

Family & General Practice: Clinical Dx Scenarios

Florida's Blue Cross and Blue Shield Plan

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Name of your system vendor, clearinghouse and/or billing service and contact data you may have for them:

Email your completed form to us at ICD-10testing@floridablue.com

Note: It is critical to successful testing that we collaborate with both providers and their vendors who enable ICD-10 transactions for their clients.

INSTRUCTIONS

1. Print this form in order to complete it by hand.
2. Complete your contact information at left of form.
3. Select up to ten (10) scenarios below for practice coding.
4. Instruct your medical coder(s) to complete this document by coding your selected scenarios first using ICD-9 Dx codes followed by ICD-10 Dx codes. Be sure coder(s) understand they are to code in ICD-10 from the selected clinical scenarios vs. coding from ICD-9 to ICD-10 (mapping).
5. Scan and return by email your completed form to ICD-10testing@floridablue.com. If you do not have access to a scanner and would like to return your form to us via fax, please fax to 904-997-5571, Attn: Martina Fiorelli.
6. Within two weeks of receipt, Florida Blue will review your completed coding document and provide you with observations for scenarios that we have identified as a potential impact to claims adjudication.

NOTE: If you prefer, you may contact Florida Blue via email ICD-10testing@floridablue.com and you will be provided an Excel spreadsheet on which you can view and code these same scenarios.

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S001	A 46-year-old male seeks medical attention with complaints that include heart palpitations, shortness of breath, chest discomfort, dizziness, fatigue and lack of energy for the past 3 days. He normally works out 3-4 times per week and experiences these symptoms from time to time. PE and EKG performed. Labs ordered. Findings: Atrial Fibrillation.				
S002	A 75-year-old man comes to the clinic for follow-up visit of his chronic kidney disease. He later developed secondary hyperparathyroidism. A physical exam was performed and medications were reviewed. Labs were ordered and a urine sample was sent for urinalysis. The patient is on fluid restriction and a salt restricted diet. He lives with his daughter and is able to perform ADL's independently. Impressions: Chronic kidney disease, Stage III (moderate) and Secondary hyperparathyroidism (of renal origin).				
S003	A 62-year-old female presents with multiple complaints, namely: joint pain, morning stiffness, hard time getting-up from long periods of sitting, fever, shortness of breath, severe cough with greenish mucus, chest pain when coughing, and feeling very tired. She smokes one pack of cigarettes every 2 days. A physical exam was performed. The plan includes bloodwork, chest x-ray, mucus culture and sensitivity test. Antibiotics and cough expectorant with codeine were prescribed. Patient advised to take Tylenol for fever, Ibuprofen for pain, and return for follow-up in 2 weeks. Impressions: Osteoarthritis and pneumonia.				

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S004	<p>A 58-year-old male established patient returns to the office to discuss the results of the laboratory tests recently performed. The labs show an elevated BUN and creatinine. He complains now of feeling weak and tired. He was previously diagnosed and treated for an old myocardial infarction. Physical examination revealed pitting edema on both lower extremities. The importance of keeping legs elevated to prevent fluid accumulation was explained to the patient.</p> <p>The plan includes: comprehensive metabolic profile, CBC, continue medication, referral to nephrologist and cardiologist, and follow-up in 4 weeks.</p> <p>Impressions: Chronic kidney disease and old myocardial infarction.</p>				
S005	<p>The patient is a 43-year-old female who has fatigue, tiredness, daytime sleepiness and snoring at night time. She also complains of dry mouth on awakening, headaches and difficulty getting out of bed in the morning. She weighs 200 pounds and is 5'3" in height. She is on Coumadin therapy for blood clots in her legs. She was evaluated and examined accordingly.</p> <p>Recommendation includes: polysomnography, PT/INR, avoid alcohol, lose weight, and exercise. Return to the office in 4 weeks.</p> <p>Impression: Obstructive sleep apnea and long term use of anticoagulant.</p>				
S006	<p>A 56-year-old male established patient with a history of stroke in 2008 was seen at the Clinic 3 weeks ago due to complaints of malaise, fatigue, and easily bruising in the forearm, for which diagnostic testing was ordered. He now returns to the Clinic for results of the laboratory tests, which show a decreased platelet count and low B12 level. The indication for having a low platelet count and B12 was explained to this patient. The patient was advised to continue current medication and repeat CBC in 3 weeks. A referral to hematologist was given for further evaluation of thrombocytopenia. Patient to follow-up in 4 weeks.</p> <p>Impressions: Thrombocytopenia and history of stroke.</p>				
S007	<p>A 68-year-old female new patient came in the office with chief complaint of low back pain. She is 5'5" and weighs 250 pounds. She reports severe low back pain after sitting for long periods. She takes an over-the-counter pain medication with no relief at all. She is a non-smoker and in no acute distress. Physical examination was performed and laboratory testing was ordered.</p> <p>Recommendation includes: weight loss, exercise program, continue taking Ibuprofen for pain, and refer for physical therapy.</p> <p>Impressions: Lumbago and morbid obesity.</p>				

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S008	<p>A 78-year-old male established patient comes into the office for evaluation of an irregular heartbeat. He was previously diagnosed with peripheral vascular disease and is currently under treatment for same. He denies shortness of breath but he has been having palpitations, some lightheadedness, and pain in the lower extremities. Physical examination was performed; an electrocardiogram was ordered and performed at the office. The results of the ECG confirm irregularities and a pattern of waves indicative of atrial arrhythmia.</p> <p>The plan includes 24-hour holter monitoring, aspirin once a day, antiarrhythmic drugs, continue Cilostazol, and follow-up in 6 weeks.</p> <p>Impression: Atrial arrhythmia and peripheral vascular disease.</p>				
S009	<p>The patient is a 65-year-old female seen at this office for shortness of breath, cough, fever and chest pain when breathing deeply. Also, patient states she has not had a bowel movement for 4 days. Examination performed revealed diminished breath sounds, decreased movement of the chest, decreased vocal resonance and bronchial fremitus, and tenderness on palpation at the left lower quadrant of the abdomen.</p> <p>The plan includes chest x-ray, antibiotic, stool softener, increase fluid intake, high fiber diet, and follow-up in 2 weeks.</p> <p>Impression: Pleural effusion and constipation.</p>				
S010	<p>The patient is a 78-year-old female who came to the office for follow up on her osteoporosis risk evaluation. She had a bone density test done a month ago and the result indicates a T-score of less than minus 2.5. She is on calcium with vitamin D supplements and she has been walking 2 miles a day. She had menopause at the age of 50. She weighs 110 pounds and is 5'5" tall. She also complains of excessive thirst, inability to sweat, confusion, and decreased urine output.</p> <p>Recommendation includes: hormone replacement therapy, chemistry profile, urinalysis, CBC, increase fluid intake, and follow-up in 6 weeks.</p> <p>Impression: Osteoporosis and dehydration.</p>				

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S011	<p>This patient is an 85-year-old male seen in the clinic for his yearly check-up. He was previously diagnosed in 2008 with mitral valve regurgitation and is currently asymptomatic. On examination the patient was found to have an enlarged prostate. There were neither urinary tract symptoms presented nor complaints of inability to urinate.</p> <p>The tests ordered include: repeat echocardiogram since the last one was done 2 years ago, CBC, urinalysis, basic metabolic profile, and PSA to further assess the enlarged prostate. The patient was instructed to call the office immediately if he experiences any symptoms related to the urinary tract and/or symptoms related to the heart. Follow-up in 4 weeks.</p> <p>Impressions: Benign prostatic hypertrophy and mitral valve regurgitation.</p>				
S012	<p>The patient is a 67-year-old man with chronic obstructive lung disease (COPD.) He recently became a widower and lives alone. According to the patient's daughter, the patient is irritable, has no appetite, is unable to sleep at night, has difficulty making decisions, and exhibits a loss of interest in going out with friends. The patient's COPD is controlled and unchanged. However, he was found to be clinically depressed.</p> <p>Recommendation includes antidepressant medication, along with individual and group psychotherapy 3X per week. Nursing care is ordered to assess his compliance with newly prescribed antidepressants and to assess the patient's psychological status and coping skills.</p> <p>Impressions: Depression and COPD.</p>				
S013	<p>The patient is a 32-year-old otherwise healthy male who presents today with severe lower leg and ankle pain. He reported that he injured his ankle three days ago when he fell from his bicycle while riding on a path in a forest preserve. Musculoskeletal examination revealed tender, painful, and swollen lower leg. Diagnostic x-ray confirmed traumatic, closed fracture of the right, lateral and medial malleolus. Patient is being referred to an orthopedic physician for further evaluation and treatment.</p> <p>Impression: Closed fracture of the right ankle, bimalleolar.</p>				
S014	<p>A 56-year-old male patient comes into the office for a scheduled follow-up visit for hypertension. Patient has a family history of HTN. No current complaints or recent stressful events. Patient is currently taking Lisinopril 5 mg per day. Physical examination was performed. BP 134/84. Patient advised to increase Lisinopril dosage to 10 mg per day and follow up in 3 months.</p> <p>Impression: Benign Hypertension.</p>				

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S015	A 40-year-old female established patient comes into the office for a yearly physical. No current complaints or problems. No previous health complications. Physical examination is performed. Patient advised to continue yearly examinations including mammograms and pap smears. Also, patient is encouraged to continue a healthy diet and exercise regimen. Impression: Annual physical examination.				
S016	A 25-year-old female comes into the office for her yearly OB/GYN visit. Patient has concerns about birth control and would like to seek information from a health care professional. Vital signs, gynecological examination and labs were performed. Discussed birth control options and provided a 3 month trial supply of Trivora-28. Also, patient given a prescription for a 6 month supply of Trivora-28. Impression: Annual gynecological examination.				
S017	A 50-year-old male established patient returns today complaining of persistent neck pain, stiffness, fatigue and soreness at the back of his neck. He is unable to turn his head because of severe pain. He feels tightness at the back of his neck, sometimes extending into his upper back, especially after working on the computer. He states the pain subsides when he relaxes and takes Ibuprofen. Physical exam revealed the neck is tender to touch, making massaging very painful, muscle tightness around the neck and restricted cervical range of motion (i.e., flexion, extension, bilateral side bending and rotation). Advised patient to wear cervical collar to support head and allow the neck muscles to rest. Prescribed 800 mg Motrin to take as needed for pain. Additionally, alternate with hot/cold compresses. If patient continues to have these symptoms despite the treatments, a referral to a specialist will be initiated. Impression: Neck pain.				
S018	A 27-year-old male comes into to the office complaining of several days of fever, chills and headache. In addition he states lately he is always feeling tired, along with complaints of muscle aches, weakness and lack of energy. He states he feels like something is just not right with him. He informed physician that he has had a flu shot. Patient has no previous medical issues or complications. Vitals showed temperature of 101.5. Labs ordered. Patient is advised to take Tylenol for his fever and he is rescheduled for a follow up appointment to discuss lab results. If problems persist, additional treatment may be required. Impressions: Fever, fatigue/tiredness, headache, and muscle weakness.				

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S019	<p>A 3-year-old boy was brought into the office for a scheduled yearly wellness visit, but the mother also mentioned that he has been coughing and sneezing for the past few days after coming in from outside. He has a history of allergies due to pollen. Physical exam was performed. Patient's general growth was measured, evaluated and discussed along with development progress. Advised parent to administer an over-the-counter allergy medication as needed to treat symptoms and if problems persist or worsen return to office for further evaluation.</p> <p>Impressions: Annual child examination, cough, and allergic rhinitis due to pollen.</p>				
S020	<p>A 65-year-old female established patient comes into the office complaining of fainting spells and falling down associated with loss of consciousness and excessive sweating. She has a longstanding history of hypertension, transischemic attack (TIA), and coronary artery disease. The patient is concerned for a possible stroke as she previously had symptoms of eyes rolling back and altered sensorium. A detailed physical examination is performed.</p> <p>The plan includes: hemoglobin count, electrocardiogram, tilt table test, and possible holter monitor. Referring patient to a Cardiologist/Neurologist for further assessment if symptoms persist.</p> <p>Impression: Syncope.</p>				
S021	<p>A 90-year-old male was brought to the ER with complaints of having severe pain in the left lower extremity. According to his caregiver, the patient has been crying due to pain with inability to get out of bed. He has not had a fall or injury. Patient has a history of hypertension, chronic atrial fibrillation, and Alzheimer disease; he also has glaucoma, coronary artery disease, and congestive heart failure.</p> <p>Examination performed; labs and imaging done; findings: Sodium 132 (low), hemoglobin 9.2 (low); Lumbar spine shows grade 1 spondylolisthesis of L5-S1. There is severe diskogenic disease at L4-5 and more severe at L5-S1.</p> <p>Impressions: Lumbosacral intervertebral disc degeneration, sodium deficiency, and anemia.</p>				
S022	<p>A 46-year-old male came into the office for a yearly wellness exam. He is a long term smoker and has a long history of alcohol use. He states he works out 1-2 times per week and that he has not had any health related issues since his last visit. Examination and labs performed. Lab findings revealed elevated levels of lipoprotein, a complex of fats and proteins, in blood due to inherited metabolic disorder.</p> <p>Ordered: Simvastatin (Zocor); Discussed healthy lifestyle changes including diet and exercise regimens.</p> <p>Impressions: Mixed hyperlipidemia and history of tobacco use.</p>				

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S023	<p>A 45-year-old female comes in the office for an unscheduled visit. Patient presents with the following symptoms: burning pain in the chest (under the breastbone), especially while lying down or eating, feeling full all the time, acid taste in the mouth, belching and feeling nauseated constantly. The symptoms have been on-going for two weeks and sometimes are relieved by antacids (Tums). Physical examination performed and labs done. Patient has positive signs of esophageal reflux. Patient advised to avoid foods that may cause or exacerbate her symptoms such as fatty/greasy foods, chocolate, caffeine and spicy foods. Patient also encouraged to eat smaller meals throughout the day, do not eat within 3 hours of bedtime or lie down right after eating; avoid drugs such as Ibuprofen or Naproxen. Prescribed Nexium 40 mg once a day.</p> <p>Impression: Gastroesophageal reflux.</p>				
S024	<p>A 35-year-old female new patient comes into the office with chief complaints of fatigue, weakness, feeling cold, and having gained 10 lbs. within the past 2 months. No past medical conditions reported. Physical examination revealed enlarged thyroid gland, brittle nails, coarse features of the face, dry skin which is cold to touch, and thinning of hair. Complete blood count, TSH, and T4 tests ordered and performed. Laboratory result showed an elevated TSH.</p> <p>Impression: Hypothyroidism, unspecified.</p>				
S025	<p>A 45-year-old male comes in with a chief complaint of pain in the right shoulder. Patient denies a fall or injury. No significant health reported. Musculoskeletal examination performed which reveals tenderness and limited range of motion in the right shoulder region.</p> <p>Plan includes x-ray of the right shoulder, NSAID, and follow-up in 2 weeks.</p> <p>Impression: Pain in shoulder joint region.</p>				
S026	<p>A 65-year-old male comes in the office today for a 6 months follow-up. He was diagnosed with coronary artery disease (CAD) and had a percutaneous transluminal coronary angioplasty (PTCA) a year ago. Patient also has restrictive cardiomyopathy w/o symptoms. Physical examination shows the patient is in no acute distress. Advised the patient to increase physical activity, lose weight, and lower stress levels and follow-up in 6 months.</p> <p>Impressions: Restrictive cardiomyopathy and s/p PTCA.</p>				

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S027	<p>A 63-year-old female came into the clinic complaining of chest pain for the past couple of days along with shortness of breath when she is up and moving around. She has a history of high blood pressure and is obese. She denies smoking. Physical examination performed and revealed a BMI of 38 and elevated BP. Labs and EKG done. Discussed diet and exercise regimen and prescribed Amlodipine (Norvasc) 5mg once daily. Follow up in 3 months.</p> <p>Impressions: Chest pain, shortness of breath, hypertension, and obesity.</p>				
S028	<p>A 62-year-old female comes into the office with complaints of abdominal pain for the past week with loose stools for the past few days. Medical history positive for congestive heart failure (CHF). Physical examination revealed lower extremities edema. Advised patient to increase Carvedilol (Coreg) from 3.125 mg twice daily to 12.5 mg twice daily; may take over-the-counter Imodium A-D to alleviate diarrhea symptoms along with drinking small amounts of fluids frequently to prevent dehydration. Return to office if symptoms persist for further testing and evaluation.</p> <p>Impressions: Abdominal pain, diarrhea, congestive heart failure, and lower extremities edema.</p>				
S029	<p>A 42-year-old female patient is seen at the office for symptoms of feeling weak, tired and some shortness of breath. She has been running a fever since last week. She has been taking Tylenol for her fever. She also has asthma which is treated with Advair Diskus. Patient's vital signs are stable without fever at this time. Physical examination revealed some wheezing. Stat CBC ordered and the result shows an elevated WBC, which is indicative of an infection.</p> <p>Plan of treatment includes continue the asthma medication, increase fluid intake, repeat CBC in 2 weeks if symptoms persist. Otherwise follow-up in 3 months.</p> <p>Impressions: Asthma and leukocytosis.</p>				
S030	<p>The patient is a 75-year-old female who comes into the office for pacemaker follow-up. She had a pacemaker single chamber inserted a month ago. She also presents with mild shortness of breath and palpitations. She has a history of rheumatic fever when she was 10 years old. She has family history of heart disease.</p> <p>Physical examination was performed and findings revealed: a rapid pulse and swollen ankles. Labs, echocardiogram, and chest x-ray were ordered to further evaluate the symptoms. Patient instructed to follow up in 8 weeks unless diagnostic tests indicate the need for return sooner.</p> <p>Impressions: Aortic valve regurgitation and s/p Pacemaker.</p>				

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S031	<p>This patient is an 85-year-old female who was seen at the office 2 1/2 weeks ago due to high fever, chills, rapid breathing, rapid heart rate, confusion, and low blood pressure. She was immediately transported via ambulance to the hospital emergency department and was found to have septicemia. She was admitted and treated with intravenous antibiotic therapy. She returns to the office today for follow-up after being discharged from the hospital. She stated she was doing fine except for abdominal cramps, bloating and discomfort in lower left abdomen that started 2 days ago. Examination revealed abdominal tenderness and slight fever. Barium x-rays were ordered and performed immediately. A result of the barium x-ray shows this patient has diverticulosis.</p> <p>Recommendation includes: increase fiber intake daily, Donnatal for abdominal cramping, and follow-up in 4 weeks.</p> <p>Impressions: Diverticulosis and septicemia.</p>				
S032	<p>A 53-year-old male patient with a history of chronic obstructive pulmonary disease and pneumonia is seen at the clinic for further evaluation of sudden sharp pain on the chest and shortness of breath. He started smoking at the age of 15 and continues to smoke one pack of cigarettes a day. He has been advised to stop smoking due to his COPD, but continues to smoke. A stat chest x-ray was ordered and performed. The chest x-ray result showed a collapsed right lung.</p> <p>Plan of treatment includes: oxygen therapy, bronchodilators to expand airways, such as albuterol (ProAir, Proventil, Ventolin) and levalbuterol (Xopenex), and chest physical therapy to help clear mucus. This patient was also referred to Urologist 3 weeks ago for further assessment and management of ureteral fistula.</p> <p>Impressions: Pulmonary collapse and ureteral fistula.</p>				
S034	<p>A 45-year-old female comes to the clinic with complaints of shortness of breath, atypical chest discomfort, dyspnea, palpitations, fatigue and dysphagia for three days. She has a history of rheumatic fever and mitral valve prolapse. Examination performed revealed a rapid heart rate, a diminished first heart sound, gallops, a pericardial friction rub and swollen legs. A stat electrocardiogram and chest x-ray performed at the clinic revealed diffused T wave inversions and saddle shaped ST-segment elevation. In addition, the chest x-ray result shows widened mediastinum and air-fluid level in mediastinum.</p> <p>Recommendation: refer to Cardiologist for further assessment/evaluation and management; advised complete bed rest, and prescribed a diuretic and digoxin.</p> <p>Impressions: Acute myocarditis and abscess of mediastinum.</p>				

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S035	<p>A 32-year-old female patient involved in a motor vehicular accident was transported to the hospital Emergency Department via ambulance. Vital signs were monitored and IV line was started. Due to the accident, she sustained multiple lacerations and injuries to the face and head. She complained of pain in the head and jaw and subsequently lost consciousness. The CT scan of the head confirmed a cerebellar and brain stem laceration. The CT scan of the face revealed a fracture of alveolar border of body of the mandible. Patient was admitted for observation for 72 hours.</p> <p>Impressions: Cerebellar and brain stem laceration and open fracture of the mandible.</p>				
S036	<p>A 25-year-old male construction worker fell to the ground from the 3rd story of a building. Rescue staff found the patient lying on the ground unconscious. The patient was stabilized and immediately transported to the hospital Emergency Department via ambulance. Vital signs were monitored and IV line was started. Upon arrival to ER, multiple laboratory tests and multiple x-rays such as chest, head, cervical/thoracic/lumbar spine x-rays were ordered and performed immediately. The patient remained unconscious while in the emergency room. Neurological assessment was performed and findings show the patient remained unresponsive and unconscious. Blood pressure remained low with a decreased pulse rate. X-rays and CT scan of the head results shows closed fracture at the base of the skull with hemorrhage in the subarachnoid, subdural, and extradural sites. CT scan of the abdomen reveals injuries to portal and splenic veins. Patient was referred for emergency surgery and remained unconscious for 36 hours post-operatively before regaining consciousness.</p> <p>Impressions: Closed fracture at the base of the skull with hemorrhage in the subarachnoid, subdural, and extradural sites and injury to portal and splenic veins.</p>				

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S037	<p>A 50-year-old male was transported via ambulance to the hospital Emergency Department due to severe smoke inhalation from a fire at the restaurant where he works. During transport to the hospital he complained of being nauseous with pain in the epigastric region. At the ER, he was examined and laboratory tests, x-ray of the abdomen, and chest x-ray were performed. He was referred to a gastroenterologist, who recommended an endoscopy to further evaluate the symptoms. Endoscopy was performed. A day later, he was running a high fever, vomiting with rapid onset of breathlessness, and wheezing. CBC, blood culture, and chest x-ray were performed. The results confirm the patient developed a respiratory complication known as aspiration pneumonitis. He was placed on IV antibiotic therapy and bronchial suction.</p> <p>Impressions: Respiratory complications from smoke inhalation from extensive fire in a restaurant building.</p>				
S038	<p>A 36-year-old female comes into the office complaining of bone pain and muscle weakness along with bouts of dizziness and giddiness. She doesn't have a history of any chronic problems. She denies any recent injuries. Physical examination performed and revealed tenderness/pain in the bones. Labs done - serum vitamin D level below 20 mg/mL</p> <p>Treatment: prescribed vitamin D supplements and follow up in 2 weeks to assess progress.</p> <p>Impressions: Vitamin D deficiency and dizziness.</p>				
S039	<p>A 32-year-old female comes into the imaging center for her annual mammogram. She was referred by her attending physician due to the concern that she has a family history of breast cancer that includes her mother and maternal aunts. Performed mammogram.</p> <p>Findings- No masses noted and advised patient to continue yearly checkups and self-monthly exams.</p> <p>Impression: Annual mammogram.</p>				
S040	<p>A 25-year-old male transported via ambulance to the hospital emergency department due to blunt trauma of the abdomen he sustained while playing football. He complains of severe pain on the left side of his abdomen under the rib cage. Examination revealed a laceration into the abdominal cavity. Results of CT scan performed do confirm active bleeding from the spleen requiring an emergency splenectomy. While waiting to be transported to operating room, the patient became very confused and restless with a rapid heart rate, and low blood pressure. He attempted to get off the stretcher and started pulling at the IV tubes. The medical staff had to restrain him physically to prevent the patient from harming himself.</p> <p>Impressions: Injury to spleen and physical restraint.</p>				

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S041	<p>A 35-year-old male established patient comes to the office today complaining of poor concentration, speech problems and difficulty remembering. He has a history of viral encephalitis at the age of 10, and in October of 2009 was diagnosed with an intra-abdominal hernia. The patient also indicated that lately his abdomen is distended, feels nauseous, and the pain is worsening. A neurological assessment revealed the patient's symptoms results from late effect of viral encephalitis. A CT scan of the abdomen revealed the presence of obstruction and gangrene at the hernia site. The patient was immediately transported to the OR for surgery.</p> <p>Impressions: Viral encephalitis, late effect and hernia with gangrene.</p>				
S042	<p>The patient is a 25-year-old male involved in an altercation wherein he sustained multiple gunshot wounds. He was transported by ambulance to the hospital emergency department. His assessment in the emergency room determined he was hemodynamically unstable due to open wound into the peritoneum and other gastrointestinal sites. He is transported to the operating room for stat surgery.</p> <p>Impressions: Peritoneal injury with open wound and gastrointestinal injury with open wound into cavity.</p>				
S043	<p>An 18-year-old female new patient comes to the office today complaining of severe headache and neck stiffness associated with high fever, confusion, and vomiting. She has had these symptoms for 3 days and she has been unable to sleep and eat. A Stat CBC, C-reactive protein and lumbar puncture were performed and indicated the patient has meningitis. She was admitted to the hospital for management of her meningitis, which included receiving IV antibiotic therapy for 10 days. After 2 days of hospitalization, the patient was complaining of inability to see well out of her left eye. An ophthalmological exam found limited visual acuity and impaired vision in her left eye possibly due to complications from meningitis.</p> <p>Impressions: Meningitis, bacterial gram-negative and near-total impaired vision on left eye.</p>				

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S044	<p>A 28-year-old male is seen at the Hospital Emergency Department with complaints of high fever with chills, nausea and vomiting, pain in the right upper abdomen, loss of appetite, weakness, and yellow skin. Two months ago he was diagnosed with pulmonary coccidioidomycosis and is still taking an oral anti-fungal medication, Diflucan 150 mg., 1 tablet daily. He is on his last dose. CBC, liver function test, blood culture, and abdominal ultrasound were performed immediately and the results show a low hemoglobin count suggesting anemia; a leukocytes count more than 10,000/mm suggesting infection; an elevated erythrocyte sedimentation rate (ESR), elevated liver enzymes and bilirubin. The abdominal ultrasound discloses a round oval hypoechoic mass consistent with a pyogenic abscess. Based on comprehensive assessment and tests results, the patient is diagnosed with portal pyemia.</p> <p>Treatment includes admission to the hospital with initiation of intravenous antibiotic therapy as well as diagnostic aspiration and drainage of the pyogenic abscess. Patient is also referred to a pulmonologist for follow-up of coccidioidomycosis, and an internal medicine doctor for the management of the portal pyemia.</p> <p>Impressions: Portal pyemia and primary pulmonary coccidioidomycosis.</p>				
S045	<p>A 13-year-old male was transported via ambulance to the hospital emergency department for severe injuries he sustained escaping from the second story of his burning home. He was unconscious when the paramedics arrived but was found to have multiple burns to his body and multiple injuries to his head as a result of jumping from the 2nd floor window and landing head first on the concrete driveway. An IV line was established and vital signs were taken. Upon arrival at the ER, an x-ray of the head/skull and a CT scan of the head confirm a fracture at the vault of the skull with cerebral laceration and contusion. The patient underwent emergency surgery and was admitted to ICU where he remained unconscious for more than a week and subsequently expired as a result of his head injuries.</p> <p>Impressions: Closed fracture of vault of skull with cerebral laceration and contusion, loss of consciousness greater than 24 hours, without return to pre-existing conscious level, and burning caused by conflagration in private dwelling.</p>				

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S046	<p>A 72-year-old female patient is transported to the hospital via ambulance due to an injury she sustained from an object falling directly on her head while at a department store. She was unconscious upon arrival at the ER. Multiple blood work, a chest x-ray and a CT scan of the head were performed immediately. Patient also has a history of quadruple coronary artery bypass surgery 5 months ago. The CT scan results revealed a subarachnoid, subdural and extradural hemorrhage and a fracture at the vault of the skull. She was immediately referred to a neurosurgeon and emergency surgery was performed to control the bleeding. The patient remained unconscious for 4 days. On the 5th day of her hospitalization she regained consciousness and normal neurological levels.</p> <p>Impressions: Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhages and post-procedural aortocoronary bypass status.</p>				
S048	<p>The patient is a 55-year-old male who was transported via Life Flight to the Trauma Center due to multiple injuries sustained in a head-on motor vehicle collision. The patient was unconscious and vital signs were dropping slowly. Initial examination showed he had sustained head and abdominal injuries. At the hospital, a CT scan of the head revealed a closed fracture at the base of the skull with subdural, subarachnoid and extradural hemorrhages. The CT of the abdomen disclosed injury to both the celiac and mesenteric arteries. The patient underwent emergency surgery to control the bleeding from the hemorrhage sites and to repair the celiac and mesenteric arteries. The patient remained unconscious after surgery and was admitted to the intensive care unit (ICU) for close monitoring. While in the ICU his blood pressure dropped significantly with a very weak pulse and rapid breathing, indicating he had developed postoperative cardiogenic shock. He did not survive that complication and expired later that day.</p> <p>Impressions: Closed fracture at the base of the skull with subdural, subarachnoid and extradural hemorrhages, postoperative cardiogenic shock, and abdominal injury to the celiac and mesenteric artery.</p>				

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S049	<p>A 23-year-old male motorcycle passenger was thrown 100 feet from the site of an accident and sustained multiple injuries to the head and other parts of the body. He was unconscious when the paramedics arrived. Initial assessment by the Paramedics revealed both pupils failed to respond to light and oculovestibular responses were absent. Vital signs were taken and monitored. He was transported by helicopter to a Trauma Center where a CT and MRI of the head/brain revealed fracture of base of skull and presence of bleeding and edema within the brain tissue. During the extensive examination he was also found to have injured his pelvic organ resulting from impact when he was thrown from the motorcycle. He had a seizure while on the examination table due to increased intracranial pressure. He underwent emergency surgery and he remained unconscious upon admission to the intensive care unit (ICU). While at the ICU, he was observed having rapid breathing, decreasing blood pressure, and cold skin, which is indicative of hypovolemic shock.</p> <p>Impressions: Closed fracture of base of skull with laceration and contusion; injury to the external pelvic organ with open laceration into lower pelvis; postoperative shock.</p>				
S050	<p>A 56-year-old female new patient was referred to our office for assessment and management of a newly diagnosed stage II Mantle Cell Lymphoma affecting the intra-thoracic lymph nodes. The diagnosis was confirmed through a series of diagnostic testing. She is evaluated today and the treatment options available were explained to her. The oncologist recommends systemic chemotherapy which involves receiving 6 cycles of treatment at the Outpatient Chemotherapy Center. Chemotherapy was started today after peripheral catheter line was established followed by infusion of Doxorubicin. At the initiation of the treatment, the patient immediately began complaining of stinging/burning and pain on the infusion site. The nurse noted the chemotherapy had infused outside of the vein (extravasate) into the skin. Treatment was stopped immediately and the IV catheter was removed. An ice pack was applied to the infusion site. Although the patient experienced pain at the site and some mild redness and blistering, there did not appear to be any tissue necrosis.</p> <p>Impressions: Mantle cell lymphoma of the intrathoracic lymph nodes, and extravasation of medication during intravenous therapy.</p>				

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S052	<p>The patient is a 36-year-old male involved in a 6 car motor vehicle accident. The paramedics found him to be diaphoretic with low blood pressure and bleeding from an open wound in the abdomen. Intravenous fluid was started and the patient was transported via ambulance to the Hospital. While in the ED, the patient's abdominal pain steadily worsened. The lab results did not reveal any abnormalities. However, the CT scan of the abdomen did reveal a hollow viscus laceration of the small intestine. Recommendation was surgery to repair the laceration. While in the recovery room, the patient began to experience low blood pressure, low heart rate, confusion, nausea and vomiting. The anesthesiologist was called in and emergency measures were carried out. Once the patient's condition was stable, he was transferred to medical-surgical floor.</p> <p>Impressions: injury to small intestine and reaction to anesthesia.</p>				
S054	<p>A 75-year-old male diabetic patient comes to the Emergency Department complaining of severe abdominal pain, vomiting blood (coffee-grounds appearance), loose dark stool, weight loss, and fever. Physical examination revealed presence of fever with mild tenderness in the epigastric region of his abdomen. Laboratory tests showed WBC of 17000 mm, hemoglobin, 7.5 gr/dl, platelets, 260000, and elevated amylase level of 826 u/L. Radiological examination of the abdomen showed a distended stomach. The patient was admitted and a Gastroenterologist was called in for consultation. An endoscopy was performed and the results revealed extensive sub-mucosal hemorrhage, severe congestion with a snake appearance, and a 10x15 cm ulcerated lesion involving the proximal part of the greater curvature of the stomach. Biopsy was performed and the specimen demonstrated only necrotic material and acute inflammatory cells that contained numerous fungal elements.</p> <p>Recommended treatment includes a total gastrectomy with Roux-en-Y esophagojejunostomy and surgical debridement of necrotic tissue.</p> <p>Impressions: Mucormycosis and chronic gastric ulcer with perforation and obstruction.</p>				

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S055	<p>A 45-year-old male patient transported via life flight to Trauma Center due to a head injury sustained in a multi-vehicle accident. The paramedics described the patient as being conscious when examined initially, but lost consciousness while being transported to the Trauma Center. Physical examination at the emergency room revealed enlarged right eye, arm weakness on one side, and an altered level of alertness. He again lost consciousness in the ER and his vital signs dropped slowly. A CT scan of the head revealed an extradural hemorrhage and increased intracranial pressure. The Neurosurgeon performed an emergency craniectomy to reduce pressure within the brain and to allow drainage of the blood from the brain. The surgery went well but the patient remained unconscious. While in the recovery room the nurse observed neurologic deficits upon examination of the patient. The anesthesiologist on-call assessed the patient and findings revealed he had suffered a postoperative stroke. He was admitted to the intensive care unit for close monitoring and management of his conditions.</p> <p>Impressions: Extradural hemorrhages due to injury and postoperative stroke.</p>				
S057	<p>The patient is a 55-year-old female established patient came to the office for 6 months gastrointestinal follow-up. She also presented with chief complaints of abdominal pain, unexplained weight loss, exhaustion, feeling bloated and diarrhea with associated vomiting for almost a week. She has a history of gastroesophageal reflux and chronic duodenal ulcer. On examination the stomach was tender with pain. Vital signs were taken. Blood chemistry, tumor marker test, 24-hr urine test, CT scan, and MRI of the abdomen were performed and the results are indicative of a carcinoid tumor. Upper endoscopy and biopsy were performed and reveals a benign carcinoid tumor of the jejunum and duodenal ulcer with obstruction.. Surgery was the recommended treatment.</p> <p>Impressions: Benign carcinoid tumor of jejunum and duodenal ulcer with obstruction.</p>				
S060	<p>The patient is a 35-year-old male transported via Life Flight to a Trauma Center due to multiple injuries he sustained in a motor vehicular accident. He remained unconscious throughout transport; it was noted his vital signs were slowly declining. Assessment at the hospital revealed a head injury and bleeding from the neck. CT scan of the head confirmed a closed skull fracture and the CT scan of the neck showed massive bleeding from the injured blood vessel in the neck. The patient remained unconscious throughout all procedures. A Neurosurgeon was called in for emergency surgery, but the patient expired before getting to the operating room.</p> <p>Impressions: Injury to blood vessels of head and neck, and closed skull fracture.</p>				

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S063	<p>The patient is a 68-year-old male who comes to the clinic feeling weak, lethargic, dizzy and short of breath. The patient has been suffering with hypertension for 10 years, and 6 months ago was diagnosed with chronic kidney disease. Physician performed physical exam and ordered necessary laboratory and diagnostic tests.</p> <p>The lab results showed that eGFR rate is 50 and hemoglobin level is 9 g/dl. Patient is already on Lisinopril and Lasix for blood pressure control.</p> <p>Impressions: Anemia in chronic disease and hypertensive kidney disease.</p>				
S064	<p>The patient is a 32-year-old female who comes to the clinic complaining of pain in the pelvic region and lower leg for more than 2 months. Patient states the pain level is 8 on a scale of 1 to 10. The pain increases with activity and she gets some relief with rest. She denies any trauma or accident. Physical examination was performed and findings revealed limited ROM in left hip and knee with weak muscle strength in left leg.</p> <p>The plan includes x-rays of the left hip and leg, application of heat and cold pads, physical therapy, and Ibuprofen as needed for pain. To follow up in 2 weeks for reassessment.</p> <p>Impressions: Pain in pelvic region and thigh, and knee joint pain.</p>				
S065	<p>A 35-year-old female patient comes into the clinic with chief complaint of severe low back pain for 2 months. Patient reports that pain is aggravated by sitting, walking, or bending and relieved by lying down. Coughing or sneezing also make the pain worse. Also, she is complaining of pain and tenderness in her ankle joint and foot. She denies any injury or trauma to the lower back or lower leg. Physical examination was performed and findings revealed flattening of the normal curvature of the lumbar area of the back and slight hip and knee flexion. MRI of lower back showed a displacement of intervertebral disc is present.</p> <p>The plan includes: complete x-ray of the foot, and conservative treatment such as rest, heat and cold application, physical therapy, over-the-counter pain medicine, and corset to provide support to the lower back. Advised the patient to follow up in 4 weeks.</p> <p>Impressions: Displacement of lumbar intervertebral disk without myelopathy; and ankle and foot pain.</p>				

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S066	<p>The patient is a 75-year-old male who comes to the clinic for difficulty falling asleep initially, waking up often during the night, and then having trouble going back to sleep. Patient also developed a wart-like growth on his skin and biopsy results confirmed seborrheic keratosis. Physician recommended no treatment for keratosis right now, but he prescribed Ambien 5 mg at night time for sleep. Physician also suggested regular good sleep habits, such as avoid caffeine late in the day, and get regular exercise. Follow up in 2 weeks for evaluation of insomnia.</p> <p>Impressions: Insomnia and seborrheic keratosis.</p>				
S067	<p>The patient is a 65-year-old male who comes to the outpatient surgery center for a screening colonoscopy. Patient is on NPO status from previous night for the procedure. History indicates he has been using Percocet for low back pain for more than a year. Patient does advise he has a family history of colon cancer. VSS without any acute distress. Health care provider performed colonoscopy and the patient was discharged home with instructions and a scheduled follow up visit in one week.</p> <p>Impressions: Screening colonoscopy, and long term use of Percocet.</p>				
S068	<p>The patient is a 40-year-old healthy female who comes in today for annual physical exam. Patient history, medications and vital signs documented in the chart. Physician performed breast screening and pelvic exam. Patient advises she has been using aspirin to prevent stroke and heart attack. Physician ordered CBC, chemistry panel and urinalysis. Patient was given influenza vaccine in this visit. Follow up visit scheduled for review of lab results.</p> <p>Impressions: Prophylactic vaccination and inoculation, influenza and long term use of aspirin.</p>				
S070	<p>The patient is a 55-year-old male who comes to the ER for chest pain and SOB. Vital signs showed elevated BP and irregular heart rate. An EKG was taken and result was abnormal. Diagnostic radiology and laboratory tests were performed. Patient was admitted for a cardiac catheterization, which showed 85% blockage in two coronary arteries. Patient was scheduled for an angioplasty with placement of stent.</p> <p>Impressions: Abnormal EKG, and coronary artery disease.</p>				

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S071	<p>A 75-year-old male comes to the ER for severe shortness of breath. His respiration showed 4 per minute with 60% oxygen saturation. He had coronary artery bypass two years ago and has been followed every 6 months by his cardiologist. He has a long-term history of COPD and recently treated with antibiotics for pneumonia. Oxygen was administered and IV fluids were started. Stat arterial blood gas, pulmonary function test, and a chest x-ray were ordered. In addition, a CT scan was ordered to check for possible pulmonary embolism and aortic dissection. The results of the tests did confirm acute respiratory failure. He was admitted to Intensive Care Unit and placed on mechanical ventilation.</p> <p>Impressions: Acute respiratory failure; and atherosclerosis of coronary arteries.</p>				
S072	<p>A 41-year-old male comes into the office complaining of pain from the base of the neck down to his mid back area. He states he has had the pain for the past several days. He advises that he had a minor car accident several weeks ago that didn't require emergency medical services. He indicates that he smokes once or twice a week. No other history noted. Physical examination revealed pain and tenderness between the T11-T12 of the spine. Naproxen 550 mg was prescribed. Patient advised to follow up in 2 weeks if symptoms have improved for further testing.</p> <p>Impressions: Pain in thoracic spine and tobacco dependence.</p>				
S073	<p>A 28-year-old female patient comes into office with complaints of throbbing and aching pain in left leg due to a slip and fall while showering about 1 week ago. Patient also states that prior to the fall she had been having muscle spasms in her lower back and can not recall any accidents or injuries. She has no previous history. Physical examination revealed tender spots and swelling in left leg. Laboratory tests and x-rays of the pelvis and left leg were performed.</p> <p>The recommended treatment includes: prescription of pain medication and muscle relaxant and application of ice/heat pack on the back. Follow up in 4 weeks if pain persists for further evaluation.</p> <p>Impressions: Pain in limb, and muscle spasm.</p>				

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S074	<p>A 74-year-old male comes into the office for a routine follow-up exam. He has a history of benign prostatic hyperplasia. He now complains of difficulty with emptying his bladder, delayed start with a slow stream of urine that contains blood. Patient also complains of deep pain in the lower back, pelvis and upper thigh bones, weight loss, loss of appetite, lower extremities swelling, and weakness in legs with difficulty walking. A digital rectal examination revealed an enlarged prostate. Laboratory result showed an elevated PSA, which is indicative of malignant neoplasm of the prostate. The Gleason grade/score showed 7. CT scan and a bone scan revealed no evidence of metastasis.</p> <p>The recommendation is to remove the prostate with subsequent therapy to be decided post operatively.</p> <p>Impressions: Malignant neoplasm of prostate.</p>				
S075	<p>A 19-year-old female comes into the office complaining of a sore throat, painful swallowing and a fever. She was diagnosed six months ago with an iron deficiency anemia and is currently taking iron supplements. Physical exam revealed swollen lymph nodes and pharyngeal erythema. Review of the laboratory tests done a month ago showed decreased level of ferritin, hemoglobin, and MCV, increased level of total iron binding capacity, ferritin, and RDW. Prescribed oral antibiotics for 7 days and patient was also advised to continue taking the iron supplements.</p> <p>Impressions: Acute pharyngitis and iron deficiency anemia.</p>				
S076	<p>A 63-year-old male patient with type II diabetes mellitus is seen at the Emergency Department for lower back pain, fluid retention, fatigue, and only urinating once in the past 48 hours. Examination revealed swelling in the legs and feet. CT, ultrasound and lab/path along with additional testing was ordered. The results showed elevated BUN, creatinine clearance, serum creatinine, serum potassium and decreased urine specific gravity. These results indicate the patient's kidneys are not functioning properly. The patient was admitted and a nephrologist was called in for further evaluation and management.</p> <p>Impressions: Acute kidney failure and type II diabetes mellitus.</p>				

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S077	<p>A 36-year-old female patient comes to the office to discuss the results of her breast biopsy. Patient states she has a long-term use of oral contraceptives and a family history of breast cancer. The result of the biopsy indicates breast cancer, stage 3. Two treatment options were discussed, and they are: 1) lumpectomy followed by radiation therapy; and 2) mastectomy, with or without breast reconstruction, followed by radiation therapy and chemotherapy to destroy the potential for cancer cells to remain as well as prevent the breast cancer from recurring. The patient elected to undergo a mastectomy with breast reconstruction. Surgery was scheduled and she was referred to a plastic surgeon for the post-mastectomy reconstruction.</p> <p>Impression: Malignant neoplasm of the breast.</p>				
S078	<p>A 52-year-old female comes into the office to receive results of her colon biopsy. She has a family history of colon cancer. She has been receiving a yearly colonoscopy for the past 8 years. Her last one revealed colorectal polyps, from which a biopsy was performed. The biopsy showed that the tumors were benign. The patient was encouraged to continue a diet high in fiber and follow-up as scheduled.</p> <p>Impression: Benign neoplasm of the colon.</p>				
S079	<p>A 26-year-old male comes into the office for a follow up visit for hypogonadism. Patient has been treated with testosterone replacement therapy in the past. Physical exam and labs were done and findings were normal.</p> <p>Impression: Testicular hypogonadism.</p>				
S080	<p>A 31-year-old established male patient comes into the office for a checkup. He was previously diagnosed with a genetic disorder of familial hypercholesterolemia. A physical exam and labs are done. Patient was advised to continue on Zocor and follow up as scheduled.</p> <p>Impression: Hypercholesterolemia.</p>				
S081	<p>A 73-year-old male comes into the office for a scheduled visit to check his lipid and blood sugar levels. He has a history of high cholesterol and diabetes as well as being overweight and a past smoker. He states that he hasn't been consistent with taking his prescribed medication to treat his high cholesterol and diabetes. Physical exam and labs done. Labs revealed LDL 165 mg/dL (high) HDL 28 mg/dL and glucose level 282.</p> <p>Impressions: Hyperlipidemia and uncontrolled diabetes mellitus type II.</p>				

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S082	<p>A 57-year-old female comes into the facility for a scheduled appointment. She is currently being treated for hypokalemia. She now is complaining of heart palpitations. Patient does not provide any additional medical problems. Physical exam and labs are done. Vital signs show a resting heart rate of 99. Labs reveal potassium levels of 2.8 mEq/L (3.7-5.2). She is encouraged to continue on daily potassium supplements and maintain follow-up visits as scheduled.</p> <p>Impressions: Potassium deficiency and palpitations.</p>				
S083	<p>A 23-year-old female is rushed to the ED by her partner due to sudden symptoms of shock. She states that she had an elective abortion less than 48 hours ago and noticed that her vaginal bleeding has increased tremendously in the last 24 hours. She said she is using 1 large sanitary napkin per hour. Vital signs were taken. Physical exam performed. Diagnostic labs revealed abnormally low hemoglobin levels associated with blood loss. Intravenous fluids were started to stabilize vitals.</p> <p>Impression: Acute post-hemorrhagic anemia.</p>				
S084	<p>A 38-year-old male comes into the office complaining of severe headache, fever and pain around cheeks and nose for several weeks. Physical exam revealed tenderness over sinuses. Prescribed a nasal corticosteroid, Flonase, and recommended Tylenol for pain and discomfort. Also, patient is encouraged to get plenty of rest and drink plenty of fluids. Return if symptoms don't improve.</p> <p>Impression: Acute sinusitis.</p>				
S085	<p>A 34-year-old female comes into the office with complaints of runny nose, sore throat and cough. She states she has been taking over-the-counter medication to treat the symptoms. Patient has no past history of complications or chronic conditions. Physical exam is done and revealed enlarged lymph nodes and facial tenderness. Patient is instructed to continue treating symptoms with OTC medications as needed, rest and drink plenty of fluids to remain hydrated. Return to office if symptoms worsen or if a changes in the color of the mucus discharge appears.</p> <p>Impression: Acute upper respiratory infection.</p>				
S086	<p>A 10-year-old male patient was brought into the office by his mother with complaints of a dry hacking cough. He was seen and treated 3 weeks ago for an upper respiratory infection that the mother said had cleared up. She has since noticed that he has recently begun to have frequent coughing episodes. Physical exam is done. Patient is encouraged to drink plenty of fluids, and use an over-the-counter cough medicine with an expectorant to loosen up the mucus when coughing. Patient's Mother should call for an appointment if symptoms have not improved in 10 days.</p> <p>Impression: Acute bronchitis.</p>				

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S087	A 32-year-old female comes into the office with complaints of itchy nose, mouth and throat along with constant coughing and sneezing. She says she has a history of allergic rhinitis due to dust. Physical exam was performed and allergen avoidance was discussed with the patient along with symptom management. Advised OTC antihistamines and prescribed Nasonex nasal spray. Impressions: Allergic rhinitis due to allergen.				
S088	A 24-year-old male comes into the office complaining of nasal congestion, headache, sore throat and swollen eyes. He states that he has a history of allergic rhinitis but no other history or chronic problems. Physical exam is performed. Advised patient on tactics to avoid possible allergen triggers. Plan is to continue OTC antihistamines and decongestants as needed. Schedule a follow-up visit if symptoms continue to persist. Impression: Allergic rhinitis, cause unspecified.				
S089	A 76-year-old male comes into the office for a routine visit. He has a history of ESRD and hypertension. He is currently undergoing dialysis treatment 3 times per week. Physical exam and routine lab testing is performed. Discussed with patient his current status on the kidney transplant wait list, along with transplant advantages and risks. Follow up as scheduled unless other symptoms arise. Impressions: End stage renal disease, and hypertensive chronic kidney disease.				
S090	A 26-year-old female comes into the office with complaints of painful, foul smelling and frequent urination. She reveals no history of complications or illness. A physical exam is performed along with lab testing to check for infection. Urinalysis revealed a urinary tract infection. Antibiotics are prescribed and patient is encouraged to drink plenty of water and urinate often, especially before and after sex to prevent UTI from reoccurring. Impression: Urinary tract infection.				
S091	A 69-year-old male comes into the office complaining of noticeable skin changes that won't go away. He states that the color of a spot in his skin that started as pink has now turned brown, is elevated and scaly. It becomes itchy and has changed size and shape. According to the patient, he had many severe sunburns early in life while working outside most of his career. Physical examination showed hard wart-like growths on his arms, a rough, dry patch of skin about 2.5 centimeters in diameter on the face, ears, and scalp. Skin biopsy was ordered to determine if the lesions were cancerous. Treatment options were discussed. Lesions on the arms, face, ears, and scalp were frozen. Plan includes follow-up in 2 weeks when biopsy results are available. Impression: Actinic keratosis.				

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S092	<p>A 50-year-old female comes into the office complaining of excruciating lower back pain where at times she is unable to get out of the bed. She has a past medical history of sciatica due to disc herniation that caused nerve compression between the L5 and S1 vertebrae. MRI revealed bone spurs on vertebral bodies in the spine, thickening of facet joints and narrowing of the intervertebral disc spaces.</p> <p>Treatment plan includes pain management (pain medications and muscle relaxants), chiropractic and physical therapy services.</p> <p>Impressions: Lumbosacral spondylosis without myelopathy, and sciatica.</p>				
S093	<p>A 42-year-old male comes into the office complaining of severe pain across the shoulder that began 2 nights ago. A medical history and examination was done and revealed wasted muscles and limited ROM in shoulder. X-rays were taken to rule out a slipped disk or tumor. Prescription for pain medication was given. Also, discussed with patient a plan that included initial pain management with subsequent physical therapy exercises once pain was controlled to regain normal arm and shoulder function.</p> <p>Impression: Radiculitis of shoulder.</p>				
S094	<p>A 66-year-old female comes into the office for treatment of a dome shaped lesion on her hand that appeared about 4 weeks ago. She denies any previous history of skin cancer, but does indicate a family history of it. Physical examination findings revealed a painless 2 cm lesion.</p> <p>The plan includes a skin biopsy to confirm the diagnosis of Keratoacanthoma with follow-up in 2 weeks to discuss treatment options once biopsy results are available.</p> <p>Impressions: Neoplasm of uncertain behavior of other and unspecified sites and tissues, skin.</p>				
S095	<p>A 56-year-old male is seen at my office today complaining of burning, searing, hot pain in the lower back radiating down his left leg into the knee. It is accompanied by numbness in the upper left thigh. These symptoms have been going on for approximately one month. The pain is so intense, it is becoming unbearable and it is affecting the patient's activities of daily living. Neurological and lumbar spine examinations were performed. The results show tenderness and pain on palpation at the lumbosacral region and weakness on the left leg.</p> <p>Plan: Nerve conduction study, non-steroidal anti-inflammatory drug (NSAID), and Vitamin B6 level. Follow-up in 6 weeks.</p> <p>Impression: Lumbosacral neuritis.</p>				

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S096	<p>A 39-year-old female patient comes to the office today complaining of unbearable back pain. It started 2 days ago when she awoke with a dull ache in the mid-section of her back. She described that the pain is progressively worsening. She is not experiencing any tingling, numbness, or loss of sensation and the pain stays in one location. She is taking Extra Strength Tylenol 500 mg. to ease the pain but it's not helping. She requested a stronger medication for the pain. Physical examination was performed and reveals the patient had pulled a back muscle due to excessive coughing.</p> <p>Plan: Prescription for NSAID, hot and cold packs application, and x-ray of the back. Follow-up in 2 weeks.</p> <p>Impression: Backache, unspecified.</p>				
S097	<p>A 45-year-old established female patient with chief complaints of pain and tenderness in her neck. According to her, she first experienced these symptoms when she quickly rotated her neck. She described the pain as unbearable and associated with stiffness. Physical examination was performed and findings revealed muscle tension (spasm) on palpation, limited movement of the neck, and tenderness in the neck area. Her gait, posture, and coordination were assessed for any abnormalities. The range of motion in her neck was also evaluated.</p> <p>Plan: CBC, ESR, Chem profile, and EMG. Ultram 50 mg, hot and cold application, and physical therapy. Follow-up in 2 weeks.</p> <p>Impressions: Myalgia and myositis, unspecified.</p>				
S098	<p>The patient is a 30-year-old male who comes to the office today for further evaluation and treatment of pain at the base of the neck, headaches, and weakness on right arm. He states these symptoms have been present for almost 6 months, with the pain now radiating to his shoulders and arms. He has limited ability to raise his arms and his neck movement is also restricted. He sometimes loses his grip as well. He indicates he has some occasional lightheadedness with loss of balance. He takes an over-the-counter pain medication (i.e., Motrin 800 mg) with little relief. According to the patient these symptoms affect his activities of daily living. Physical examination revealed localized pain and tenderness in the cervical region upon palpation, restricted range of motion in the neck and upper extremity, sUBLUXATION from C2 to C6.</p> <p>Plan: MRI of the neck, NSAID, hot and cold pack application, physical therapy 3X per week, and follow-up in 3 weeks.</p> <p>Impression: Nonallogenic lesion of cervical region, NEC.</p>				

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S099	<p>A 58-year-old male patient comes in today complaining of continuous pain at the midsection of his back. According to the patient, about 3 days ago he experienced a bout of strenuous coughing when he felt severe pain at the midsection of his back. He took an over-the-counter pain medication that provided little relief. He cannot sleep at night due to intermittent pain and spasm. Physical examination revealed pain and tenderness upon palpation in the thoracic region, subluxation at T1 thru T5 level, and restricted range of motion.</p> <p>Plan: MRI thoracic spine, hot and cold pack application, Tylenol III with codeine for pain, and physical therapy.</p> <p>Impression: Nonallopathic lesion of the thoracic region, NEC.</p>				
S100	<p>A 37-year-old female patient comes in to the office with chief complaints of severe pain at the lower back radiating to right thigh and leg associated with loss of balance and restrictive movements. The pain was characterized as dull, but increasing in intensity daily. At times she experiences difficulty getting in and out of bed due to the pain. Physical examination revealed pain and tenderness upon palpation at the L1 thru L6 level, subluxation at L1 thru L6 levels, restricted forward and backward bending, decreased abduction and adduction of the lower extremity, and left leg weakness.</p> <p>The plan includes MRI of the lumbar spine, Ultram 50 mg for pain, hot and cold application, and physical therapy.</p> <p>Impression: Nonallopathic lesion of lumbar region, NEC.</p>				
S101	<p>A 75-year-old male comes in accompanied by his daughter with the following problems: waddling when walking, consistently poor balance with unsteadiness on his feet, and inability to lift his legs. The patient was diagnosed with early stage Alzheimer's a year and half ago. Physical and neurological examination, including gait evaluation was performed. Findings revealed a wide stance and posture; slow walking with feet dragging; and inability to rise from a chair.</p> <p>Plan: referral for physical therapy, use of walker for poor balance, muscle relaxant, and follow-up in 4 weeks.</p> <p>Impression: Gait abnormality.</p>				

Scenario #	Scenario Description	ICD-9 Code	ICD-9 Description	ICD-10 Code	ICD-10 Description
S102	<p>A 12-year-old female patient seen at the office for symptoms of feeling weak, tired and some shortness of breath. She has been running a fever since last week. She took Tylenol for her fever. She also has asthma and is treated with Advair Diskus. Patient's vital signs are stable without fever at this time. Physical examination revealed some wheezing. Stat CBC ordered and the result shows an elevated WBC, which is indicative of infection. Prescribed antibiotic and instructed the patient and her mother to continue her asthma medication, increase fluid intake, repeat CBC, and follow-up in 3 months unless she is not improved after the course of therapy.</p> <p>Impressions: Asthma and leukocytosis.</p>				
S103	<p>A mother brings her 4-year-old son into the office stating he has nasal congestion, a headache, sore throat and swollen eyes. She states that he has a history of allergic rhinitis but has no other chronic problems. Physical exam was performed. Discussed plan on ways to avoid possible allergen triggers with the mother. Ordered OTC antihistamines and decongestants to use as needed. Follow up if symptoms continue to determine any additional treatment options.</p> <p>Impression: Allergic rhinitis, cause unspecified.</p>				