day.

Social History: She is a nonsmoker.

Objective:
Vital Signs: Temperature: 98.2. Pulse: 64. Respirations: 16. Blood pressure: 110/56. Weight: 169.
General: Alert and oriented x 3. No acute distress noted.
Neck: No lymphadenopathy, thyromegaly, JVD or bruits.
Lungs: Clear to auscultation.
Heart: Regular rate and rhythm without murmur or gallops present.
Musculoskeletal: She did have full range of motion of her shoulders. There is no swelling, crepitus or discoloration noted.

Medical Decision Making: Most recent hemoglobin A1c was 5.6 percent back in October 2004. Most recent lipid checks were obtained back in July 2004. We have not had this checked since that time.

Assessment:

1. Type II diabetes mellitus.
2. Mixed hyperlipidemia.

Plan: She is going to go to lab to obtain a hemoglobin A1c, BMP, lipids, CPK, liver enzymes and quantitative microalbumin.

ICD-10-CM Codes: _____

Case 2

Subjective: The daughter brings this patient in because the right ear had started draining. The patient was strongly advised to leave the hearing aid out of that ear.

Objective: Under the microscope, there is gross pus in the ear canal. It was cleaned and 5 drops of ofloxacin placed in the ear.

Assessment: Acute otitis media on the right.

Plan: Ofloxacin 5 drops b.i.d. x10 days. I also put in a prescription for Claritin 10 mg per day. The patient was advised to return in 2 weeks if the ear continued to drain. Otherwise, he will keep the appointment next month.

ICD-10-CM Codes: _____

Case 3

Jack presents with 6 weeks of nasal congestion, yellow-green sinus drainage, fatigue, and intermittent facial and head pain. His symptoms started as a post-nasal drip, and then progressed to nasal congestion with the aforementioned sinus drainage. He initially was treated with 10 days of oral clarithromycin and an extended-release guafenesin-pseudoephedrine product, with no relief. His symptoms did abate temporarily, but then returned with similar intensity.

On examination, there is again injection and erythema of the turbinates, this time with visible purulent nasal discharge. There is severe facial tenderness to percussion. The remainder of the ENT examination is within normal limits.

Acute maxillary sinusitis. The patient is switched to oral levofloxacin for 10 days and continues on the guafenesin + pseudoephedrine. Will see back in 14 days.

ICD-10-CM Codes: _____

Case 4

Chief Complaint: Right knee pain.

History of the Present Illness: The patient presents today for follow up of osteoarthritis Grade IV of the bilateral knees and flexion contracture, doing great. Physical therapy is helping. The subjective pain is on the bilateral knees right worse than left. Quality: There is no swelling, no redness, or warmth. The pain is described as aching occasionally. There is no burning. Duration: Months. Associated symptoms: Includes stiffness and weakness. There is no sleep loss and no instability.

Hip Pain: None.

Back pain: None.

Radicular type pain: None. Modifying factors: Includes weight bearing pain and pain with ambulation. There is no sitting, and no night pain. There is no pain with weather change.

Viscosupplementation in Past: No Synvisc.

VAS Pain Score: 10 bilaterally.

Review of Systems: No change.
Constitutional: Good appetite and energy. No fever. No general complaints.
HEENT: No headaches, no difficulty swallowing, no change in vision, no change in hearing.
CV - RESP: No shortness of breath at rest or with exertion. No paroxysmal nocturnal dyspnea,

orthopnea, and without significant cough, hemoptysis, or sputum. No chest pain on exertion.
GI: Clear without nausea - vomiting - and absent of diarrhea. Absent of abdominal pain. No complaints of dyspepsia. No dysphagia. No hematochezia, and no melena.
Skin: No lesions seen.
Neurological: No signs or symptoms are reported. No TIA or CVA symptoms are reported. No radicular pain is reported.

Objective: No change.
Head: Normocephalic, atraumatic, and no headaches.
Neck: Full range of motion.
Lymph nodes: No abnormalities noted.
Respiratory: Stable respiratory rate. Lung fields are clear.
Cardiovascular: Regular rate and rhythm without murmurs, gallops, or rubs
Abdomen: Non-tender, no palpable masses.
Spine w/ pelvis: Full range of motion. No spine tenderness.
Skin: No rash or lesions noted.
Neurovascular: Grossly intact.
Psycho: Awake, alert, and oriented times 4. No depression.

Knee Examination: The patient comes to the clinic today and is full weight bearing. Exam of the right knee shows neurovascular status is normal. The skin reveals a scar. Crepitance is 2, and active range of motion is 10 to 110 degrees and passive range of motion is 7 to 120 degrees. There is a flexion contracture at 10 degrees, right knee. Effusion is 0 and ligaments are normal. The meniscal signs are absent. Exam of the left knee shows neurovascular status is normal. The skin reveals a scar. Crepitance is 2, and range of motion is 5 to 120 degrees. Effusion is 0 and ligaments are normal. The meniscal signs are absent.

Diagnoses: Osteoarthritis.

Recommendations/Plan of Treatment:
1. Excellent results with physical therapy.
2. Continue physical therapy.
3. Refill pain medication on a p.r. n. basis.

ICD-10-CM Codes: _____

Case 5

Phil is coming in today for a check on his hypertension, CKD stage 3, and morbid obesity. He has a BMI of 42. He has never smoked and is negative for diabetes or proteinuria. He states he is feeling well and is working on his diet and lifestyle modifications to lose weight. His blood pressure is 145/95 (last measurement 165/102). Current weight 275 lbs (15 lb loss). His most recent labs are as follows:

Serum potassium = 4.4 mmol/litre

Serum creatinine = 260 micromol/litre

eGFR = 33 mL/minute/1.73 m2

Fasting total cholesterol = 3.4 mmol/litre

Liver function and other U + Es are normal

His medications include: lisinopril 20 mg daily, bendroflumethiazide 2.5 mg daily, simvastatin 40 mg daily.

Will continue current meds. Discussed continued weight loss measures with the patient. He states he is starting with a personal trainer this week.

ICD-10-CM code(s): _____

Case 6

History of Present Illness: The patient is here for recheck of his diastolic congestive heart failure. He is status post mechanical aortic valve replacement on 10/15/2009 for which he has been on chronic anticoagulation.

Review of Systems:
General: Unremarkable.
Cardiopulmonary: No chest pain, shortness of breath, palpitations, or dizziness.
Gastrointestinal: Unremarkable.
Musculoskeletal: Unremarkable.
Neurologic: Unremarkable.

Family History: There are no family members with coronary artery disease. His mother has congestive heart failure.

Social History: The patient is married. He lives with his wife. He is employed as a barber. He does not use alcohol, tobacco, or illicit drugs.

Allergies: None.

Physical Examination:
General: A well-appearing, obese black male.
Vital Signs: BP 140/80, HR 88, respirations 16, and afebrile.
HEENT: Grossly normal.
Neck: Normal. Thyroid, normal. Carotid, normal upstroke, no bruits.
Chest: Midline sternotomy scar.
Lungs: Clear.
Heart: PMI fifth intercostal space mid clavicular line. Normal S1 and prosthetic S2. No murmur, rub, gallop, or click.
Abdomen: Soft and nontender. No palpable mass or hepatosplenomegaly.
Extremities: Normal. No edema. Pulses bilaterally intact, carotid, radial, femoral, and dorsalis pedis.
Neurologic: Mental status, no gross cranial nerve, motor, or sensory deficits.

Impression:

1. Congestive heart failure, diastolic, chronic, stable, NYSHA class I to II.
2. Status post aortic valve replacement on 10/15/2009, on chronic anticoagulation.

ICD-10-CM Codes: _____

Case 7

Subjective—Patient is a 54-year-old male who complains of an ulcer underneath his L big toe x 3 years. States that he is a truck driver. States that he had 2 previous surgeries from another physician.

PMH—Gout, Chronic Ulcer L, HTN, Low Back pain.

Medications—Zestril, Allopurinol.

Allergies—NKDA

On Exam—Chronic ulcer with keratoma L plantar hallux and 1st MPJ area with breakdown through epidermis into dermis. Positive odor. Positive swelling L hallux. No signs of Osteomyelitis on X-ray. X-rays show a prominent osteophyte joint at L plantar hallux.

Assessment—Non healing Ulcer L plantar hallux and 1st MPJ area. Prominent osteophyte. Chronic idiopathic gout left foot. Plan - Exostectomy L hallux. Following the planned surgery, the patient's ulcer should completely heal within 5 weeks.

Goal—By removing prominent bone this will reduce pressure off the chronic ulcer an allow healing. (I used a medial incision L hallux above the ulcer, and left the ulcer alone. Keep sutures in 3 to 4 weeks to prevent a wound dehiscence.)

ICD-10-CM Codes: _____

Case 8

Preoperative Diagnosis: Prostate carcinoma.

Postoperative Diagnosis: Prostate carcinoma.

Procedure: Robotic-assisted radical prostatectomy

Anesthesia: General.

Complications: None

Drains: A 20-French Foley catheter and a 1 cm Jackson-Pratt drain in the pelvis.

Condition: Patient to recover room in stable condition.

Indications for the Procedure: The patient is a 67-year-old white male with prostate carcinoma now admitted for robotic prostatectomy. The patient understands all the risks of the procedure including bleeding, infection, bowel, vessel, bladder injury, urinary incontinence, urinary retention, erectile dysfunction and is now brought for surgery. Patient also has an umbilical hernia. We will repair this at the same time.

Procedure in Detail: Patient brought to the operating room, prepped and draped in the usual sterile fashion in the dorsal lithotomy position. A small supraumbilical incision was made. This was carried down through the skin and subcutaneous tissue. The fascia was opened. There was a large amount of omentum that was into his umbilical hernia. This was transected. The remaining part of the omentum was removed from the umbilical hernia. There was no bowel in the umbilical hernia.

Camera trocar was inserted. Da Vinci ports and working ports were placed in their standard position. Retroperitoneal space was entered by taking down the bladder flap anteriorly. Prostate was identified. The endopelvic fascia on either side of the prostate was incised. The puboprostatic ligaments were left intact. Dorsal venous complex was secured with a #1 Vicryl in a figure-of-eight fashion and tied anteriorly to help with postoperative continence. The anterior bladder neck was then transected. Foley catheter balloon was deflated and brought into field using retractor of the 4th arm. Posterior bladder neck was transected. Both ureteral orifices were set back. Seminal vesicles were dissected out to their tips and transected. Vas were cauterized and transected. Lateral pedicles of the bladder neck were taken down with clips and sharp dissection. Prostate was dissected off the rectum. The dorsal venous complex was transected. The urethra was transected, and the specimen was placed into a lap bag. Bladder neck urethral anastomosis was undertaken using a running 2-0 Monocryl after the bladder neck had been closed with a 2-0 Monocryl. JP drain was placed in the pelvis. The anastomosis was watertight. All port sites were removed under direct vision. There was no bleeding seen. The umbilical hernia site was closed with #1 Vicryl as well as the remaining part of the fascia after the lap bag was removed. Clips were placed on the skin, a sterile dressing was applied. Patient was taken to recover room in stable condition.

ICD-10-CM Codes: _____

Case 9

Patient is a 59-year-old male who presents for a recheck of Depressive Disorders. Symptoms include depressed mood, hopelessness, crying spells, fatigue, sense of failure, and poor concentration. Sudden onset and patient describes this as severe and worsening. Symptoms do not include anxiety, manic symptoms, and obsessive compulsive disorders. The patient has suicidal thoughts but has no organized plan. No homicidal thoughts or plan.

Judgment and insight is appropriate concerning matters about self, displays appropriate response to everyday activities and judgment is appropriate for social situations. The patient displays or has experienced abnormal thoughts, has thoughts of suicide. Appropriate fund of knowledge, appropriate speech, and no impairment in reasoning is observed.

Impression: Depressive Disorder; major single episode, unspecified

ICD-10-CM Codes: _____

Case 10

A 41-year-old Caucasian male is concerned about his alcohol use. He was admitted under a court commitment filed by the patient's wife. This is his first marriage, has 3 children, age 18, 8, and 5. Lives in a rented apartment in Buffalo, has lived there for 4 years. He is currently unemployed. Last employer he was working for was a street painting company.

History of Present Illness: Patient has been in chemical dependency treatment twice in the last 12 months. July 2011 he reportedly hit a pole with his car and lost his job. He has been hospitalized two times for detoxification. Seen in the ER 2 days ago, with blood alcohol of .427. The patient had a temporary restraining order placed against him this spring because he threatened to hit his wife if she would not return the vodka bottle. He has also talked about putting a gun to his head. He is

described as lying on the couch and drinking all day and all night. She reports also that he does drink and drive. The patient was in the hospital 3 weeks ago for alcohol withdrawal seizures. The patient has been falling over because of intoxication and is described as drinking between a pint and a liter of vodka daily.

The patient tends to minimize the alcohol usage when talking to him today. He reports that he cannot go into treatment, which he needs to be finding employment to support his family. The patient states that he drinks a half pint daily. He reports that he was sober for 30 days after completing the chemical dependency treatment in March; however, the history from the ER doctor was that the patient started drinking shortly after this treatment. The patient denies any illicit drug use. He does report having a DUI in high school but denies any of these difficulties as an adult. The patient denies any gambling difficulties.

In terms of mood, his mood is good—he denies sadness. He reports he is sleeping well, appetite is good. He states his main enjoyment is riding a bike and spending time with his children. He denies having any suicidal ideation and when asked about a suicide comment of putting a gun to his head, he states he never said that. The patient does not describe himself as a chronic worrier. He has no history of anxiety, no history of psychotic symptoms or paranoia. Denies any obsessive compulsive symptoms, and describes himself as "a happy drunk."

PMH: No current medications, does report a seizure thought to be alcohol withdrawal which occurred 3 days after the patient stopped drinking. The patient does have tremors when he withdraws from alcohol. He denies any history of delirium tremors, denies a history of traumatic brain injury.

Family History: No mental illness in his family, although he does report that his father had a problem with alcohol.

Social History: Alcohol use as described in HPI. The patient's major stressors, he describes, is related to his drinking as well as unemployment. He did describe some marital difficulties and conflict related to alcohol use. His major support was describes as his wife, brother, and sister.

Developmental History: The patient was born in Kansas and grew up with his mother and father. Father was a farmer. The patient has 7 sisters and 4 brothers. He is the oldest in the family. He describes his growing up years as "a lot of kids." He reports frequent conflict between his siblings. He denies history of violence in the home. He denies history of sexual abuse. He describes some attention-seeking behaviors while in elementary school. He reports his grades as Bs and Cs. He states he had no difficulty making friends, completed a high school education. He does describe some alcohol use in high school. The patient was employed by Piggly Wiggly, was a manager of the frozen food department for 20 years, leaving the job in February stating that he wanted to do something else. The patient describes his marriage as going good.

Mental Status: The patient was casually dressed and he was somewhat slow in his thought process as well as his speech. The patient is oriented to place and time. His mood is described as good. His affect was flat and somewhat anxious and mildly irritable. Speech was somewhat flat. Thought content was normal – there are no delusional thoughts. No hallucinations were noted. Insight and judgment is poor. He reported suicidal ideation. The patient did not appear a reliable historian.

Continue to monitor the patient's mental status and review the need for any psychiatric medications. The patient is to be seen by Central Human Services for an evaluation of his chemical issues. The patient has been seen by occupational therapy and will be involved in groups when able.

Diagnosis:

AXIS I

Alcohol dependence, depressive disorder

AXIS II deferred

AXIS III

Report of history of seizure secondary to alcohol withdrawal

AXIS IV

Stress relating to chronic alcohol and difficulty maintaining sobriety

Stress relating to relationship

AXIS V

Global Assessment of Functioning (GAF) 40–45

D.K.G, MD

ICD-10-CM Codes: _____

Case 11

CC: OB with gestational diabetes, here for regular prenatal visit.

HPI: Gestational diabetic at 29-3 weeks using oral medications and diet that was diagnosed two weeks ago. Patient feeling well and taking medication as prescribed, see flow sheet. Patient tries to follow diet and exercises sporadically. Patient uses OneTouch Ultra and keeps a log book. Glucose readings are in the range of 110-135. No hypoglycemic episodes. Patient to have bi-weekly NST and BPP until delivery.

Assessment:

1. Gestational Diabetes mellitus without complications; will check Hg A1c. Refills on med
2. Patient to continue bi-weekly NST and BPP until delivery.

ICD-10-CM Codes: _____

Case 12

The patient is admitted by her OB. She is a 17-year-old G1P0 at 39-2 weeks. Admitted with contractions and is quite uncomfortable. She is 4–5 cm on admission, 80 percent and -2 station. She continues to labor throughout the morning and got to 7 cm when rupture of membranes occurred spontaneously. Over the course of the next hour she progressed to complete AND +2 STATION. She was instructed on pushing, pushing effectively, and at 15:08 a spontaneous delivery was completed. The baby's nose and mouth were bulb suctioned. The baby was vigorous upon delivery and was placed on the mother's abdomen, and he was dried thoroughly. The cord was doubly clamped and cut. Cord blood was obtained. This was followed by spontaneous delivery of placenta with an eccentric insertion of a 3-vessel cord. The fundus firmed with massage and 20 units Pitocin

was added to the IV fluid. Inspection of the perineum and vaginal vault revealed no lacerations or tears. Estimated blood loss was 300 ml. This is a male infant weighing 6-13, 20 inches with Apgars of 8 and 9. Mom and baby are both stable.

ICD-10-CM Codes: _____

Case 13

This 37-year-old patient is seen for a screening Pap and pelvic gyn examination at our office today. She is an established patient and complaining of abnormal vaginal discharge for approximately three weeks. She denied any trauma. Patient is sexually active and her LMP was ten days ago. She denies any chest pain, shortness of breath, or urinary problems. Patient has Pap and pelvic exam one year ago and is requesting a Pap and pelvic exam today.

Past Medical History: Two vaginal deliveries without complications. Allergies, unknown. Medications include Micardis 80 mg for hypertension. She does not smoke or drink. She is married and lives with her husband.

Examination: Vital Signs: BP 125/70; Pulse 85, Respirations 20. Height 5' 5", Weight 135 lb. Well developed, well-nourished female in no acute distress.

HEENT: Pupils equal, round and reactive to light and accommodation. Extraocular muscles are intact:

Neck: Thyroid not palpable. No jugular distention. Carotid pulses are present bilaterally.

Breasts: Manual breast exam reveals no masses, tenderness or nipple discharge. The breasts are asymmetrical with no nipple discharge.

Abdomen: No masses or tenderness noted. No hernias appreciated. No enlargement of the liver or spleen.

Pelvic: Vaginal examination reveals no lesions or masses. Discharge is noted and a sample was collected for testing and sent to an outside laboratory for testing. No bleeding noted. Examination of the external genitalia reveals normal pubic hair distribution. The vulva appears to be within normal limits. There are no lesions noted. A speculum is inserted. There is no evidence of prolapse. The cervix appears normal. A cervical smear is obtained and will be sent to pathology. The speculum is removed and a manual pelvic examination is performed. It appears that the uterus is smooth and no masses can be felt. Rectal examination is within normal limits. Screening occult blood is negative. Uterus is not enlarged. Urethral meatus is normal. No masses noted for urethra or bladder.

Assessment and Plan: Vaginal Discharge, Routine Pap and Pelvic performed today. Patient had Pap and pelvic examination one year ago. Patient was sent to our in-house lab for blood draw today and she is to follow-up in one week for lab results.

ICD-10-CM Codes: _____

020414

Case 14

History of Present Illness: This 59-year-old white male is seen for comprehensive annual health maintenance examination. He is in excellent overall health. Medical problems include dyslipidemia well controlled with niacin, and also history of concha bullosa of the left nostril, followed by ENT associated with slight septal deviation. There are no other medical problems. He has no symptoms at this time and remains in excellent health.

Past Medical History: Otherwise noncontributory. There is no operation, serious illness or injury other than as noted above.

Allergies: There are no known allergies.

Family History: Father died at age 67 with COPD and was a heavy smoker. His mother is 88, living and well. Two brothers, living and well. One sister died at age 20 months of pneumonia.

Social History: The patient is married. Wife is living and well. He jogs or does Cross Country track 5 times a week, and weight training twice weekly. No smoking or significant alcohol intake. He is a physician.

Review of Systems: Otherwise noncontributory. He has no gastrointestinal, cardiopulmonary, genitourinary or musculoskeletal symptomatology. No symptoms other than as described above.

Physical Examination:
GENERAL: He appears alert, oriented, and in no acute distress with excellent cognitive function. VITAL SIGNS: His height is 6 feet 2 inches, weight is 181.2, blood pressure is 126/80 in the right arm, 122/78 in the left arm, pulse rate is 68 and regular, and respirations are 16. SKIN: Warm and dry. There is no pallor, cyanosis or icterus. HEENT: Tympanic membranes benign. The pharynx is benign. Nasal mucosa is intact. Pupils are round, regular, and equal, reacting equally to light and accommodation. EOM intact. Fundi reveal flat discs with clear margins. Normal vasculature. No hemorrhages, exudates or microaneurysms. No thyroid enlargement. There is no lymphadenopathy. LUNGS: Clear to percussion and auscultation. NSR. No premature beat, murmur, S3 or S4. Heart sounds are of good quality and intensity. The carotids, femorals, dorsalis pedis, and posterior tibial pulsations are brisk, equal, and active bilaterally. ABDOMEN: Benign without guarding, rigidity, tenderness, mass or organomegaly. NEUROLOGIC: Grossly intact. EXTREMITIES: Normal. GU: Genitalia normal. There are no inguinal hernias. The prostate is small, if any, normal to mildly enlarged with discrete margins, symmetrical without significant palpable abnormality. There is no rectal mass. The stool is Hemoccult negative.

Impression:
1. Comprehensive annual health maintenance examination.
2. Dyslipidemia.

Plan: At this time, continue niacin 1000 mg in the morning, 500 mg at noon, and 1000 mg in the evening; aspirin 81 mg daily; multivitamins; vitamin E 400 units daily; and vitamin C 500 mg daily. Consider adding lycopene, selenium, and flaxseed to his regimen. All appropriate labs will be obtained today. Follow-up fasting lipid profile and ALT in 6 months.

ICD-10-CM Codes: _____

Case 15

Chief Complaint: Right inguinal hernia.

History of Present Illness: This patient is a 42-year-old African American male who presents today with a chief complaint of right inguinal hernia. The patient's history is provided by the patient. The patient states that this hernia has been ongoing for approximately 1 year. The patient states that he used to work in construction. The patient states that most recently he has noticed an increase in pain in the inguinal area that radiates down to his scrotal area with coughing, sneezing, or standing. The patient states that occasionally he does hear the bowel sounds in the hernia area.

He states it has not affected his bowel regimen. He states he still has a bowel movement daily. The patient's pain is characterized as stabbing. The patient states his symptoms have no relieving factors. The patient states he has been able to lie down occasionally and reduce the hernia.

Past Medical History: None.

Past Surgical History: None.

Allergies: No known drug allergies.

Medications: None.

Family History: Mother is deceased. She had high blood pressure and stroke. Father has unknown history. He has 4 brothers.

Social History: The patient is currently unemployed. However, he does work construction when he is able to work. The patient states that he drinks a 6-pack of beer on the weekends. He states he smokes ½ pack of cigarettes a day. He denies any illicit drug use.

Review of Systems:
CONSTITUTIONAL: Otherwise negative.

EARS/NOSE/MOUTH/THROAT: Otherwise negative.

CARDIOVASCULAR: Negative.

RESPIRATORY: Negative.

GASTROINTESTINAL: Negative.

GU: Large right inguinal hernia.

MUSCULOSKELETAL: Otherwise negative.

SKIN: Otherwise negative.

NEUROLOGIC: Negative.

PSYCHIATRIC: Negative.

Physical Examination:
GENERAL: This is a 42-year-old pleasant African American male, alert and oriented x3, in no acute distress.

SKIN: Warm, dry, and intact.

HEENT: Pupils are equal, round, and reactive to light. Extraocular movements intact. Mouth and pharynx are normal. Poor dentition noted.

NECK: Full range of motion. Trachea midline, No masses. No lymphadenopathy.

HEART: Regular rate and rhythm. No murmurs, rubs, or gallops. S1, S2 normal.

CHEST: Clear to auscultation bilaterally. No wheezes, rales, or rhonchi. Unlabored. Chest symmetrical.

ABDOMEN: Soft, nondistended. Normoactive bowel sounds. No hepatosplenomegaly.

GU: Testes descended. Circumcised penis. He has a large right inguinal hernia present which is reducible.

EXTREMITIES: Moves all extremities x4. Good range of motion, 5/5 muscle strength. No cyanosis, no clubbing, no edema. Cap refill less than 3 seconds.

NEUROLOGIC: Cranial nerves 2–12 intact. Motor intact in all extremities.

PSYCHIATRIC: No abnormalities of mood or affect noted.

Assessment: Right inguinal hernia.

Plan: The patient was also examined by Dr. Thomas today. The risks and benefits of surgery were discussed with the patient, and the patient verbalized understanding. The risks of surgery are infection, bleeding, and/or death. The patient wishes at this time to proceed with the operation. We have had the patient fill out financial aid assistance papers. We have faxed them to the office. We will schedule the patient for surgery at the end of May. The patient has been instructed that he needs to wear a hernia belt. However, at this time he refuses.

ICD-10-CM Codes: _____

Case 16

Progress Note Wound Care Center

Patient is here for follow-up of her sacral pressure ulcer. It is making good progress and has gotten a lot smaller since her visit a month ago. Today's measurements are 2.8 x 1.1 x 1.3 cm. It is now at stage 2. Last measurements are 5.5 x 3.1 x 1.5 cm. The entire ulcer surface is healthy and well granulated. No debridement is required. We are going to continue the negative pressure wound therapy and see her back in one month.

ICD-10-CM Codes: _____

Case17

Complaint: Syncope.

History of Present Illness: The patient is a pleasant 74-year-old gentleman who presented to the Emergency Room today after experiencing a syncopal episode in church today. He actually had a similar syncopal episode about one week ago while climbing a ladder. He was placed under the DASH protocol by the Emergency Room physician and came in emergently to the cardiac catheterization lab. There is no evidence of significant obstructive disease in his epicardial coronary arteries and his ejection fraction was found to be normal. His presentation is suspicious for possible cardiac arrhythmias. Going to be kept overnight for monitoring now and will likely undergo electrophysiologic study by May 10th. He has no recent chest pain, left arm or jaw discomfort or any chest pain today, also denies any recent orthopnea, PND or edema. In addition, he has had no presyncope or palpitations.

Past Medical History: 1. Diabetes. 2. Hypertension. There is no history of stroke, myocardial infarction, congestive heart failure.

Social History: Negative for cigarette smoking or alcohol.

Allergies: No known drug allergies.

Medications: Glipizide, Starlix, and Lisinopril.

Review Of Systems: Negative, except as in HPI.

Physical Examination: VITAL SIGNS: Blood pressure is 132/70, heart rate is 60, respiratory rate 14, afebrile. GENERAL: Elderly male in no acute distress. EYES: Pupils equal, round, and reactive. Extraocular movements intact. ENT: Oral mucosa normal. NECK: Supple, no jugular venous distention, no carotid bruits. LUNGS: Clear. CARDIAC: Regular rate and rhythm, S1, S2. No S3 or S4 gallop. 1/VI systolic murmur left lower sternal border and diastolic murmurs heard. No rubs noted. Carotid, radial and femoral pulses palpable and symmetric. ABDOMEN: Soft. Bowel sounds present. SKIN: No rashes or lesion. LYMPHATICS: No cervical or inguinal adenopathy. MUSCULOSKELETAL: No joint tenderness or effusion. No clubbing, cyanosis or edema. NEUROLOGICAL: Nonfocal. DIAGNOSTIC DATA: Electrocardiogram, sinus rhythm, normal PR, QRS and QT intervals. No acute ischemic changes. LABORATORY DATA: White count 5.6, hemoglobin 10.9, platelets are 186,000. BUN is 27, creatinine 1.3.

Assessment: A 74-year-old gentleman with recurrent syncope, actually brought in under the DASH protocol, but with no acute myocardial infarction.

Suggestions: 1. Restart medications including Lisinopril and diabetes medication. 2. Presentation is suspicious for cardiac arrhythmia. There is no evidence of arrhythmia at this point, I am going to schedule the patient for an electrophysiologic study tomorrow by with further recommendations to follow. Chest X-ray is pending.

ICD-10-CM Codes: _____

Case 18

Subjective: The patient states that he feels sick and weak. Mike reports he has decreased urine output, increased thirst, and some dizziness.

Physical Examination:
VITAL SIGNS: Highest temperature recorded over the past 24 hours was 102.1, and current temperature is 100.2.
GENERAL: The patient looks tired.
HEENT: Oral mucosa is dry.
CHEST: Clear to auscultation. He states that he has a mild cough, not productive.
CARDIOVASCULAR: First and second heart sounds were heard. No murmur was appreciated.
ABDOMEN: Soft and nontender. Bowel sounds are positive. Murphy's sign is negative.
EXTREMITIES: There is no swelling.
NEURO: The patient is alert and oriented x 3. Examination is nonfocal.

Laboratory Data: White count is normal at 6.8, hemoglobin is 15.8, and platelets 257,000. Glucose is in the low 100s. Comprehensive metabolic panel is unremarkable. UA is negative for infection.

Assessment and Plan:
1. Fever of undetermined origin, probably viral since white count is normal. Would continue current antibiotics empirically.
2. Dehydration. Hydrate the patient.

ICD-10-CM Codes: _____

Case 19

Reason for Visit: Overactive bladder with microscopic hematuria.

History of Present Illness: The patient is a 56-year-old noted to have microscopic hematuria and overactive bladder. Her cystoscopy performed was unremarkable. She continues to have some episodes of frequency and urgency mostly with episodes during the day and rare at night. No gross hematuria, dysuria, pyuria, no other outlet obstructive and/or irritative voiding symptoms. The patient had been previously on Ditropan and did not do nearly as well. At this point, what we will try is a different medication. Renal ultrasound is otherwise unremarkable, notes no evidence of any other disease.

Impression: Overactive bladder and microscopic hematuria. She has no other significant findings other than her overactive bladder, which had continued. At this juncture what I would like to do is try a different anticholinergic medication. She has never had any side effects from her medication.

Plan: The patient will discontinue Ditropan. We will start Sanctura XR and we will follow up as scheduled. For the microscopic hematuria, we will perform follow-up urinalysis and cytology at 6 months.

ICD-10-CM Codes: _____

Case 20

Jackie is here for a check-up on her migraines. She has had migraines for the past 9 years. Her "attacks" used to last between 12–20 hours with throbbing pain, photophobia, vomiting, and blurred vision. She does not have preceding aura. She states the propranolol continues to help keep her migraine attacks in check. When she does have a migraine, Treximet is successful in relieving her symptoms. She also has decreased postdrome length and severity.

Vital Signs: Blood pressure of 115/66, heart rate of 69, respiratory rate of 13, temperature normal, and pulse oximetry 98 percent on room air at the time of initial evaluation.
HEENT: Head, normocephalic, atraumatic. Neck supple. Throat clear. No discharge from the ears or nose. No discoloration of conjunctivae and sclerae. No bruits auscultated over temple, orbits, or the neck.
LUNGS: Clear to auscultation.
CARDIOVASCULAR: Normal heart sounds.
ABDOMEN: Benign.
EXTREMITIES: No edema, clubbing or cyanosis.
SKIN: No rash. No neurocutaneous disorder.
NEURO: The patient is awake, alert and oriented to place and person. Speech is fluent. No language deficits. Mood normal. Affect is clear. Memory and insight is normal. No abnormality with thought processing and thought content. Cranial nerve examination intact II through XII. Motor examination: Normal bulk, tone and power. Deep tendon reflexes symmetrical. Downgoing toes. No sign of any myelopathy. Cortical sensation intact. Peripheral sensation grossly intact.

Patient with chronic migraine, without aura, not intractable. Doing well on medications. Continue present management. Patient to follow up as necessary.

ICD-10-CM Codes: _____