



STUDY SESSIONS

WEEK 3 - ICD-10-CM

SCRATCH WEEK 1



1. S: A 55-year-old male presents today with severe abdominal pain, nausea, and vomiting, persistent over the last 24 hours. Diarrhea has developed, and abdominal cramping is also present. The patient states that he cannot keep anything down. Upon questioning, he states that he attended a neighborhood clambake and ate at least a dozen raw clams.

No over-the counter (OTC) medications were tried because the patient cannot keep anything down.

O: Pleasant, alert gentleman who appears in mild discomfort. Vital signs: Temp—99, pulse—70, resp—22, BP—120/75. Skin: Warm and clammy.

HEENT: Unremarkable except for dryness around conjunctiva and the mouth. The patient appears slightly dehydrated.

Neck: No JVD; no thyromegaly or bruits.

Lungs: Clear to auscultation and percussion.

Heart: No murmurs.

Extremities: No edema.

A: Food poisoning due to salmonella

P: Will order a suppository to help with the nausea. Stressed the importance of forcing fluids once the suppository has had time to work. The patient will call in the morning if he does not feel better. If he is improving, he will follow up as needed.

ICD-10-CM: _____

2. Oncology Clinic Note

The patient was seen today to receive his first chemotherapy treatment for his diagnosis of acute lymphoid leukemia.

EXAM:

VITALS: Temperature 98.9, B/P 125/80. Pulse: regular.

LUNGS: Normal

ABDOMEN: Soft, no masses noted.

HEENT: Normal

HEART: Normal rate and rhythm

Chemotherapy schedule was reviewed, and side effects of treatment were discussed.

Chemotherapy was given; the patient tolerated treatment well.

ICD-10-CM: _____, _____

3. Discharge Note

This 39-year-old male patient is being discharged today following a splenectomy. The splenectomy was completed because the patient had hypersplenism, which could not be treated by other more conservative measures. The patient tolerated the procedure and has been instructed to follow the postoperative orders that I have given him. He is to see me in my office in 1 week.

ICD-10-CM: _____

4. Clinic Visit

The patient presents today with symptoms of excessive thirst and frequent urination, which has been going on for approximately 1 month. The patient states that these symptoms are affecting her sleep, and she is concerned that there might be something wrong. Patient denies any shortness of breath, nausea, or stomach cramping. The patient does state that her mother had type 2 diabetes, and she is fearful since the symptoms are similar. The patient states that she was borderline diabetic during her pregnancy.

WEIGHT: 198 lb Temp: 98.7 BP: 110/70

HEART: No murmurs, RRR

LUNGS: Normal

SKIN: Warm and dry

EXTREMITIES: No edema

We did a finger stick, which indicated an elevated blood sugar level of 201. An HgA1C was ordered, which came back at a level 9. With these results and the symptoms involved, type 2 diabetes is the diagnosis. We will try to control her diabetes with diet, exercise, and Glucophage. She will be set up for diabetic education as soon as possible.

ICD-10-CM: _____, _____

5. Physician's Office Note

NAME: John Nown DATE OF SERVICE: 3/1/XX

BLOOD PRESSURE: 130/83 WEIGHT: 168 TEMPERATURE: 98.6

John is being seen today at his request because he has felt tired and has lost his appetite for the last 3 weeks since his wife died. He has no other complaints at this time. He said he wants to make sure that he has no physical problems. Reviewing his record, I noted that all of his immunizations are current and that he is not due for any additional preventative medicine testing at this time.

Physical Exam:

HEENT: Within normal limits

HEART: Normal R&R, no murmurs

ABDOMEN: Soft and nontender, no masses; active bowel sounds

EXTREMITIES: Within normal limits

Patient is oriented to time, person, and surroundings with no confusion. Patient expressed that he is sad because of the loss of his wife. I told the patient that his tiredness is most likely due to the loss of his wife and that there are no abnormal physical findings at this time.

DIAGNOSIS: Adjustment disorder with depressed mood.

PLAN: Patient refused antidepressive medications and said he would seek counseling if he felt he needed it. He was instructed to call the office if he experienced any other symptoms and said he wanted to follow up with me in 3 weeks.

ICD-10-CM: _____

6. Discharge Note

Mary Smith, a 43-year-old, is being discharged home today following her admission 3 days ago. At the time of admission she was experiencing a severe headache. After diagnostic testing, it was confirmed that she had a persistent migraine, with aura with cerebral infarction with refractory migraine and status migrainosus. She is to follow up with me in my office in 2 weeks.

ICD-10-CM: _____, _____

7. Observation Note

This patient is being placed in observation due to an increase in the symptoms of her acute angle-closure glaucoma in her right eye, severe stage. She is being placed on IV meds to see if symptoms decrease. She will be monitored and then admission for peripheral iridectomy will be made if needed.

ICD-10-CM: _____

8. Office Note

This 84-year-old patient presents today with a complaint of loss of hearing, tinnitus, and pain in her left ear.

Vital Signs: BP: 130/80, Weight: 194 pounds

Ear: Inspection of right ear—no findings

Inspection of left ear—there is impacted cerumen in the ear.

Mineral oil was placed in her ear and then the ear was irrigated and the wax removed.

ICD-10-CM: _____

9. DISCHARGE SUMMARY:

Admitted 2/03/XX

Discharged 2/07/XX

Admitting Diagnosis:

1. Unstable angina
2. Atrial fibrillation

HISTORY: This 69-year-old man was admitted through the ER with chest pain that began while he was eating his lunch. After lunch he went to do his grocery shopping, and he began to develop discomfort in his chest as well as in his jaw. He drove himself to the ER. The ER physician admitted the patient due to unstable angina.

Vital signs at time of admission: BP: 140/60, Heart rate: 110 to 120

HEART: Patient complains of chest pain.

All other physical findings were within normal limits.

HOSPITAL COURSE:

Cardiac enzymes—CPK of 105, Troponin—4.7 with a relative index of 5.4

Digoxin level was 1.8.

All other lab values were normal.

EKG was positive for a new anterior wall infarction.

The patient was maintained on Imdur 30 mg daily and metoprolol 50 mg in the morning and evening.

The patient stabilized and was instructed to see me in 7 days.

Discharge Diagnosis:

1. Acute anterolateral transmural Q wave infarction
2. Hypertension

ICD-10-CM: _____, _____

10. Discharge Note

This 85-year-old male patient is being discharged to Sunny Side Nursing facility. He has had a 4-day length of stay due to a number of issues. Today he is stable and he is to be discharged. His final diagnosis is:

Stage 4 chronic renal disease accompanied by congestive heart failure due to hypertension.

I will follow up with him at the nursing facility in 10 days or sooner if needed.

ICD-10-CM: _____, _____, _____

Answer Key

1. S: A 55-year-old male presents today with severe abdominal pain, nausea, and vomiting, persistent over the last 24 hours. Diarrhea has developed, and abdominal cramping is also present. The patient states that he cannot keep anything down. Upon questioning, he states that he attended a neighborhood clambake and ate at least a dozen raw clams.

No over-the counter (OTC) medications were tried because the patient cannot keep anything down.

O: Pleasant, alert gentleman who appears in mild discomfort. Vital signs: Temp—99, pulse—70, resp—22, BP—120/75. Skin: Warm and clammy.

HEENT: Unremarkable except for dryness around conjunctiva and the mouth. The patient appears slightly dehydrated.

Neck: No JVD; no thyromegaly or bruits.

Lungs: Clear to auscultation and percussion.

Heart: No murmurs.

Extremities: No edema.

A: Food poisoning due to salmonella

P: Will order a suppository to help with the nausea. Stressed the importance of forcing fluids once the suppository has had time to work. The patient will call in the morning if he does not feel better. If he is improving, he will follow up as needed.

ICD-10-CM: A02.9

Rationale: The encounter states that the patient presented to the office today with severe abdominal pain, nausea and vomiting. After the examination, he is diagnosed with food poisoning which will be the only diagnosis coded for this encounter.

Alphabetic Index:

- Poisoning → food → due to → salmonella

2. Oncology Clinic Note

The patient was seen today to receive his first chemotherapy treatment for his diagnosis of acute lymphoid leukemia.

EXAM:

VITALS: Temperature 98.9, B/P 125/80. Pulse: regular.

LUNGS: Normal

ABDOMEN: Soft, no masses noted.

HEENT: Normal

HEART: Normal rate and rhythm

Chemotherapy schedule was reviewed, and side effects of treatment were discussed.

Chemotherapy was given; the patient tolerated treatment well.

ICD-10-CM: Z51.11, C91.00

Rationale: This encounter is for the purpose of receiving chemotherapy. Guideline I.C.2.e.2 states "if the encounter is chiefly for the administration of chemotherapy... assign code Z51.11... as the first listed diagnosis. The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis."

Alphabetic Index:

- Encounter (for) → chemotherapy for neoplasm
- Leukemia → acute lymphoblastic

3. Discharge Note

This 39-year-old male patient is being discharged today following a splenectomy. The splenectomy was completed because the patient had hypersplenism, which could not be treated by other more conservative measures. The patient tolerated the procedure and has been instructed to follow the postoperative orders that I have given him. He is to see me in my office in 1 week.

ICD-10-CM: D73.1

Rationale: This patient was admitted previously for a splenectomy which was the result of hypersplenism. When coding the discharge summary, you should list the reason for the admission as the first listed diagnosis, even though the condition is no longer present.

Alphabetic Index:

- Hypersplenism

4. Clinic Visit

The patient presents today with symptoms of excessive thirst and frequent urination, which has been going on for approximately 1 month. The patient states that these symptoms are affecting her sleep, and she is concerned that there might be something wrong. Patient denies any shortness of breath, nausea, or stomach cramping. The patient does state that her mother had type 2 diabetes, and she is fearful since the symptoms are similar. The patient states that she was borderline diabetic during her pregnancy.

WEIGHT: 198 lb Temp: 98.7 BP: 110/70

HEART: No murmurs, RRR

LUNGS: Normal

SKIN: Warm and dry

EXTREMITIES: No edema

We did a finger stick, which indicated an elevated blood sugar level of 201. An HgA1C was ordered, which came back at a level 9. With these results and the symptoms involved, type 2 diabetes is the diagnosis. We will try to control her diabetes with diet, exercise, and Glucophage. She will be set up for diabetic education as soon as possible.

ICD-10-CM: E11.65, Z83.3

Rationale: The documentation supports diagnoses of type 2 diabetes mellitus and the fact that the patient has an elevated blood sugar and family history of diabetes. Since the patient is not currently taking the medication at the time of the encounter, but they were prescribed the medication at the end of the encounter, it would not qualify for the long term (current) use Z79.84 code.

Alphabetic Index:

- Diabetes → type 2 → with hyperglycemia
- History → family → diabetes mellitus

5. Physician's Office Note

NAME: John Nown DATE OF SERVICE: 3/1/XX

BLOOD PRESSURE: 130/83 WEIGHT: 168 TEMPERATURE: 98.6

John is being seen today at his request because he has felt tired and has lost his appetite for the last 3 weeks since his wife died. He has no other complaints at this time. He said he wants to make sure that he has no physical problems. Reviewing his record, I noted that all of his immunizations are current and that he is not due for any additional preventative medicine testing at this time.

Physical Exam:

HEENT: Within normal limits

HEART: Normal R&R, no murmurs

ABDOMEN: Soft and nontender, no masses; active bowel sounds

EXTREMITIES: Within normal limits

Patient is oriented to time, person, and surroundings with no confusion. Patient expressed that he is sad because of the loss of his wife. I told the patient that his tiredness is most likely due to the loss of his wife and that there are no abnormal physical findings at this time.

DIAGNOSIS: Adjustment disorder with depressed mood.

PLAN: Patient refused antidepressive medications and said he would seek counseling if he felt he needed it. He was instructed to call the office if he experienced any other symptoms and said he wanted to follow up with me in 3 weeks.

ICD-10-CM: F43.21

Rationale: The patient is evaluated today in the physicians office and diagnosed with adjustment disorder with depressed mood. The symptoms of feeling tired and loss of appetite will not be coded in addition to the definitive diagnosis.

Alphabetic Index:

- Disorder → adjustment → with → depressed mood

6. Discharge Note

Mary Smith, a 43-year-old, is being discharged home today following her admission 3 days ago. At the time of admission she was experiencing a severe headache. After diagnostic testing, it was confirmed that she had a persistent migraine, with aura with cerebral infarction with refractory migraine and status migrainosus. She is to follow up with me in my office in 2 weeks.

ICD-10-CM: G43.611, I63.9

Rationale: Mary is diagnosed with a persistent migraine, that includes an aura and cerebral infarction. At code G43.611, there is a code also note indicating to also code the type of cerebral infarction that is present.

Alphabetic Index:

- Migraine → with aura → persistent → with cerebral infarction → with refractory migraine → with status migrainosus
- Infarction → cerebral

7. Observation Note

This patient is being placed in observation due to an increase in the symptoms of her acute angle-closure glaucoma in her right eye, severe stage. She is being placed on IV meds to see if symptoms decrease. She will be monitored and then admission for peripheral iridectomy will be made if needed.

ICD-10-CM: H40.211

Rationale: The patient presents with an exacerbation of her acute angle-closure glaucoma. This is considered an acute attack of the glaucoma.

Alphabetic Index:

- Glaucoma → angle-closure (primary) → acute (attack)

8. Office Note

This 84-year-old patient presents today with a complaint of loss of hearing, tinnitus, and pain in her left ear.

Vital Signs: BP: 130/80, Weight: 194 pounds

Ear: Inspection of right ear—no findings

Inspection of left ear—there is impacted cerumen in the ear.

Mineral oil was placed in her ear and then the ear was irrigated and the wax removed.

ICD-10-CM: H61.22

Rationale: After exam it is revealed that there is impacted cerumen within the left ear. The symptoms are not coded in addition to the impacted cerumen definitive diagnosis.

Alphabetic Index:

- Impaction, impaction → cerumen (ear) (external)

9. DISCHARGE SUMMARY:

Admitted 2/03/XX

Discharged 2/07/XX

Admitting Diagnosis:

1. Unstable angina
2. Atrial fibrillation

HISTORY: This 69-year-old man was admitted through the ER with chest pain that began while he was eating his lunch. After lunch he went to do his grocery shopping, and he began to develop discomfort in his chest as well as in his jaw. He drove himself to the ER. The ER physician admitted the patient due to unstable angina.

Vital signs at time of admission: BP: 140/60, Heart rate: 110 to 120

HEART: Patient complains of chest pain.

All other physical findings were within normal limits.

HOSPITAL COURSE:

Cardiac enzymes—CPK of 105, Troponin—4.7 with a relative index of 5.4

Digoxin level was 1.8.

All other lab values were normal.

EKG was positive for a new anterior wall infarction.

The patient was maintained on Imdur 30 mg daily and metoprolol 50 mg in the morning and evening.

The patient stabilized and was instructed to see me in 7 days.

Discharge Diagnosis:

1. Acute anterolateral transmural Q wave infarction
2. Hypertension

ICD-10-CM: I21.09, I10

Rationale: The patient is diagnosed with an acute anterolateral transmural Q wave infarction during this encounter. It is also documented that the patient has hypertension.

Alphabetic Index:

- Infarction → myocardium, myocardial → Q wave → *see also* Infarct → myocardium → ST elevation → anterior (anterolateral)
- Hypertension

10. Discharge Note

This 85-year-old male patient is being discharged to Sunny Side Nursing facility. He has had a 4-day length of stay due to a number of issues. Today he is stable and he is to be discharged. His final diagnosis is:

Stage 4 chronic renal disease accompanied by congestive heart failure due to hypertension.

I will follow up with him at the nursing facility in 10 days or sooner if needed.

ICD-10-CM: I13.0, I50.9, N18.4

Rationale: Guideline I.C.9.a states “The classification presumes a causal relationship between hypertension and heart involvement and hypertension and kidney involvement, as the two conditions are linked by the term ‘with’ in the Alphabetic Index.” Guideline I.C.9.a.e states “assign codes from combination category I13, Hypertensive heart and chronic kidney disease, which there is hypertension with both heart and chronic kidney disease. 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 a secondary diagnosis code with a code from category I13 to identify the stage of chronic kidney disease.”

Alphabetic Index:

- Hypertension → cardiorenal → with heart failure → with stage 1 through stage 4 chronic kidney disease
- Failure → heart → congestive
- Disease → kidney → chronic → stage 4