

ABSTRACTING CASES AND QUESTIONS

CHAPTER 1: EVALUATION AND MANAGEMENT SERVICES

Case 1-1

LOCATION: Inpatient, Hospital

PATIENT: Mike Bahs

ATTENDING PHYSICIAN: Loren White, MD

CONSULTANT: Timothy Pleasant, MD

REASON FOR CONSULTATION: Rule out neck injury.

HISTORY: This patient is a 17-year-old male who was involved in a motor vehicle accident last night. He remembers driving down the road and the next thing he remembers was trying to reach for his cell phone at a stop sign after the accident. He does not remember any of the details. The car apparently went off the road and hit a tree. The patient is amnesiac for the event but does not believe he lost consciousness. His vehicle was apparently traveling 35-40 miles an hour. There was no report that he was ejected from the vehicle.

PAST MEDICAL HISTORY: He had childhood asthma.

MEDICATIONS: None.

ALLERGIES: None.

FAMILY HISTORY: Noncontributory to the present problem.

SOCIAL HISTORY: He chews tobacco. Alcohol use is rare.

EXAMINATION: Vital signs show he is afebrile. Pulse 64. Blood pressure 110/50. Neurologic: He is awake, alert, and fully oriented. His cranial nerves are grossly intact. **HEENT:** His extraocular movements are full. His eyes are conjugate. His pupils are equal. His facial strength is intact. On motor examination, he has grossly normal motor strength bilaterally in the upper and lower extremities. His reflexes are normal and symmetric at the biceps, triceps, and brachioradialis. The ankle jerks and the knee jerks are normal and symmetric. Gait is not tested. Sensory examination is grossly intact to light touch. Spine examination: The patient's cervical collar was removed. He has no tenderness to palpation of the cervical spine whatsoever.

The x-rays of the cervical spine, as well as the CT scan of the cervical spine, were reviewed. No fractures or subluxations are noted. CT scan of the head was reviewed, and it is negative for any intracranial pathology.

IMPRESSION/PLAN: In summary, we have a 17-year-old male involved in a motor vehicle accident. He has a mild concussive head injury, as evidenced by his amnesia, and I believe he did lose consciousness for a brief period; however, the exact amount of time for his loss of consciousness is unknown. There is no evidence of any cervical spine injury. The patient is neurologically normal. He does not need to wear a cervical collar. I explained to him and his

mother, Gloria, that if the patient develops any weakness, numbness, or tingling in the arms or legs, trouble with his balance, sleepiness, vomiting, weakness of one side of the body, or any other symptoms, they should call their physician immediately.

I want to thank Dr. White for asking me to see this patient.

CPT Code(s): _____

ICD-10-CM Code(s): _____

Abstracting Questions:

1. What items of Review of Systems (ROS) were documented? _____
2. Under what report heading(s) would the ROS be found? _____
3. Was the patient the driver or passenger in the motor vehicle? _____

CHAPTER 1: EVALUATION AND MANAGEMENT SERVICES

Case 1-2

LOCATION: Inpatient, Hospital

PATIENT: Sorrento Hernandez

PHYSICIAN: Rolando Ortez, MD

CHIEF COMPLAINT: Prematurity with respiratory difficulty.

HISTORY: This is a 30 weeks, 1 day gestation female infant with birth weight of 1808 grams. Mom is a 26-year-old gravida 2, now para 2 mom. Her blood type is O positive, antibody negative, RPR nonreactive, rubella immune, hepatitis B surface antigen negative, HIV negative, GC negative, chlamydia negative, Group B Strep status unknown. Mom's MSAFP was elevated at 14.2 with a 1:180 risk for Down syndrome. No neural tube defect. No amniocentesis performed. She was on prenatal vitamins. First pregnancy went to 35 weeks without complications. He is doing well at 10 years of age; however, he does have Noonan syndrome.

Although this is my first visit, I did attend the delivery of the baby. Spontaneous cry noted, and Apgar score was 7 at 1 minute, with points off for color, tone, and grimace, and then at 5 minutes, Apgar score of 8 with points off for grimace and tone. The infant was then brought back to the NICU for further management. Baby's face does look somewhat dysmorphic with concerns for Noonan syndrome; very small posterior pharyngeal space was noted with difficult intubation, and after several attempts, the anesthesiology department was called and the infant was intubated. Throughout the intubation attempts, standard procedure was followed and the baby tolerated the attempts very well. The intubation was performed because of concerns of hypoventilation noted on exam with decreased breath sounds bilaterally as well as increased work of breathing.

Umbilical artery catheter was also placed without difficulty. First blood sugar did come back at 23, a peripheral IV was placed promptly, and 2 cc/kilo of D10 was given along with placing the infant on D10 at 80 cc/kilo. Second blood sugar has come back elevated. Chest x-ray is obtained, as well as abdominal films, and shows good placement of the UAC at T7, and the endotracheal tube is also in good placement and is a 3.02. The OG has been advanced. The lung fields do show significant granularity present. No pneumothorax, no cardiomegaly. Blood gas is 7.32, PCO_2 of 50, PO_2 of 100 and that is on a setting of 22/4, rate of 60% and 80% FIO_2 .

PHYSICAL EXAMINATION: Currently is intubated, her weight is 1808 grams. OFC is 30.5 cm, length is 39.4 cm. Heart rate is in the 130s to 140s. Respiratory rate is at 60 on the ventilator.

O_2 sat. is in the mid 90s. Blood pressure is right arm, 67/34 with a mean of 46, right leg 67/32 with a mean of 44.

Mild splitting of the cranial sutures is noted along with open posterior and anterior fontanel. Red reflex $\times 2$. Eyes appear to have hypertelorism present and questionable epicanthal folds along with some down-slanting palpebral fissures. Ears appear to be low set and posteriorly rotated. Palate is intact. There is a small retropharyngeal space. Clavicles are intact. I do not appreciate

any webbing on the neck. Nipples, questionable, mildly wide spaced. Lungs at this time are clear to auscultation. She has good symmetric aeration; minimal chest rise noted. Prior to that, lungs were remarkable for decreased aeration with crackles. Heart is regular rate and rhythm, no murmurs noted. Femoral pulses palpable, cap refill less than 2 seconds. Abdomen is without hepatosplenomegaly, three-vessel cord. Genitourinary: Normal female. Extremities: Adequate range of motion, no contractures or hip abnormalities noted. Skin is ruddy in complexion. Neurologic Exam: Hypotonia diffusely.

Developmental assessment: No breast buds, soft pinna with minimal recoil, no creases on the feet, consistent with a 30-week preterm infant.

IMPRESSION

1. Premature female infant.
2. Respiratory distress due to hyaline membrane disease as well as a component of hypoventilation secondary to maternal elevated magnesium.
3. Observation for sepsis.
4. Maternal hypermagnesemia with elevated magnesium in the infant as well.
5. Family history of Noonan syndrome in an older brother.

PLAN: Admission to the NICU. Intubation has been performed, and she is on mechanical ventilation. Will go ahead with the surfactant therapy per protocol, close cardiorespiratory monitoring and monitoring of blood gases and chest x-rays. NPO status, and she will be on D10 with 0.94 mEq of calcium gluconate added to run at 80 cc/kilo/day. Ampicillin and gentamicin administered per protocol. Blood cultures have been obtained as well as a CBC, magnesium level, and further glucose monitoring. She will also need chromosomal testing, and that will be drawn in the near future. Also, head ultrasound at 6 days of life will need to be performed. I have not talked with the mother. Her condition has deteriorated post cesarean section and she is not available at this time. I have talked in detail with the father in regard to the above, including possibility of further deterioration prompting transfer to another facility. All of his questions have been addressed.

CPT Code(s): _____

ICD-10-CM Code(s): _____

Abstracting Questions:

1. Was this the initial or subsequent visit? _____
2. Does the age of the patient affect CPT code selection? _____
3. What two factors affect diagnosis code assignment? _____

CHAPTER 2: MEDICINE

Case 2-1

LOCATION: Outpatient, Hospital

PATIENT: Gordon Monday

ORDERING PHYSICIAN: Laddie N. Noss, MD

ATTENDING/ADMIT PHYSICIAN: Laddie N. Noss, MD

RADIOLOGIST: Morton Monson, MD

PERSONAL PHYSICIAN: Ronald Green, MD

EXAMINATION: Bilateral laser-Doppler test.

CLINICAL SYMPTOMS: Peripheral angiopathy due to diabetes.

BILATERAL LASER-DOPPLER TEST: The patient is an 84-year-old man with diabetes and renal disease. He had an arterial Doppler 6 months previously that showed bilateral disease and calcified vessels. The right side showed a digital pressure of 70. The left side was more abnormal with a digital pressure of only 12. Again, vessels were calcified. On the left side, the toe pressure is 35, which is right at the borderline of healing. Transmetatarsal is at the same level. Above the ankle, paradoxically, the pressure is even a little lower at 30, which is right at our threshold. On the right side at the toe, the level is 70, which indicates a good likelihood of healing. Transmetatarsal the level is 60 and above the ankle is 50, all of which should be adequate for healing.

The laser-Doppler studies basically back up the digit pressures. The right side looks abnormal, but adequate for healing. The left side is marginal. Laser-Doppler levels look a little better than the digit pressures regarding this area.

CPT Code(s): _____**ICD-10-CM Code(s):** _____**Abstracting Questions:**

1. Does the laser description affect the CPT code selection for the Doppler scan?

2. Is CPT code selection affected by type (arterial or venous) of study?

3. Does bilateral versus unilateral affect CPT assignment? _____

CHAPTER 2: MEDICINE

Case 2-2

LOCATION: Inpatient, Hospital

PATIENT: Jo Littledove

REFERRING PHYSICIAN: James Noonar, MD

CARDIOLOGIST: Marvin Elhart, MD

INDICATIONS: Abnormal Cardiolute stress test and shortness of breath.

PROCEDURE: Right and left selective coronary angiogram, LV gram left heart, right femoral artery #6 French sheath, right femoral artery angiogram.

HEMODYNAMICS: Aortic pressure 138/57, LV 148/4. No aortic gradient on pullback.

RESULTS: Ventriculography: The LV displayed normal size with excellent contractility and no segmental wall motion abnormality. The ejection fraction is estimated at 60-80%.

Coronary Angiography

1. Right coronary artery: This is a dominant vessel. It has a shepherd's crook takeoff. Through its course the right coronary artery has no significant stenosis. Distally, it trifurcated to give rise to posterior descending artery, posterolateral branch, and a marginal branch. Through its course the right coronary artery has intimal disease from 10-20%.
2. Left main: Normal.
3. Circumflex artery: The circumflex artery is a codominant system. The circumflex in its midportion branched to give first marginal that is moderate in size, tortuous, but no significant obstructive disease, and a very large second marginal that has in its midportion 40% stenosis. Distally, it branched to give smaller marginals.
4. Left anterior descending artery: After the takeoff of the left main, has steep angulations of close to 90 degrees. Thereafter it takes off and through its course has significant tortuosity. The proximal part of the left anterior descending appears slightly hazy, probably from the angulations; the artery itself has 30% stenosis. At the level of the stenosis there are two diagonals taking off, the first of which is before the stenosis and is small, and the second one is moderate in size and has at its origin an ostial stenosis that appeared to be 60%. The left anterior descending artery is tortuous and in its midportion gave rise to another diagonal that appeared to be free of any significant disease.

IMPRESSION/CONCLUSION: Normal left ventricular systolic functions with disease involving predominantly the left anterior descending artery that appeared to be in its proximal third of 40-50% at the level of the second diagonal. Angiographically, it did not appear severely obstructed, with some mild disease involving the right coronary artery at the circumflex. At this point, my recommendation is to aggressively manage her medically, and if we are unable to control her symptoms with medications, then later on we might consider percutaneous revascularization of

the left anterior descending artery. Considering her size, the location of the lesion, and the takeoff of the left anterior descending artery, this procedure is not without risk.

CPT Code(s): _____

ICD-10-CM Code(s): _____

Abstracting Questions:

1. What does the LV referred to in the report stand for? _____
2. What is the definition of “circumflex”? _____
3. The report states in point 4 that the left anterior descending artery has significant tortuosity. What does this mean? _____