

Chapter 1: Evaluation and Management Services Test 2

CASE**1. T1-2A INITIAL HOSPITAL CARE**

LOCATION:	Inpatient, Hospital
PATIENT:	Dorothy Lien
ATTENDING PHYSICIAN:	Alma Naraquist, MD
CHIEF COMPLAINT:	Pelvic pain and pain with periods

HISTORY: This lady is a 34-year-old married white female, gravida 2, para (to bring forth) 2. Her LMP (last menstrual period) was April 30, and she received an injection of Depo-Provera at 200 mg (milligram) IM (intramuscular) on May 2. The patient has a long-standing history of endometriosis dating back to June 10 years ago when she had bilateral ovarian cystectomies for endometriosis in her hometown. She was then treated with Danazol for 6 months. I saw her initially back 3 years ago for secondary infertility. She had a laparoscopy with lysis of adhesions the following year, at which time the right ovary was mildly adherent to the pelvic sidewall but was broken up somewhat with dissection, and she had some small bowel adherent to the left ovary. She was then treated on multiple cycles of Klonopin citrate because of luteal phase deficiency but failed to conceive. Last year, she underwent repeat laparoscopy with exploratory laparotomy and pelvic adhesiolysis, having had bowel and pelvic adhesions, and she had resection of several areas of endometriosis. At that point, the patient continued to try and get pregnant but was having more problems; therefore, she was treated with oral contraceptives and nonsteroidal anti-inflammatory drugs. The patient did spontaneously conceive and delivered her second child on August 20. She was not having much success in alleviating her symptoms of dysmenorrhea and dyspareunia; therefore, she was begun on continuous oral contraceptives in the form of Demulen 1/50 back in January. This did result in the expected amenorrhea, and her symptoms were initially controlled fairly well. She then started having more in the way of cramping and pain; however, dyspareunia had improved. At this point, she is being brought in for definitive surgery because of persistent pelvic pain and cramping.

CURRENT MEDICATIONS: None

ALLERGIES: None

REVIEW OF SYSTEMS: She has occasional lower abdominal cramping, but this has improved somewhat since her injection of Depo-Provera. She has no URI (upper respiratory infection) symptoms or cough. No GI (gastrointestinal) or GU (genitourinary) symptoms. No vaginal discharge.

FAMILY HISTORY: Her dad has maturity onset diabetes, coronary artery disease, and hypertension, but he is living. Her mom is in good health. She had two maternal aunts with breast cancer, and there are other types of cancer in her mother's siblings, the specifics of which are unknown.

SOCIAL HISTORY: The patient is a teacher at the local elementary school in her hometown. Habits: Occasional alcohol. Very rarely does she smoke a cigarette.

PAST SURGICAL HISTORY:

1. Laparoscopy, exploratory laparotomy with adhesiolysis.
2. Ovarian cystectomy and appendectomy.
3. Diagnostic laparoscopy.

PHYSICAL EXAMINATION: Weight is 162 pounds. Blood pressure is 100/60. Pulse, 60. HEENT (head, ears, eyes, nose, throat) are unremarkable. Neck has no masses. Lungs are clear to auscultation. Heart has a regular rhythm without audible murmurs or gallops. Breasts are negative. Abdomen is soft and shows a laparoscopy scar and Pfannenstiel scar. Vulva and vagina are normal. Cervix is parous. Uterus is anterior and normal size. Adnexa reveal tenderness on the left but not on the right. On rectovaginal examination, there is some extreme nodularity on the left side of the cul-de-sac. Extremities show no phlebitis.

LABORATORY STUDIES: Preop laboratory work shows the urinalysis to be normal. White count is 5440. Hemoglobin is 13.6 g (gram).

PREOPERATIVE DIAGNOSIS: Endometriosis with chronic dysmenorrhea and pelvic pain.

OPERATIVE PLAN: Total abdominal hysterectomy and bilateral salpingo-oophorectomy. The patient will receive a mechanical and antibiotic bowel prep, and she will also have ureteral catheters placed preoperatively by Dr. Avila. The patient understands the potential complications, infections, bleeding, bowel, bladder, and ureteral injury. Potential complications of blood clot formation and pulmonary emboli are also discussed with the patient. She understands the necessity of the operation, its intended outcome and risks, and agrees to proceed as planned.

T1-2A:

SERVICE CODE(S): _____

ICD-10-CM DX CODE(S): _____

ANS:

Professional Services: 99221-57 (Evaluation and Management, Hospital)

ICD-10-CM DX: N80.9 (Endometriosis)

RATIONALE: The HPI included 4 elements: location (pelvis), duration (long-standing history, back to June 10 years ago), modifying factors (contraceptives improved the condition), and associated signs and symptoms (cramping) for a level 4 or comprehensive HPI. The ROS included 3 elements: respiratory (URI), gastrointestinal (no GI symptoms), and genitourinary (no GU symptoms) for a level 3 or detailed ROS. The PFSH contained all 3 elements for a level 4 or comprehensive PFSH. A comprehensive HPI, detailed ROS, and comprehensive PFSH place this case in level 3 or a detailed history.

The examination included 3 constitutional elements: blood pressure, weight, and pulse for 1 OS. There were 4 BAs reviewed: head (H in HEENT, unremarkable), neck (no masses), chest (breast and adnexa), and abdomen (soft). There were 7 OSs reviewed: ophthalmologic (E in HEENT), otolaryngologic (ENT in HEENT, unremarkable), cardiovascular (heart regular, no phlebitis), respiratory (lungs clear), integumentary (scar), gastrointestinal (recto in rectovaginal), and genitourinary (vaginal in rectovaginal, vulva, cervix, and uterus). There was a total of 12 BAs/OSs which would usually make this a level 4 or comprehensive examination; however, BAs are not counted for the comprehensive examination. Recounting there was 1 OS for the constitutional elements and 7 OSs noted during the examination. This examination still qualifies as a comprehensive examination.

The MDM included a limited number of diagnoses/management options, a minimal amount of data to review (labs), and a moderate risk to the patient (elective surgery is moderate risk). This is a level 2 or low MDM.

The key components consist of a detailed history, comprehensive exam, and low MDM. This supports 99221.

Note that the choice of the correct code depends on all three of the key components to assign an Initial Hospital Care code. 99221 requires a detailed or comprehensive history, a detailed or comprehensive exam, and straightforward or low MDM. 99222 requires a comprehensive history and comprehensive examination level and MDM of a moderate level. While the exam is comprehensive and meets the requirements of the higher levels of codes, the history and MDM support the lower level; therefore 99221 is the correct code.

Modifier -57 is added to indicate a decision for surgery was made during the E/M service.

The diagnosis is endometriosis as stated in the Preoperative Diagnosis section of the report. Dysmenorrhea and pelvic pain are not coded because they are symptoms of endometriosis, which is the more definitive diagnosis.

PTS: 1

2. **T1-2B CONSULTATION**

LOCATION:	Inpatient, Hospital
PATIENT:	Karen Carp
ATTENDING PHYSICIAN:	Leslie Alanda, MD
CONSULTANT:	Gerald Lorabi, MD

REASON FOR CONSULTATION: Dr. Alanda asked me to see the patient over concerns that she might have an autoimmune hemolytic anemia.

HISTORY: The patient is a 59-year-old female who has had a stormy course after open reduction internal fixation of a supracondylar fracture of her left femur. Postoperatively, she developed respiratory problems, ARDS (acute or adult respiratory distress syndrome), and also has been felt to have a cholestatic liver problem.

Chief problem is that her bilirubin is over 4. Her hemoglobin has failed below 7 g, and she has increased reticulocytes. She has been transfused recently several units and despite that her hemoglobin has dropped. Dr. Alanda was under the impression that her direct Coombs' test was positive but in checking into this further, her direct antiglobulin test was negative, but she did have multiple other alloantibodies.

In reviewing the chart, her past history is significant for coronary artery disease, obesity, hypertension, tobacco abuse, and hyperlipidemia. She had a right CVA (stroke/cardiovascular accident) with hemiparesis last year.

From the chart, I am not aware if she previously had blood transfusion.

MEDICATIONS: She is on a panoply of medications as listed in Dr. Naraquist's consultation notes.

ALLERGIES: None known.

SOCIAL HISTORY: No significant alcohol abuse, but a 2-pack-a-day smoker. She does not work outside the home.

FAMILY HISTORY: Her mother died of leukemia. Father died of congestive heart failure at age 58. A sister died at age 29 of a myocardial infarction.

REVIEW OF SYSTEMS: At this time is impossible as the patient is sedated on a ventilator and unresponsive to questions.

She has hepatitis serology and HIV (human immunodeficiency virus) serology pending at the time of this dictation. Clotting studies were negative. Her Coombs' test was negative as mentioned above and antibody screen was positive. Reticulocytes were done late last night and absolute reticulocyte count was 113,000. Recent troponin level was negative.

PHYSICAL EXAMINATION: The patient is moribund. She is obese. She is sedated at this time on a ventilator. Vital signs are being maintained within a reasonable range at this point. She is not grossly jaundiced. Lungs reveal diminished air entry. Heart tones are normal and regular. Her abdomen is massively obese. No definite liver or splenic enlargement. No external bruising noted. Sclerae may be slightly icteric. No lymphadenopathy. There is no gross edema appreciated in extremities. She has a Foley catheter in place and the urine from that is pink. Other formal testing was not possible because of the patient's condition.

I spent time looking at her peripheral smear. She does have enucleated red cells in the peripheral smear and a left shift. This is probably a leukoerythroblastic reaction related to some hemolysis and to her recent ARDS and surgical procedure. There are no increased numbers of spherocytes noted. There is significant polychromasia. Her liver functions were significantly abnormal with elevation of her hepatic enzymes and her bilirubin was as high as 9.6, but is down to 4. Almost all this bilirubin is direct reacting which would certainly be more consistent with hepatic disease on the face of hemolysis or excessive bleeding.

IMPRESSION:

1. Significant anemia, which probably is related to hemolysis. This, at least in part, is probably related to alloantibodies and engendered by her recent blood transfusion. She had no antibodies, probably a result of the transfusion and probably a result of previous exposure to blood transfusion. The elevated bilirubin is in part due to her hemolysis and in part due to impaired hepatic function. There is no evidence of autoimmune hemolytic anemia in her case.
2. ARDS (acute or adult respiratory distress syndrome).
3. Obesity.

In this situation, it would be critical to give plenty of IV (intravenous) fluids with appropriate diuresis to try and maintain adequate urine flow.
Thank you for this consultation.

T1-2B:

SERVICE CODE(S): _____
ICD-10-CM DX CODE(S): _____

ANS:

Professional Services: 99255 (Evaluation and Management, Consultation)

ICD-10-CM DX: D64.9 (Anemia), **K72.90** (Impaired/impairment, liver), **J80**

(Syndrome, respiratory distress, acute, adult), **E66.9** (Obesity), **Z99.11** (Dependence, on, ventilator)

RATIONALE: *There are 5 HPI elements: context (after open reduction internal fixation), modifying factors (transfusion), associated signs and symptoms (ARDS [adult respiratory distress syndrome], ORIF [open reduction with internal fixation], and liver), quality (stormy course), and severity (transfusion and decreased Hgb) for a level 4 HPI. The ROS is unobtainable due to the fact that the patient is on a ventilator, which is a level 4 or comprehensive ROS. There were 3 PFSH elements identified for a level 4 or comprehensive PFSH. This is a level 4 or comprehensive history.*

The examination included constitutional elements of general appearance (obese, jaundice) and vitals (although not specific to which ones). This counts as 1 OS. There was 1 BA: abdomen (massively obese). There were 7 OSs: ophthalmologic (sclerae), cardiovascular (heart tones, edema in extremities), respiratory, gastrointestinal (liver/abdomen), integumentary (no bruising, no jaundice), lymphatic (no lymphadenopathy), and genitourinary (Foley catheter, pink urine). There was a total of 9 BAs/OSs which would usually make this a level 4 or comprehensive examination; however, BAs are not counted for the comprehensive examination. Recounting there was 1 OS for the constitutional elements and 7 OSs noted during the examination for a total of 8 OSs. This examination still qualifies as a comprehensive examination.

The MDM included extensive diagnoses/management options of significant conditions (anemia, ARDS [adult respiratory distress syndrome], obesity, and impaired hepatic function), extensive data (labs), and high risk to the patient, for a level 4 or high MDM.

The diagnoses are as listed in the Impression section of the report. The patient has unspecified anemia (D64.9) and impaired liver function (K72.9). The elevated bilirubin is partially due to the impaired liver function, which also generates the hemolysis and is a symptom of her liver impairment as stated in the Impression section of the report. The impairment causes the hemolysis, which in turn generates the increased bilirubin. The patient also has adult respiratory syndrome that developed postoperatively (J80). The patient is obese (E66.9). Note the statements in the physical exam, "The patient is moribund. She is obese." These two separate statements do not equal "morbid obesity." The physical exam states she is "massively obese"; but does not state "morbid obesity" which is defined as 125% over ideal weight. Therefore, the correct code is E66.9. The patient is dependent on a ventilator, which is reported with Z99.11.

PTS: 1

3. AUDIT REPORT T1.2 OBSERVATION

LOCATION:	Hospital Observation Unit
PATIENT:	Lloyd Hanson
ATTENDING PHYSICIAN:	Alma Naraquist, MD
REASON FOR ADMISSION:	Exacerbation of COPD.

HISTORY OF PRESENT ILLNESS: The patient is a 74-year-old male who comes in tonight complaining of progressive shortness of breath over the past 4 days. He had upper-respiratory tract symptoms a week ago with nasal discharge and cold-like symptoms. It progressed to shortness of breath over the past 4 days. I was called by a family member of his earlier tonight, and I advised him to come to the Emergency Room, which he did. In the ER, he was wheezy and had oxygen saturation of 92%. He received a nebulizer treatment. A chest x-ray was done, which I reviewed myself and showed no evidence of infiltrates. He has a large heart. The patient was admitted to the 6th floor.

I proceeded by doing ABGs on him. His pH was 7.46, PCO₂ 94, bicarb 33.5 on 2 liters per nasal cannula.

The patient has some cough with clear phlegm. No fever or chills now. He had some chills a week ago.

The patient recently had an angiogram for his abdominal aortic aneurysm. He also had a stress test that apparently was positive.

The patient is known to have chronic renal failure with a baseline creatinine of 2 to 2.2 with creatinine clearance of 32 ml per minute with a serum creatinine of 2.0 back in December.

He does have severe congestive heart failure with ejection fraction less than 20%.

PAST MEDICAL HISTORY:

1. Chronic renal failure as mentioned.
2. Coronary artery disease, post two myocardial infarctions.
3. Post AICD placement.
4. Atrial fibrillation with rapid ventricular response, controlled.
5. Congestive heart failure with ejection fraction of less than 20%.
6. Abdominal aortic aneurysm, which is infrarenal measuring 6.2 cm.
7. Bilateral common iliac aneurysm, approximately 3.5 to 3.6 cm.
8. Left internal iliac artery aneurysm, questionably coiled lately.
9. COPD/asthma.
10. History of gouty arthritis with a recent gouty attack in his right first metatarsal phalangeal joint.
11. History of diverticulitis.
12. Hyperlipidemia.
13. Status post cholecystectomy, inguinal hernia repair, appendectomy.
14. Chronic renal failure, post PD catheter placement.

ALLERGIES: No known drug allergies.

MEDICATIONS:

1. Nebulizer at home.
2. Bumex 2 mg in the morning and 1 mg in the evening.
3. Coumadin 2 mg on Monday, 1 mg on other days.
4. Digoxin 0.125 mg po daily.
5. Potassium chloride 20 mEq po b.i.d.
6. Zocor 10 mg po q.hs.
7. Coreg 25 mg po b.i.d.
8. Allopurinol 100 mg po daily.
9. Ranitidine 150 mg po q.hs.

FAMILY HISTORY: Mother died of pancreatitis. Father died at age 71. Otherwise, family history is noncontributory.

SOCIAL HISTORY: Lives here in town with his wife. She was not available today. He quit smoking 16 years ago.

REVIEW OF SYSTEMS: CONSTITUTIONAL: No fever, chills, or night sweats. ENT: Resolved upper-respiratory tract symptoms. RESPIRATORY: As mentioned. CARDIOVASCULAR: Exertional dyspnea. No chest pain. GI: Questionable dark stool but no diarrhea, nausea, or vomiting. He had some abdominal discomfort with coughing. MUSCULOSKELETAL: History of gouty arthritis, but seems to be controlled. SKIN: Trace edema. NEURO: Negative. PSYCHIATRIC: Negative.

PHYSICAL EXAMINATION: The patient was in mild respiratory distress. He was awake, oriented times three without any focal neurological deficits. His heart rate is in the 70s range, blood pressure has been 120s/80s, sats 92% when he came in, 98% on 2 liters per nasal cannula. Slightly increased jugular venous pressure. No cervical lymphadenopathy. LUNGS: Good air entry bilaterally but expiratory wheezes bilaterally. No crackles. No sacral edema. ABDOMEN: Soft and nontender, no masses. He has PD catheter in the left lower quadrant. Small hematoma in the right inguinal area from his recent aortogram.

LOWER EXTREMITIES: Very trace edema.

LABORATORY STUDIES: CBC tonight shows a white count of 8.6 thousand, hemoglobin 12.3, platelets 140,000, BUN 29, sodium 139, potassium 3.6, chloride 98, bicarb 31, creatinine 2.2, calcium 8.5. BNP 536 picogram/ml. INR 1.5 with a pro-time of 14.3. Digoxin 0.6. Troponin-I less than 0.04. His last uric acid level was 7.4.

IMPRESSION:

1. Exacerbation of COPD/asthma with wheezes.
2. Abdominal aortic aneurysm.

PLAN:

1. Albuterol MDI 2 puffs t.i.d.
2. Atrovent MDI 2 puffs t.i.d.
3. Azmacort MDI 2 puffs b.i.d.
4. Solu-Medrol 80 mg IV q8h.
5. Continue the current PO medications.
6. Zithromax 500 mg IV daily.
7. The patient is code level I.

Discussed all of the above with the patient. He seems to understand and agrees with the plan. Will discuss further issues to his abdominal aortic aneurysm and further plans with his positive stress test when the rest of the family is available in the next couple of days.

T1.2:

SERVICE CODE(S): 99221

ICD-10-CM DX CODE(S): R06.02, J44.1, I50.9

INCORRECT/MISSING CODE(S):

ANS:

INCORRECT/MISSING CODE(S): **99218, R06.02, I71.4**

RATIONALE: *The HPI was a level 4 and contains the 4 elements of quality (progressive), context (URI 1 week ago), duration (4 days), and associated signs and symptoms (nasal drainage, cold-like symptoms, SOB). The ROS is a level 3 (8 elements) and includes constitutional, otolaryngologic, cardiovascular, respiratory, gastrointestinal, musculoskeletal, neurologic, and psychiatric. Note that skin is not counted as an ROS due to the fact that “trace edema” is an objective (examination) finding. All three of the PFSH elements were reviewed, making this a level 4 PFSH. The HPI, ROS, and PFSH elements make this a level 3 or detailed history.*

The examination included three elements of constitutional (general appearance of mild respiratory distress, blood pressure, and heart rate) so this will count as 1 organ system. The body areas were abdomen (soft), neck (increased jugular venous pressure) for 2 BAs. There were 6 organ systems: cardiovascular (edema), respiratory (wheezes), gastrointestinal (no masses), integumentary (exam dialysis catheter site with noted hematoma), neurologic (oriented, no deficits), and lymphatic (lymphadenopathy) for a total of 9 BAs/OSs, which would make this a level 4 or comprehensive examination; however, BAs are not counted in determining a comprehensive level examination. With a total of 7 OSs, this examination is a level 3 or detailed examination.

The MDM elements included limited diagnosis management options, moderate data to review, and a moderate risk to the patient, making this a moderate MDM or level.

The detailed history, detailed examination, and moderate MDM are reported with 99218.

The diagnosis on admission was progressive shortness of breath, but upon examination the diagnosis changed to an exacerbation of COPD with asthma (J44.1). This is the diagnosis to assign and not the shortness of breath since the SOB (R06.02) is a symptom of the COPD. The diagnosis for abdominal aortic aneurysm (I71.4) would also be reported since it is going to be investigated further. The CHF is also reported as it impacts the treatment of the COPD.

PTS: 1