

JustCoding

Clinical Scenario Workbook

2020 CPT® Edition

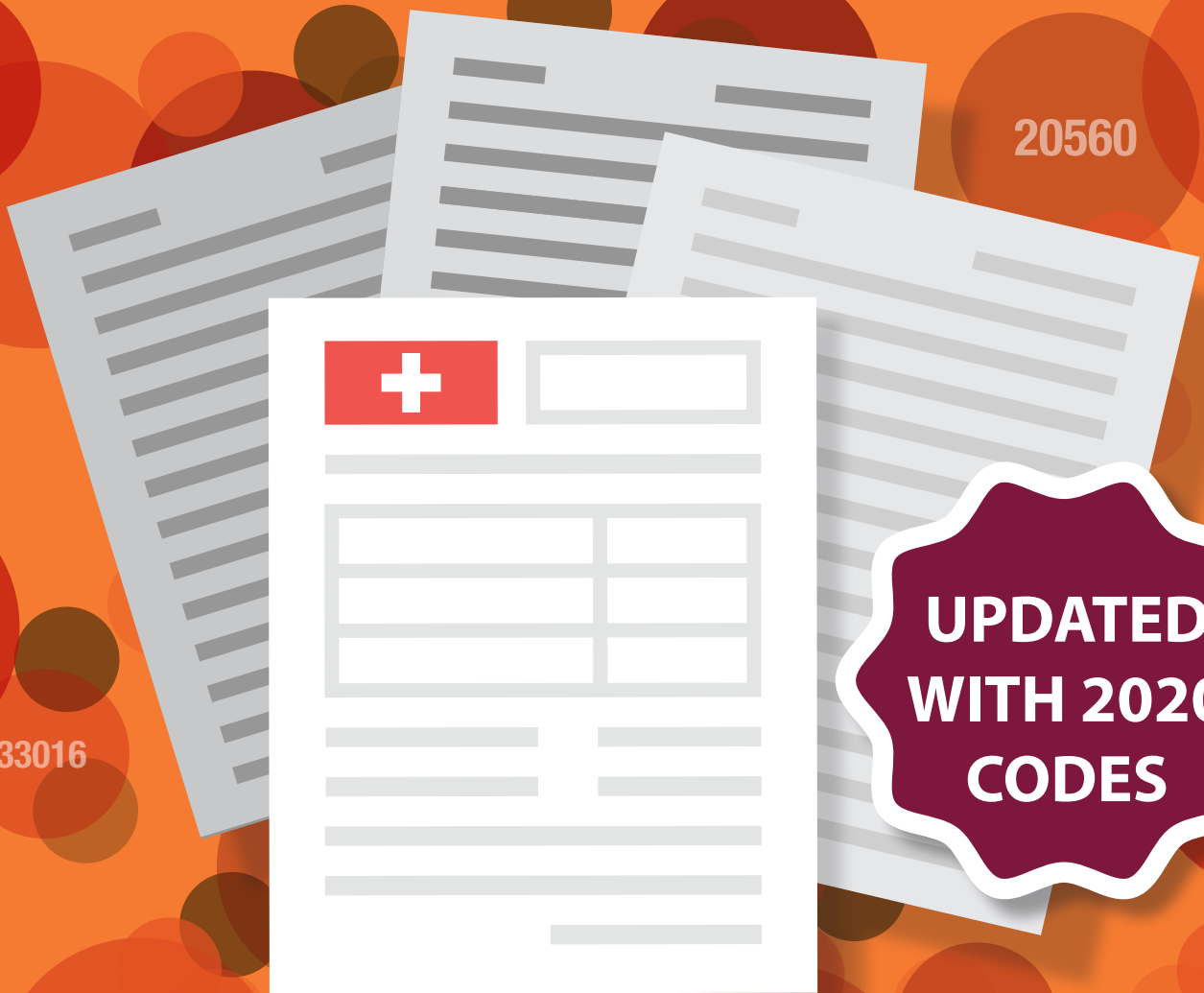
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**UPDATED
WITH 2020
CODES**

Reviewed by

**Shannon McCall, RHIA, CCS, CCS-P, CPC, CEMC, CRC, CCDS, CCDS-O, HCS-D
Adrienne Commeree, CPC, CPMA, CCS, CEMC, CPIP**

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JustCoding

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Sarah Gould, Associate Editor

Matt Sharpe, Senior Manager, Creative Layout

AnnMarie Lemoine, Cover Designer

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HCPro

100 Winners Circle, Suite 300

Brentwood, TN 37027

Telephone: 800-650-6787 or 781-639-1872

Fax: 800-639-8511

Email: customerservice@hcpro.com

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About the Contributors

Stacie L. Buck, RHIA, CCS-P, RCC, CIRCC, AAPC Fellow

Stacie L. Buck, RHIA, CCS-P, RCC, CIRCC, AAPC Fellow, is president and senior consultant for RadRx of Stuart, Florida, and provides coding, auditing, and education services for diagnostic and interventional radiology service providers on a nationwide basis. Buck has 25 years of experience in healthcare, 17 of those in radiology. She is a nationally sought-out speaker who has presented over 200 coding seminars. She also is the author of the coding reference book *Cracking the IR Code: Your Comprehensive Guide to Mastering Interventional Radiology Coding* and the *Cracking the IR Code* comprehensive online training program.

Shannon E. McCall, RHIA, CCS, CCS-P, CPC, CEMC, CRC, CCDS, CCDS-O, HCS-D

Shannon E. McCall, RHIA, CCS, CCS-P, CPC, CEMC, CRC, CCDS, CCDS-O, HCS-D, is the director of HIM and coding for HCPro, a Simplify Compliance brand, in Middleton, Massachusetts. She oversees all of the Certified Coder Boot Camp programs. McCall developed the Certified Coder Boot Camp®—Inpatient Version, the Evaluation and Management Boot Camp™, and most recently collaborated with the CDI team on the Risk Adjustment Documentation and Coding Boot Camp™. McCall works with hospitals, medical practices, and other healthcare providers on a wide range of coding-related custom education sessions.

Lori-Lynne Webb, CPC, CCS-P, CCP, CHDA, CDIP, COBGC, AHIMA-approved ICD-10-CM/PCS trainer

Lori-Lynne Webb, CPC, CCS-P, CCP, CHDA, CDIP, COBGC, AHIMA-approved ICD-10-CM/PCS trainer, is an E/M and procedure-based coding, compliance, data charge entry, and HIPAA privacy specialist based out of Melba, Idaho, with more than 20 years of experience. Webb's coding specialty is OB/GYN office/hospitalist services, maternal fetal medicine, OB/GYN oncology, urology, and general surgical coding.

Edward O'Beirne, PA, MHS, CCS, CDIP

Edward O'Beirne, PA, MHS, CCS, CDIP, is the director of HIM revenue integrity at HRG and an ICD-10 educator of providers and coders with a specialization in ICD-10-PCS and CPT, based out of Richmond, Virginia. Before joining HRG, he was a director of physician assistants and patient relations for an ER with 80,000 visits annually, a physician assistant in emergency medicine for more than 10 years, a coding supervisor, auditor, and consultant for nine years, and an EMT and respiratory therapist for five years.

Laura Legg, RHIT, CCS, CDIP

Laura Legg, RHIT, CCS, CDIP, is the director of HIM optimization at Healthcare Resource Group in Spokane Valley, Washington. Legg has more than 25 years of experience in HIM, including critical access hospitals, large hospitals, and a major health system.

Laura Evans, CPC

Laura Evans, CPC, is an editor at DecisionHealth in Washington, D.C. She has experience in ICD-10-CM and CPT orthopedic coding education, and previously worked as a reporter at *The Washington Times*.



About the Reviewers

Adrienne Commeree, CPC, CPMA, CCS, CEMC, CPIP

Adrienne Commeree, CPC, CPMA, CCS, CEMC, CPIP, serves as a regulatory specialist for HCPro, teaching the Certified Coder Boot Camp® programs. She is an instructor with extensive knowledge of inpatient and outpatient coding guidelines as well as E/M and auditing guidelines. She has many years of experience in the healthcare industry, including coding, auditing, training, and compliance expertise.

Shannon E. McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CRC, CCDS, HCS-D

Shannon E. McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CRC, CCDS, HCS-D, is the director of HIM and coding for HCPro. She oversees all of the Certified Coder Boot Camp programs. McCall developed the Certified Coder Boot Camp®—Inpatient Version, the Evaluation and Management Boot Camp™, and most recently collaborated with the CDI team on the Risk Adjustment Documentation and Coding Boot Camp™. McCall works with hospitals, medical practices, and other healthcare providers on a wide range of coding-related custom education sessions.



Introduction

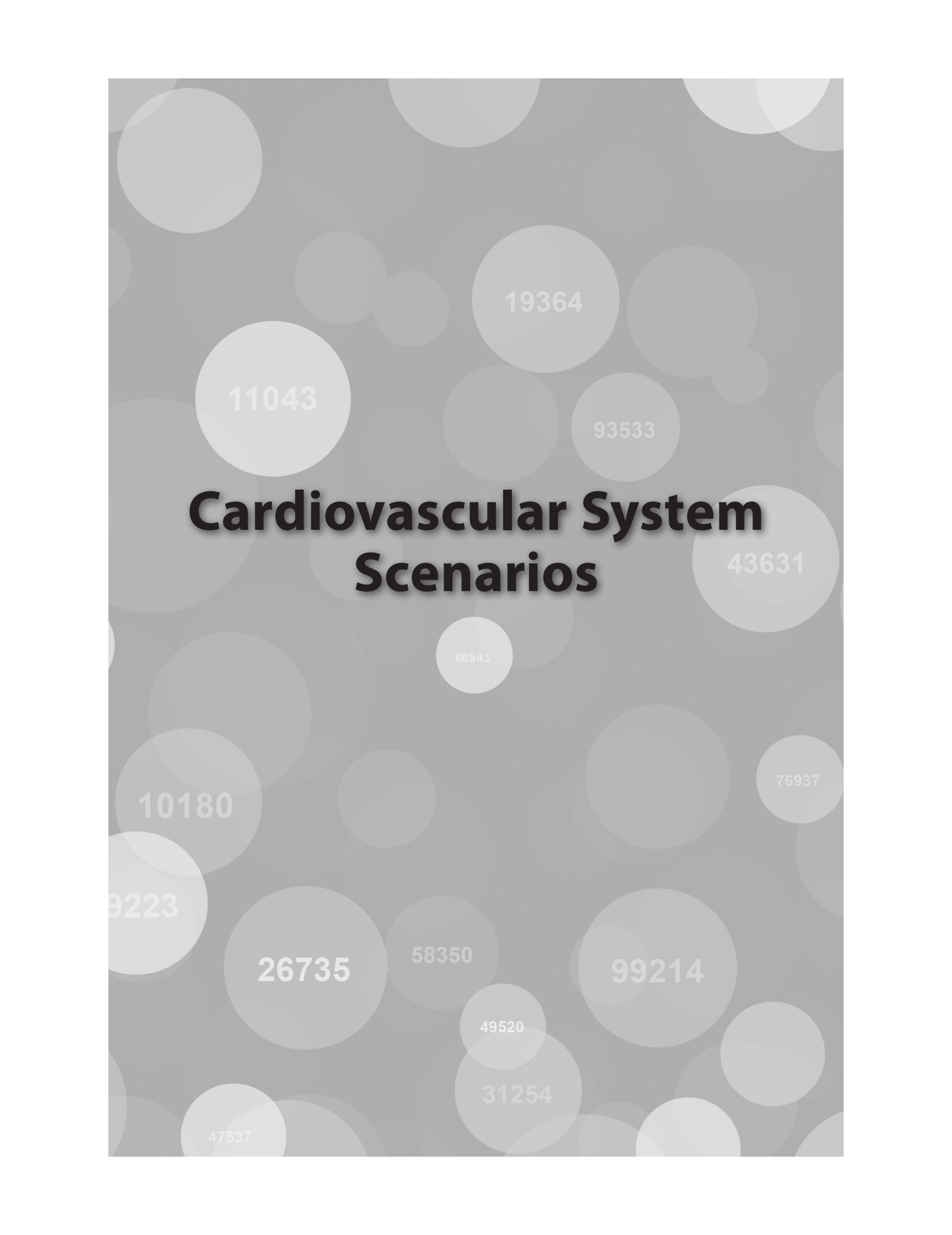
JustCoding's Clinical Scenario Workbook: 2020 CPT® Edition contains 52 sample clinical cases to provide hands-on reinforcement of coding concepts. The cases range in difficulty, length, and medical specialty. They are designed to simulate real-life coding processes for training and assessing new coders or keeping skills sharp for experienced staff.

Each case includes operative reports based on real clinical scenarios. Cases offer a variety of documentation styles to reflect inconsistencies between different electronic health record systems and providers.

After reviewing the cases, coders should report the most applicable ICD-10-CM diagnosis codes and all relevant CPT procedural codes. Answer keys are included at the end of each chapter with the correct codes to report for each case. The answer keys were reviewed by HCPro's coding instructors and include:

- A list of reportable ICD-10-CM and CPT codes, as well as rationale for using those codes.
- Applicable coding guidance, where appropriate, including references from the *2020 ICD-10-CM Official Guidelines for Coding and Reporting*, the *CPT Manual*, and the AHA's *Coding Clinic*.
- Instructions for looking up ICD-10-CM codes and certain CPT codes in the coding manuals.

All codes and guidance have been reviewed and are up to date as of January 1, 2020. The ICD-10-CM and CPT code sets as well as any guidance are subject to changes. These cases therefore should not be used as a guide for coding any real claims.

The background is a dark gray field filled with numerous overlapping circles of varying sizes and shades of gray. Some of these circles contain white numerical values. The central focus is the title 'Cardiovascular System Scenarios' in a large, bold, black font with a slight drop shadow.

Cardiovascular System Scenarios

11043

19364

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43631

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76937

9223

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58350

99214

49520

31254

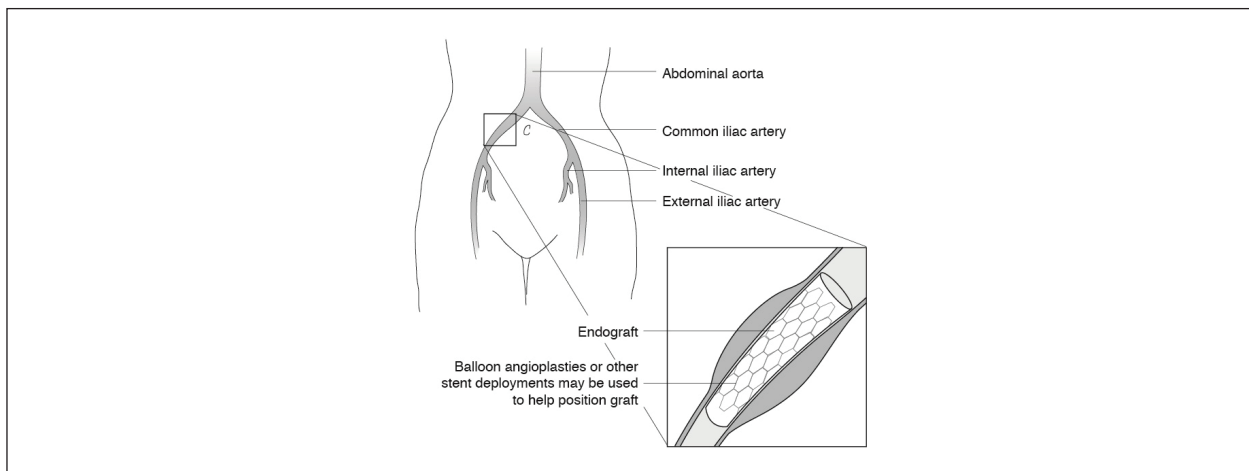
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Case 1: Abdominal Aortic Aneurysm Repair

FIGURE 1.1

Endovascular graft placement



Provider Documentation

Preoperative diagnosis:

Abdominal aortic aneurysm (AAA)

Postoperative diagnosis:

AAA, right renal artery stenosis

Operation performed:

1. Endovascular repair of abdominal aortic aneurysm using fenestrated endograft system, Cook Z-Fen stent graft system

2. Reduction of a sliding inguinal hernia
3. Balloon angioplasty of right renal artery

Anesthesia:

General

Complications:

None

Procedure:

The patient was brought to the operative room. He underwent general anesthesia. The abdomen and lower extremities were prepped and draped in sterile fashion. Both femoral vessels were exposed through transverse bilateral inguinal incisions. There was a fairly large sliding hernia in the inguinal area with the hernia sac extending over the common femoral artery. Both femoral vessels were then exposed and circumferentially controlled proximally and distally. Both sides were then cannulated in retrograde fashion. There was a significant amount of tortuosity involving the iliac arteries.

We advanced a 6-French sheath on the left side, which was chosen as the contralateral side for delivery purposes. A Lunderquist stiff wire was advanced, allowing the iliac system to straighten out. At this time, we placed a 20-French Cook sheath in the left iliac system without difficulty. We proceeded to cannulate the hub of the 20-French sheath on the left side and successfully cannulated both renal arteries, placing a Rosen wire into the left renal artery without difficulty. There was stenosis at the origin of the right renal artery. This was cannulated and balloon angioplasty performed of the origin of the right renal artery using a 5 × 20 mm Viatrac balloon. In a similar fashion, Rosen wire was left in the right renal artery for marking purposes.

The main body of the device was chosen and had been designed using the patient's CT scan. There were two small fenestrations for each renal vessel with a scallop for the superior mesenteric artery. The graft diameter was 30 mm and it was two main body stents. This was oriented and successfully advanced. The device was then deployed using aligning markers. We then cannulated the distal aspect of the proximal graft and were able to successfully cannulate each of the small renal fenestrations extending out into the renal vessels with Glidewires.

Six-French Ansel flex sheaths were then advanced into the origin of both renal arteries. ICast 6 × 22 stents were then advanced into the origin of both renal vessels. Two stent links were left in the main body of the device. At this time, each renal stent was successfully deployed. A 10 × 20 mm angioplasty balloon was then used to complete the deployment at the very proximal end and anchor the stent in place.

The distal body was chosen and advanced via the right iliac artery. This was advanced with approximately one stent extending distally and successfully deployed down to the contralateral gate. The contralateral gate was successfully cannulated from the left iliac artery. We then completed our left iliac deployment using a 74 × 20 mm iliac limb. At this time, on the ipsilateral right side, the final two stents of the distal body were deployed, and we completed the deployment of the right iliac system using a 56 × 20 mm iliac stent. The Coda balloon was used for the junction between the components. At this time, a completion angiogram was performed. The superior mesenteric artery was patent as were both renal stents and renal perfusion. We angioplastied just distal to the renal stent deployment.

At this time, sheaths and wires were withdrawn. The arteriotomies were closed using 5-0 Prolene suture. The large hernia on the right inguinal area was reduced, and we used a mesh Bard plug placed and secured it anteriorly with Prolene suture. Each inguinal wound was then irrigated and closed with 2-0 Vicryl, 3-0 Vicryl, and 4-0 Monocryl subcuticular stitch. The patient was extubated in the operating room and transported to the recovery room in satisfactory condition. Total fluoroscopy time was 80.7 minutes. Total recorded Visipaque was 130 ml full strength.

Codes:

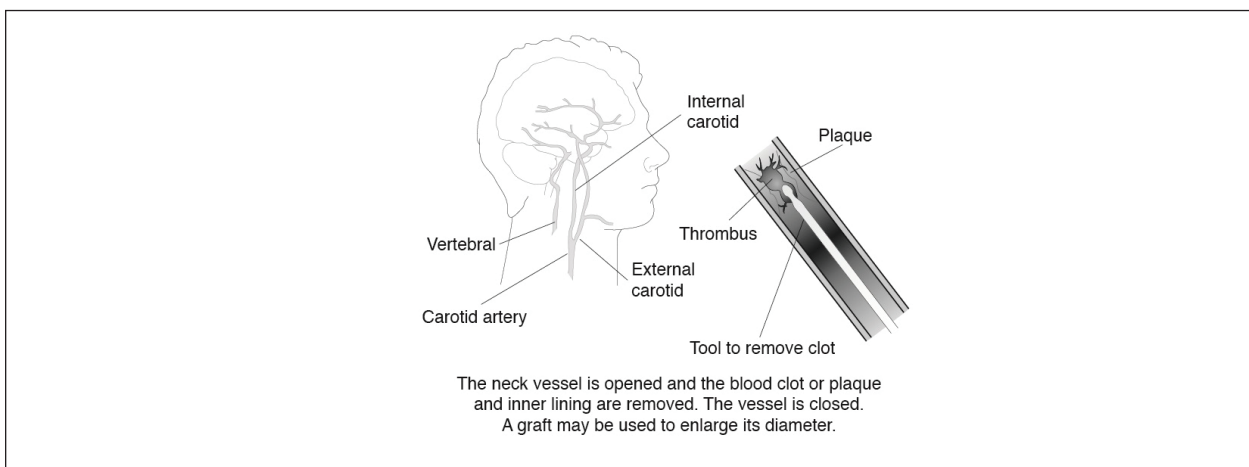
CPT:

ICD-10-CM:



Case 2: Carotid Artery Stenosis

FIGURE 1.2 Thromboendarterectomy



Provider Documentation

Preoperative diagnosis:

Left carotid artery stenosis

Postoperative diagnosis:

Same

Operation performed:

Left carotid endarterectomy with bovine pericardial patch

Anesthesia:

General

11043

19364

93533

Cardiovascular System Answers

43631

66943

10180

76937

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Answers for Case 1: Abdominal Aortic Aneurysm Repair

Codes and explanation:

CPT:

- 34847, endovascular repair of visceral aorta and infrarenal abdominal aorta with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including three visceral artery endoprotheses (superior mesenteric, celiac and/or renal artery[s])
- 34812-x 2, open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, bilateral
- 49525 [-51], repair inguinal hernia, sliding, any age

Typical endovascular AAA grafts are tubular in shape because they are confined only to the aorta. For patients that have an aneurysm that extends below the renal arteries (possibly extending into the iliac arteries), it is imperative to have fenestrations or holes in the graft to accommodate the vessels that branch off the visceral aorta. Endovascular fenestrated AAA repairs of the visceral aorta (upper abdominal aorta containing the celiac, superior mesenteric and renal arteries) are complex procedures that involve the patient being seen in advance for high resolution cross sectional imaging (e.g., CT) and utilization of 3D software for modeling of the aorta. The graft is created as a patient-specific prosthesis based on the location and orientation of the patient's renal and visceral artery origins.

CPT selection is based on the extent of the aorta treated. If the endoprosthesis is limited to only the visceral vessels (superior mesenteric, celiac, and/or renal artery[s]), CPT codes 34842–34844 are assigned depending on the number of prostheses placed. However, if the device extends into the iliac arteries, then CPT codes 34845–34848 would be appropriate. These codes are also assigned based on the total number of visceral and/or renal arteries requiring placement of an endoprosthesis (i.e., bare metal or covered stent) through the aortic endograft fenestration.

In this operative report, the device involved the renal and the right iliac artery. There were a total of 3 vessels stented (endoprotheses) including the right/left renal arteries and the right iliac artery. The procedure code includes the balloon angioplasty of the target zone (where the grafts are being placed).

Codes 34841–34848 are used to report the placement of a fenestrated endovascular graft in the visceral aorta, either alone or in combination with the infrarenal aorta when performed for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption. For reporting purposes, the following services are included in the work of codes 34841–34848 and therefore may not be reported separately:

- Balloon angioplasty within the target treatment zone of the endograft, either before or after endograft deployment
- Fluoroscopic guidance and radiological supervision and interpretation in conjunction with fenestrated endovascular aortic repair that includes angiographic diagnostic imaging of the aorta and its branches prior to deployment of the fenestrated endovascular device, fluoroscopic guidance in the delivery of the fenestrated endovascular components, and intraprocedural arterial angiography (e.g., to confirm position, detect endoleak, evaluate runoff) done at the time of the endovascular aortic repair
- Introduction of guidewires and catheters in the aorta and visceral and/or renal arteries

The open incision into both femoral arteries can be reported separately per the Fenestrated Endovascular Repair guidelines with CPT code 34812. CPT code 34812 is for unilateral procedures, but in the parenthetical notes, the AMA advises to report the CPT code 34812 twice when performed bilaterally.

The repair of the sliding inguinal hernia would be separately reported. Per the CPT guidelines, the use of mesh is not separately reported.

There are no National Correct Coding Initiative edits prohibiting this combination of codes from being reported together; therefore, modifier -59 would not be necessary. However, some payers may require modifier -51 (multiple procedures) for the professional services claim to adjust for multiple procedure discount purposes.

ICD-10-CM:

- I71.4, abdominal aortic aneurysm, without rupture
- K40.90, unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent
- I70.1, atherosclerosis of renal artery



Case 1: Nasal Endoscopy

Provider Documentation

Preoperative diagnosis:

Epiphora with chronically deficient drainage, right eye

Postoperative diagnosis:

Same

Anesthesia:

General endotracheal anesthesia

Estimated blood loss:

None

Complications:

None

Indications:

This is a male patient with a history of severe tearing on his right eye. This is markedly symptomatic and blurs his vision. We have tried interval dilation and palliative stents in the nasolacrimal duct, without success. He presents today for definitive treatment of this problem consisting of right dacryocystorhinostomy with silicone stent placement. The risks, benefits, alternatives, and the need for possible additional treatment were discussed in depth with the patient regarding the procedure. The risks include but are not limited to bleeding, infection, decrease in vision, blindness, dry eye syndrome, eyelid retraction, double vision, continued tearing, ocular irritation from stent, need for more surgery, and no improvement. All questions were answered, and he elected to proceed with surgery.

Procedure:

After obtaining informed consent, the patient was brought back to the operating room. The right side was confirmed for surgery and then general anesthesia was induced. The patient was then prepped and draped in the usual sterile ophthalmic fashion.

First, attention was directed to the right side, where nasal endoscopy was performed to assess anatomy. This demonstrated normal recesses and no septal deviation or masses. This completed the diagnostic right nasal endoscopy.

Then, Takahashi forceps, Kerrison rongeurs, and an osteotome were used to create a 1 cm bony osteotomy. The lacrimal sac was slit from its most superior to inferior position. A portion of the lacrimal sac was sent for routine biopsy. This completed the right dacryocystorhinostomy and the scope was withdrawn.

Then, internal and external probing and irrigation were performed on the right side which confirmed patency to the bony osteotomy. Then, a stent was placed in the upper and lower puncta and retrieved through the osteotomy. The stent was tied with four square knots and secured inside the lateral vestibule of the naris with a 5-0 Prolene suture. This completed the right silicone stent placement. Hemostasis was achieved with a Kenalog soaked gelfoam sponge.

The patient tolerated the procedure well. He was extubated and taken to the recovery room in stable condition.

Codes:

CPT:

ICD-10-CM:

11043

19364

93533

Eye/Ocular System Answers

66943

10180

76937

9223

26735

58350

99214

49520

31254

47537

Answers for Case 1: Nasal Endoscopy

Codes and explanation:

CPT:

- 31239 [-RT], nasal/sinus endoscopy with dacryocystorhinostomy
- 68815, probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent

Insufficient drainage of tears through the right nasolacrimal duct was treated by connecting the right tear gland to the nasal passageways via a direct connection (dacryocystorhinostomy) made through an intranasal approach, with nasal endoscopic assistance and placement of a stent.

One key in coding this is to distinguish the nasal endoscopy (31239) from the open approach (68720 [dacryocystorhinostomy]), which would involve incision and repair of the skin on the face and nose. The documentation is not quite as explicit as we would like as far as the approach but note the absence of any external incision or suture repair. The dacryocystorhinostomy was performed via nasal approach, not through the scope per se, but with scope assistance.

Code 31239 is for a unilateral procedure. Therefore, it would be appropriate to append HCPCS modifier -RT (right side) to indicate the side on which the procedure was performed. The use of modifier -RT is dependent on the payer.

Surgical sinus endoscopy includes a sinusotomy, when appropriate. Diagnostic endoscopy also includes sinusotomy, when performed.

Do not code any of the following as they are implicit in the definitive procedure:

- Excision of the tear gland as a separate biopsy; code 68510
- Diagnostic nasal endoscopy performed to assess anatomy; code 31231
- Probing of the nasolacrimal duct, with or without irrigation; code 68810

ICD-10-CM:

- H04.221, epiphora due to insufficient drainage, right side

To reference this diagnosis code, in the ICD-10-CM Alphabetic Index, look up “Epiphora, due to, insufficient drainage (H04.22-).”

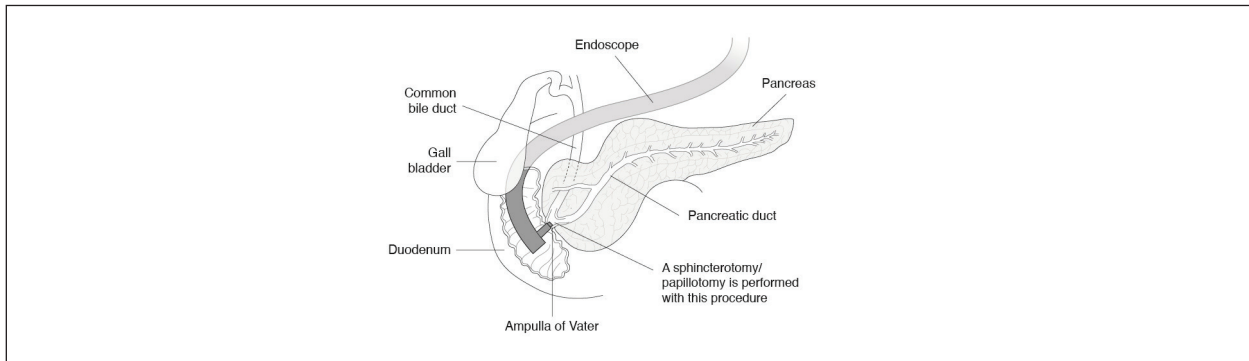
Excess tearing is attributed to deficient drainage on the right, not to tear overproduction, as the related codes would describe epiphora due to excess lacrimation.



Case 1: Bile Duct Stone

FIGURE 3.1

Endoscopic retrograde cholangiopancreatography (ERCP) with sphincterotomy/papillotomy



Provider Documentation

Operative procedure:

Sphincterotomy and stone extraction

Indication for procedure:

Paroxysmal right upper quadrant pain associated with disturbed liver function that is post-cholecystectomy

Procedure description:

The Olympus video side-viewing duodenoscopy was atraumatically introduced into the esophagus and advanced with slide-by technique into the stomach. The gastric mucosa was normal. The pyloric channel was normal and easily intubated. The first and second parts of the duodenum were visualized. The ampulla appeared normal. Initial cannulation with a precurved

catheter revealed a normal pancreatic duct. A single injection was made into the pancreas. Repositioning was accomplished with the assistance of a straight 0.035 guidewire and free cannulation of the common duct was obtained, revealing a large multifaceted free floating stone within the common bile duct. The intrahepatic biliary system appeared normal. The extrahepatic biliary system appeared dilated. An exchange was made with a 20-mm sphincterotome and a sphincterectomy was performed with perfect hemostasis. The duct was then swept with a 15-mm stone extraction balloon, and the stone was pulled into the duodenal lumen and removed. The duct was “swept” 2 more times with negative results. The procedure was terminated with the patient in satisfactory condition and she returned to the recovery area for observation.

Assessment:

Cholelithiasis associated with recurring obstruction and biliary colic in a post cholecystectomy patient.

Codes:

CPT:

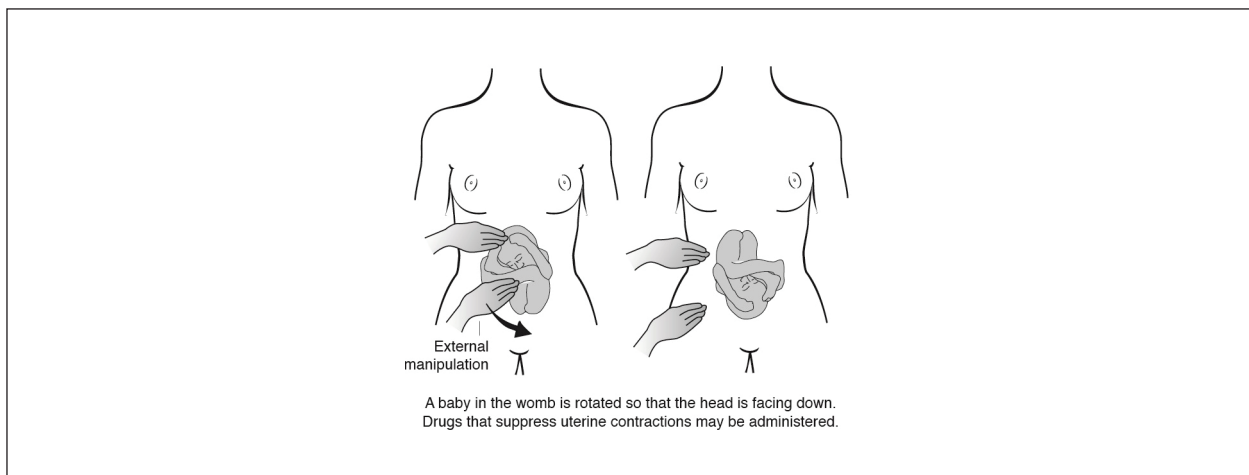
ICD-10-CM:



Case 2: Maternal Care for Breech Presentation

FIGURE 7.2

External cephalic version



Provider Documentation

Preoperative diagnosis:

A 39-week intrauterine pregnancy with complete breech presentation

Postoperative diagnosis:

A 39-week intrauterine pregnancy in vertex presentation, status post successful external cephalic version

Procedure:

External cephalic version



Case 3: Observation Services

Provider Documentation

Place of service:

Hospital observation

Chief complaint:

Shortness of breath

History of present illness:

The patient is a 66-year-old female with a history of asthma/COPD with chronic sputum colonization with gram-negative rods. She was seen in the office at the end of last week complaining of a one-week history of shortness of breath with cough productive of green sputum. Her symptoms began with activity but, over the prior two days to her appointment last week, she began to notice increasing shortness of breath when lying flat. A chest X-ray was obtained at that time which showed a right-sided pleural effusion.

The patient underwent thoracentesis in which 400 cubic centimeters of serosanguineous fluid was drained. Cultures returned negative, and the effusion was transudative in nature. A sputum culture was obtained at that time which showed a moderate amount of gram-positive cocci suggestive of streptococci. This organism was sensitive to ceftazidime, gentamicin, piperacillin, Bactrim, Cipro, imipenem, and Levaquin.

Following the thoracentesis, her shortness of breath did not improve. She now complained with symptoms at rest as well as with activity. She has a continued cough which is productive of green sputum. She had been running a low-grade fever of 99 degrees Fahrenheit on Friday. This was associated with fever and chills. She has not had any since. She was admitted to observation status yesterday morning and remains slightly short of breath, yet improved from yesterday.

Medications:

- Spiriva 1 inhalation daily
- Advair 500/50 1 puff b.i.d.
- Proventil MDI 2 puffs p.r.n.
- Cardizem CD 360 mg 1 p.o. daily
- Lisinopril 5 mg 1 p.o. daily
- Edecrin 25 mg 2 p.o. daily
- Cymbalta 60 mg 1 p.o. daily
- Digoxin 0.125 mg 1 p.o. daily
- Flaxseed oil 1000 mg p.o. daily
- Coreg 6.25 mg 2 p.o. daily
- Zetia 10 mg 1 p.o. daily
- Crestor 40 mg 1 p.o. daily
- Calcium plus vitamin D 2 p.o. daily
- Stool softener 2 p.o. daily
- Xopenex nebulizers q4hours p.r.n.
- Byetta 10 units b.i.d.
- NovoLog insulin 10 units plus sliding scale 3 times a day
- Lantus insulin 30 units in the morning

Review of symptoms:

General: History of fever, chills, and sweats as noted above

HEENT: Denies headache, eye pain, eye discharge, earache, nasal congestion, or sore throat

Neck: Denies masses or pain

Clinical Scenario Workbook 2020 CPT® Edition

JustCoding's Clinical Scenario Workbook: 2020 CPT® Edition provides an opportunity for coders to practice and refine their skills in a hands-on way by using a wide range of real-life case scenarios. In this book of 52 case scenarios, coders will determine the correct CPT and ICD-10-CM codes to report for each case scenario based on provided documentation, evidence of sufficient medical necessity, and any conditions present that would allow for Hierarchical Condition Category capture. The book also includes labeled illustrations for select cases to help coders by highlighting important anatomic details.

A full answer key with coding rationale for each case allows coders to self-audit and find immediate answers to their questions. When applicable, cases will also include references to guidance from *CPT Assistant*, *Coding Clinic*, the ICD-10 and CPT guidelines, and the *NCCI Manual*.

About Simplify Compliance

Simplify Compliance, with its three pillars of thought leadership, expertise, and application, provides critical insight, analysis, tools, and training to healthcare organizations nationwide. It empowers healthcare professionals with solution-focused information and intelligence to help their facilities and systems achieve compliance, financial performance, leadership, and organizational excellence. In addition, Simplify Compliance nurtures and provides access to productive C-suite relationships and engaged professional networks, deploys subject matter expertise deep into key functional areas, and enhances the utility of proprietary decision-support knowledge.

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