ADDITIONAL CODING EXERCISES

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AH 201
Basic Coding

1. Polydactyly of fingers	
2. Pneumonia with influenza	
3. Hiatal hernia	
4. Acute and chronic conjunctivitis, left eye	
5. Psoriatic arthropathy and parapsoriasis	
6. Acute gastritis with bleeding	
7. Benign hypertension	
8. Chronic venous hypertension due to deep vein thrombosis, right leg	
9. Stomach cancer, primary site	
10. Hodgkin's sarcoma	
11. Hemiplegia, due to old CVA, left side of body Patient is left handed	

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ICD-10-CM

1. Severe mitral stenosis and mild aortic insufficiency	
2. Cerebrovascular accident due to cerebral embolism Patient is a smoker	
3. Hypertension due to calculus of the ureter	
4. Pulmonary HTN secondary to mitral stenosis	
5. CHF due to hypertension	
6. Congestive heart failure Hypertension	
7. ESRD Hypertensive heart disease	
8. Acute embolic CVA with infarction: hemiplegia Previous CVA wit residual facial droop	
9. Spontaneous epistaxis secondary to uncontrolled HTN	
10. Dissecting thoracoabdominal aneurysm	

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ICD-10CM – Cardiovascular Case study

History: The patient is an 87-year-old white male who has coronary artery disease, systolic hypertension, exogenous obesity and peripheral venous insufficiency. He recently had a kidney stone removed. He claims that his only symptom of the stone was persistent back pain. Since the surgery, he has been doing fairly well.

Physical Examination: The exam showed a well-developed, obese male who does not appear to be in any distress, but has considerable problems with mobility and uses a cane to ambulate. VITAL SIGNS: Blood pressure today is 158/86, pulse is 80 per minute and weight is 204 pounds. He has no pallor. He has rather pronounced shaking of the arms, which he claims is not new. NECK: No jugular venous distension. HEART: Very irregular. LUNGS: Clear. EXTREMITIES: There is edema of both legs.

Assessment:

1. Coronary artery disease
2. Exogenous obesity
3. Degenerative joint disease, involving multiple joints
4. Congestive Health Failure
5. Atrial fibrillation
6. History of myocardial infarction

Plan: The patient will return to the clinic in four months

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ICD-10-CM

1. Pathological fracture of the femur due to metastatic bone cancer from the lung	
2. Herniated lumbar interveterbral disc with paresthesia	
3. Pyogenic arthritis of the hip due to Group A Strep	
4. Bunion of left foot and hammertoe of right toe.	
5. Psychogenic dysuria	
6. Abnormal glucose tolerance	
7. Gross painless hematuria	
8. Hyperplastic lymph node, left axialla	
9. Atypical chest pain	
10. Generalized abdominal pain due to pancreatitis versus cholecystitis	

11. Urethral calculus	
12. ESRD patient is admitted for hemodialysis	
13. Patient is infertile due to a blockage of the fallopian tubes	
14. BPH with urinary retention and obstruction	
15. Boil of the left face	
16. Abscessed pilondial cyts	
17. Abscess with cellulitis of the abdominal wall. Culture is positive for staph aureus	
18. Assign the Glasgow coma scale code(s) when the patient had the following documented by the EMT. Eyes do not open, no verbal response, with no motor response.	
19. Recurrent dislocation of shoulder	
20. Decubitus ulcer of the buttock, right side. Stage 4	

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CPT – Evaluation and Management

1. Dr Smith visited a skilled nursing facility for a routine evaluation of his patient, who suffers from Parkinson's disease with visible hand tremors and gait disturbances. He reviews the medical record and signs orders. Dr. Smith performs an exam on his patient which reveals that her condition is stable without notable change in status since the last visit. During this visit Dr Smith spent about 15 minutes examining his patient and reviewing the records.	
2. Dr Howard saw an 89-year-old patient in the critical care unit of St. Mary's hospital. Patient was critically ill and in multisystem organ failure. The patient needed Dr Howard's constant attention for 1.5 hours. 3.	
4. Patient is a 5-year-old child. This is the first visit for this patient and presents with a low grade fever, runny nose, lethargy and decreased appetite. The doctor performs a expanded problem focused history and physical exam. He takes a nasal culture and makes a diagnosis of suspected RSV upper respiratory infection.	
5. Initial in-patient admission for a patient requiring a comprehensive physical and comprehensive exam with highly complex medical decision making Patient was then discharged 9 days later. The discharge services required and hour to perform	
6. An established patient was seen in the doctor's office because of a sore throat, fever, and difficulty swallowing. The patient's temperature was 101degreees. The final diagnosis was strep throat infection.	

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CPT Anesthesia

Assign the correct anesthesia, physical status modifiers and qualifying circumstance codes

1. Anesthesia services for radical mastectomy with internal mammary node dissection :patient has DM well-controlled with ADA diet	
2. Anesthesia services for closed treatment of fracture of humerus, patient is 85 years old but healthy	
3. Anesthesia services for CABG surgery of five vessels with pump oxygenator: patient has severe CAD as well as hypertensive end-stage renal disease requiring hemodialysis	
4. Anesthesia services for left lobectomy due to lung carcinoma; patient also has severe COPD and emphysema treated with bronchodilators	
5. Anesthesia services for left carotid endarterectomy; patient is healthy.	
6. Anesthesia services for heart transplant secondary to congenital heart defect; patient is 3 weeks old and requires a transplant to survive	
7. Anesthesia services for laparoscopic cholecystectomy with cholangiography for acute cholecystitis patient is 35 years old and in good health	
8. Anesthesia services for partial nephrectomy in a patient with renal cell carcinoma; 45 year old patient also has mild CAD and HTN treated with medication.	

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CPT Integentary System

1. Simple suture of upper lip laceration (5 cm) and left side of nose laceration (5 cm)	
2. Porcine graft 150 sq cm, burn wound of the trunk	
3. Excision of 3 cm scar on the back, with 6cm defect closed by complex repair	
4. Excision of 1.5 cm lesion on cheek, 4 sq c. defect repaired by adjacent tissue transfer	
5. Excision of malignant lesion of skin, right side of neck, 3 cm. Simple closure	
6. Excision of 2 benign lesions. 1 cm lesion of the forehead and 1 cm lesion of the cheek. Followed by intermediate closure of the forehead 4 cm and intermediate closure of the cheek 6 cm	
7. Cryosurgical destruction of 14 benign lesions of the back	
8. Layered closure of a skin wound , 13.4 cm arm	
9. Excision of benign lesion, skin, leg 5.1 cm	
10. I&D of simple abscess	

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CPT – Integumentary System

Operative Report

Preoperative Diagnosis: Lesion, right lower extremity

Postoperative Diagnosis: Undetermined lesion, right lower extremity, most likely benign with clear margins

Surgical Findings: There was a 2-cm diameter, raised erythematous lesion with a central pore of keratin.

Surgical Procedure: Excision of lesion, right lower extremity

Description of Procedure: Under satisfactory spinal anesthesia, the patient's right leg was prepped with Betadine scrub and solution and draped in a routine sterile fashion.

The lesion was excised with a 1-cm margin laterally. Dissection was carried down to the deep layer of fascia, and bleeding was electrocoagulated. One 2-0 Monocryl suture was used subcuticularly to take tension off the wound and then the skin was closed with interrupted vertical mattress sutures of 3-0 Prolene. We submitted the specimen for frozen section, and the frozen section diagnosis was benign lesion.

CPT code(s): _____

ICD-10-CM code(s) _____

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CPT Cardiovascular #2

1. Repair lacerated aorta with cardiopulmonary bypass	
2. Patient undergoes 2 CABGs including aortocoronary saphenous vein grafts to the right coronary artery (RCA) and the left anterior descending (LAD) artery	
3. Coronary artery bypass graft using 2 arterial grafts	
4. Replacement of a permanent dual chamber pacemaker with transvenous electrodes	
5. Replacement of aortic valve, with prosthetic valve, while on heart lung machine	
6. Embolectomy, carotid artery, by neck incision	
7. Insertion of a dual chamber pacing cardioverter-defibrillator (transvenous electrodes)	
8. Repair of patent ductus arteiousus by division (18-year-old patient)	

Preoperative Diagnosis: Heart Block

Post-operative Diagnosis: Heart Block

Procedure: Insertion of permanent pacemaker

The patient was premedicated before arriving at the OR. The patient was prepared and draped in the usual manner. A pocket was created for the pacemaker. The bipolar electrode was introduced and taken to the pulmonary artery, and brought out slowly to the apex of the right ventricle. Measurements were taken, and the position was excellent. The electrode was anchored to the fascia over the sleeve and connected to the pacemaker battery. The wound was closed. Patient tolerated the procedure well and returned to the outpatient recovery area.

CPT code: _____

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CPT – Pathology and Laboratory

1. Lipid panel and triglycerides	
2. FSH *gonadotropin* test	
3. Sputum culture	
4. HIV confirmation with Western blot	
5. Automated thrombocyte count	
6. Gross and microscopic examination of TURP	
7. Arterial blood gases	
8. Stool guaiac	
9. Glucose tolerance test, three specimens	
10. Monospot test	

EMERGENCY ROOM VISIT

5. Patient brought to the ER after falling off a swing, in a playground. The patient had a 3 cm laceration on his arm and a 2 cm laceration on his forehead. Both wounds were closed with simple closure. The physician performed an expanded problem focus history and exam. Decision making was moderate.

ICD _____

CPT _____