

CCS Sample Multiple-choice Questions and Answer Key

1. A patient was discharged from the hospital with a diagnosis of bronchial asthma. Upon reviewing the record, the coder notes the patient was described as having prolonged and intractable wheezing, airway obstruction not relieved by bronchodilators, and a decreased PAO₂ lab value. The physician should be queried to determine whether the code for _____ is appropriate as the principal diagnosis:

 - A. Acute viral Bronchitis
 - B. COPD
 - C. Respiratory failure
 - D. Status asthmaticus
2. A patient was admitted to the hospital with severe dehydration and malnutrition. His blood sugar was elevated. The patient is a known alcohol abuser. Intravenous fluid replacement was given to hydrate the patient, who signed out against medical advice after two days. Final diagnoses were: severe dehydration with malnutrition and adult-onset diabetes vs. early cirrhosis associated with alcoholism. The principal diagnosis is:

 - A. Adult-onset diabetes
 - B. Alcohol abuse
 - C. Cirrhosis of liver due to alcoholism
 - D. Severe dehydration
3. A patient is admitted to the hospital to undergo a radical mastectomy for recurrent carcinoma of the breast (Previously, she had elected to have a lumpectomy). The attending physician lists a history of atrial fibrillation as a secondary diagnosis. The patient is currently not on any medication. For medical clearance prior to surgery, the patient is seen by a consultant, who says that the patient was satisfactory for the procedure. The coder should:

 - A. Report atrial fibrillation as a current condition, because it was documented by the physician in the history.
 - B. Code atrial fibrillation as a current condition, because the patient was seen by a consultant for surgical clearance.
 - C. Add the code for observation for suspected cardiovascular condition
 - D. Omit reporting the code for atrial fibrillation, because it was not treated and did not affect the course of treatment.

4. A patient was admitted with complaints of severe vertigo, headache, and nausea of two weeks' duration. The patient had a malignant melanoma of the face removed two years ago. An MRI ordered during this stay showed no sign of malignancy; however, toxicology studies indicated high levels of insecticide in the blood, which the physician documented as being toxic neuropathy. Which of the following represents the conditions to be coded?
- A. Toxic neuropathy due to insecticide
 - B. Toxic neuropathy due to insecticide; history of malignant melanoma
 - C. Vertigo; headaches; nausea; malignant melanoma
 - D. Vertigo; headaches; nausea; insecticide poisoning

5. The following ICD-9-CM index entries appear:

Encephalitis
infectious (acute) (virus) NEC 049.8
postinfectious NEC 136.9 [323.6]

The diagnosis listed by the physician is encephalitis after infection. Which of the following represents the correct coding and sequencing?

- A. 049.8
 - B. 323.6
 - C. 136.9; 323.6
 - D. 049.8; 136.9
6. A patient undergoing hemodialysis for renal disease in the outpatient unit of a hospital develops what is believed to be heartburn. After a few hours of observation, he is admitted to the hospital for further care. The consulting cardiologist diagnoses this patient's condition as unstable angina. What is the principal diagnosis for the hospital stay?
- A. Complication of dialysis
 - B. Heartburn
 - C. Renal disease
 - D. Unstable angina
7. A patient was being treated for gastric ulcer with hemorrhage, cirrhosis of liver, portal hypertension, and esophageal varices. Of the following medications, which would indicate a possible complication or comorbid condition that would impact DRG reimbursement?
- A. Bactrim®, 1 tablet q.i.d.
 - B. Darvocet-N®, 100 mg prn
 - C. HydroDIURIL®, 50 mg PO daily
 - D. Tagamet®, 300 mg IM q 6 hrs

8. What is the diagnosis code assignment for contraction of the anterior capsule causing the intraocular lens implant to be displaced following extraction of a cataract? The physician uses a laser to repair the torn capsule and reposition the lens.
- A. 996.69
 - B. 996.53
 - C. 998.82
 - D. 998.89
9. The coding supervisor conducts weekly quality controls to assess the accuracy of coded data. Which of the following codes listed as the principal diagnosis is the only code appropriate for principal diagnosis assignment?
- A. 321.2 Meningitis due to viruses, not elsewhere classified
 - B. E855.0 Accidental poisoning by anticonvulsant and anti-Parkinsonism drugs
 - C. V27.0 Outcome of delivery, single liveborn
 - D. V71.1 Observation for suspected malignant neoplasm
10. A patient with a complaint of cough(786.2) was referred by his physician to the outpatient department for a chest x-ray (V72.5) to rule out pneumonia (486). The results were negative. Which of the following is the appropriate sequencing?
- A. V72.5; 786.2
 - B. 786.2
 - C. V72.5; 486
 - D. V72.5
11. A patient came to the emergency department with hypotension and tachycardia. Upon examination, the patient's condition was determined to be the result of a tetanus toxoid vaccine administered four hours earlier. Which of the following is the appropriate sequencing?
- A. Hypotension; tachycardia; and accidental poisoning E code, tetanus toxoid
 - B. Hypotension; tachycardia; and therapeutic use E code, tetanus toxoid
 - C. Poisoning due to tetanus toxoid and therapeutic use E code, tetanus toxoid
 - D. Unspecified adverse reaction and undetermined cause E code, tetanus toxoid

12. The following is an operative report to be coded:
Preoperative Diagnosis: Nonossifying fibroma
Postoperative Diagnosis: Aneurysmal bone cyst
Procedure: Excisional bone biopsy

The patient was brought to the operating room, and after adequate spinal anesthesia, the right lower extremity was prepped and draped. A transverse incision was carried down through the skin and subcutaneous tissue. The soft tissues were dissected. The lesion was curetted from the bone, revealing a cavity approximately 5.0 cm in length and 2.5 cm in width. The cavity was irrigated and the margins electrocauterized. A specimen that was sent for frozen section was consistent with aneurysmal bone cyst. The subcutaneous tissue was closed with 2-0 Vicryl, and the skin was closed with 4-0 nylon. A sterile dressing was applied. The patient tolerated the procedure well. Which of the following CPT procedures is to be coded?

- A. Arthrotomy of ankle, with biopsy for removal of loose body
 - B. Bone biopsy of leg or ankle area, deep
 - C. Curettage of bone cyst or benign tumor, tibia or fibula
 - D. Resection of tumor, radical; tibia
13. A cardiovascular procedure that is unfamiliar to the coder is performed, and the procedural name used by the physician does not appear in the CPT index. In such a situation, what should the coder do first?
- A. Ask the physician to review the codes in the cardiovascular section of CPT
 - B. Assign a similar cardiovascular procedure code
 - C. Postpone coding the specific procedure until a code is established by the AMA
 - D. Use an unlisted procedure code from the cardiovascular section
14. A patient has six actinic keratoses destroyed cryosurgically. What should be referenced under the CPT index?
- A. Excision, lesion, skin (malignant)
 - B. Excision, lesion, skin (benign)
 - C. Lesion, skin, excision
 - D. Lesion, skin, destruction
15. The following CPT codes appear:

19120 Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple, or areolar lesion (except 19140), male or female, one or more lesions

19125 Excision of breast lesion identified by preoperative placement of radiological marker; single lesion

19290 Preoperative placement of needle localization wire, breast

The patient underwent a needle localization with excision of a right breast lesion. Pathology revealed diffuse fibrocystic disease. Which of the following is the appropriate coding for this procedure?

- A. 19125; 19290
- B. 19125
- C. 19120; 19125
- D. 19120; 19290

CCS Multiple Choice Answer Key

1. D 2. D 3. D 4. B 5. C 6. D 7. A 8. B 9. D 10. B 11. B 12. C 13. A 14. D 15. A

Procedures for Coding Part II of the CCS Examination

Instructions and official guidelines for coding medical records are included in the following resources: ICD-9-CM, CPT, UHDDS, *Coding Clinic for ICD-9-CM* and *CPT Assistant*. However, hospitals and other organizations may develop their own procedures in the absence of approved guidelines. To ensure consistent coding, the following procedures have been developed for use in the CCS examination. **The procedures do not supersede or replace official coding advice and guidelines included in the resources identified above.**

These procedures are to be used only in completing the CCS examination. They will be provided to test takers as part of the examination packet. Not adhering to these procedures may result in the miscoding of an exercise, which may result in the deduction of points when the item is scored.

Inpatient Coding

1. Apply UHDDS definitions, ICD-9-CM instructional notations and conventions, and current approved national ICD-9-CM coding guidelines to assign correct ICD-9-CM diagnostic and procedural codes to hospital inpatient medical records.
2. Sequence the ICD-9-CM codes, listing the principal diagnosis first.
3. Code other diagnoses that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. These represent additional conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care and/or monitoring. (*Coding Clinic for ICD-9-CM*, Second Quarter 1990.)
 - A. Code diagnoses that require active intervention during hospitalization. For example: Admission for small-bowel ileus and subsequent aspiration pneumonia that is treated with antibiotics and respiratory therapy. Code the ileus and aspiration pneumonia.
 - B. Code diagnoses that require active management of chronic disease during hospitalization, which is defined as a patient who is continued on chronic management at time of hospitalization. For example: Admission for acute exacerbation of COPD. The patient has depression that extends the stay and for which psychiatric consultation is obtained. Code the COPD and depression. For example: Admission for acute exacerbation of COPD. Physician lists "history of depression" on face sheet, and the patient is given Desyrel. Code the COPD and depression.
 - C. Code diagnoses of chronic systemic or generalized conditions that are not under active management when a physician documents them in the record and that may have a bearing on the management of the patient. For example: Admission for

breast mass; diagnosis is carcinoma. Patient is blind and requires increased care. Code the breast carcinoma and blindness.

D. Code status post previous surgeries or conditions likely to recur that may have a bearing on the management of the patient. For example: Admission for pneumonia; status post cardiac bypass surgery. Code the pneumonia and status post cardiac bypass surgery (V code).

E. Do not code status post previous surgeries or histories of conditions that have no bearing on the management of the patient. For example: Admission for pneumonia; status post hernia repair six months prior to admission. Code only the pneumonia.

F. Do not code localized conditions that have no bearing on the management of the patient. For example: Admission for hernia repair; the patient has a nevus on his leg that is not treated or evaluated. Code only the hernia and its repair.

G. Do not code abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) unless there is documentary evidence from the physician of their clinical significance. For example: Admission for elective joint replacement for degenerative joint disease. The laboratory report shows a serum sodium of 133; no further documentation addresses this laboratory result. Code only the degenerative joint disease and the replacement surgery. For example: Admission for elective joint replacement for degenerative joint disease. The laboratory report shows a low potassium level, and the physician documents hypokalemia. Intravenous potassium was administered by the physician for hypokalemia. Code the degenerative joint disease, the replacement surgery, and hypokalemia.

H. Do not code symptoms and signs that are characteristic of a diagnosis. For example: A patient has dyspnea due to COPD. Code only the COPD.

I. Do not code condition(s) in the Social History section that has no bearing on the management of the patient.

4. Do not assign External Cause of Injury and Poisoning Codes (E codes), except those that identify the causative substance for an adverse effect of a drug that is correctly prescribed and properly administered (E930-E949).
5. Do not assign Morphology codes (M codes).
6. Code all procedures that fall within the code range 01.01 through 86.99, but do not code 57.94 (Foley catheter).
7. Do not code procedures that fall within the code range 87.01 through 99.99. But code procedures in the following ranges:

87.51-87.54	Cholangiograms
87.74 and 87.76	Retrogrades, urinary systems
88.40-88.58	Arteriography and angiography
92.21-92.29	Radiation therapy

94.24-94.27	Psychiatric therapy
94.61-94.69	Alcohol/drug detoxification and rehabilitation.
96.04	Insertion of endotracheal tube
96.70-96.72	Mechanical ventilation
98.51-98.59	ESWL
99.25	Chemotherapy

Ambulatory Care Coding

1. Apply ICD-9-CM instructional notations and conventions and current approved "Basic Coding Guidelines for Outpatient Services" and "Diagnostic Coding and Reporting Requirements for Physician Billing" (*Coding Clinic for ICD-9-CM*, Fourth Quarter 1995 and 1996) to select diagnoses, conditions, problems, or other reasons for care that require ICD-9-CM coding in an ambulatory care encounter/visit either in a hospital clinic, outpatient surgical area, emergency room, physician's office, or other ambulatory care setting.
2. Sequence the ICD-9-CM code so that the first diagnosis shown in the medical record is the one chiefly responsible for the outpatient services provided during the encounter/visit.
3. Code the secondary diagnoses as follows:
 - A. Chronic diseases that are treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
 - B. Code all documented conditions that coexist at the time of the encounter/visit that require or affect patient care, treatment, or management.
 - C. Conditions previously treated and no longer existing should not be coded.
4. Do not assign External Cause of Injury and Poisoning Codes (E codes), except those that identify the causative substance for an adverse effect of a drug that is correctly prescribed and properly administered (E930-E949).
5. Do not assign Morphology codes (M codes).
6. Do not assign ICD-9-CM procedure codes.
7. Assign CPT codes for all surgical procedures that fall in the surgery section.
8. Assign CPT codes from the following ONLY IF indicated on the case cover sheet:
 - a) Anesthesia section
 - b) Medicine section
 - c) Evaluation and management services section
 - d) Radiology section
 - e) Laboratory and pathology section

9. Assign CPT/HCPCS modifiers for hospital-based facilities, if applicable.

10. Do not assign HCPCS Level II (alphanumeric) codes.

CCS Sample Medical Record Coding Cases and Answer Sheets

Case No. 1

INPATIENT FACE SHEET

Admit Date: 4/28

Discharge Date: 4/29

Sex: F

Age: 68

Disposition: Home

Admitting Diagnosis: Primary peritoneal epithelioid carcinoma

Discharge Diagnosis: Primary peritoneal epithelioid carcinoma

Procedures: Infusion chemotherapy

DISCHARGE SUMMARY

Admitted: 4/28

Discharged: 4/29

Discharge Diagnosis: Primary peritoneal epithelioid carcinoma

Operation/Procedures: Infusion chemotherapy

History of Present Illness:

This was the seventh admission for this 68-year-old female with primary peritoneal epithelioid carcinoma, who presented for her sixth cycle of chemotherapy. Her history dates back to October when she developed a sensation of lower abdominal pressure and fullness. These increased in intensity to the point of pain, and she presented to the office in late November. A CT scan revealed a pelvic mass, with evidence of mesenteric involvement. She was referred to this hospital and in December underwent laparotomy, with findings of what appeared to be Stage III ovarian epithelial carcinoma. Upon histologic review of the specimen, the tumor was felt to be a primary peritoneal epithelioid carcinoma, and the patient was referred to Medical Oncology.

After a review of the literature, the patient was offered chemotherapy and received the first cycle of Cytosan 750 mg/m² with cisplatin 75 mg/m² intravenously during her hospital stay. Her first cycle of treatment was given on 1/7, and she returned for a second cycle on 1/27. A third cycle of treatment was given on 2/17 and a fourth cycle on 3/8. A fifth cycle was administered on 4/3, and she has now been admitted for her sixth cycle of treatment at this time. She has tolerated her chemotherapy extremely well, with minimal toxicity. An audiogram obtained during the time of her fifth cycle of treatment revealed a moderate degree of high-frequency hearing loss due to chemotherapy. Since her last discharge she had experienced an earache; however, it had resolved at the time of admission.

Medications on Admission:

Percocet 1Ø2 tablets p.o. q4 h prn pain, heparin sulfate 5,000 units subcutaneously q 12 hours, Colace 100 mg p.o. b.i.d.

Past Medical History:

The patient underwent a total abdominal hysterectomy and bilateral salpingo-oophorectomy in the 1960s for uterine fibroids. She underwent cholecystectomy in 1988 and has undergone cesarean section once in the past. At the time of her laparotomy in 12/90 she was found to have a deep vein thrombosis in the right femoral vessel, and a Greenfield filter was placed at that time. She has been maintained on heparin since then.

Physical Examination:

The patient is a short, female, awake, alert, and fully oriented in no acute distress. Blood pressure 120/75, respirations 18, pulse 88 and regular, temperature 36.8¼Celsius. Skin: Full turgor. HEENT: Normocephalic, atraumatic. Pupils equal, round, and reactive to light and accommodate. Extraocular muscles intact. Oropharynx without lesions. Neck: Supple without adenopathy. Lungs: Clear to percussion and auscultation. Cardiac: Regular rhythm and rate. Point of maximal impulse not displaced. S1 and S2 without rub, gallop, or murmur. Abdomen: Active bowel sounds, soft and nontender. Scar present in the right upper quadrant and in the midline. No palpable organomegaly. Pelvic/Rectal: Deferred. Extremities: Without clubbing, cyanosis, or edema. Neurologic: Mental status fully intact. Cranial nerves intact, with the exception of cranial nerve VIII, which shows moderate hearing loss. Motor and sensory intact throughout.

Hospital Course:

The patient was admitted to the Medical Oncology Ward and underwent an evaluation at the time of admission. She was hydrated aggressively. She received cyclophosphamide 750 mg/m² intravenously with cis-platinum 75 mg/m². She received aggressive fluid hydration and was monitored for toxicity throughout her hospital stay. Careful attention was paid to her inputs and outputs as well as her electrolyte balance. Serum electrolytes remained normal throughout the hospital stay. CA-125 level obtained at the time of this admission had returned to normal limits.

Disposition:

The patient was discharged home in good condition to return to the Medical Oncology Clinic in May. She was also scheduled to undergo reevaluation by the Gynecologic Oncology Service on the same day. A CT scan of the abdomen was also requested to be scheduled at that time.

Discharge Condition: Good.

Discharge Medications:

Heparin 5,000 units subcutaneously bid, Compazine 25 mg per rectum q 8 h prn nausea, Ativan 1 mg p o q 6 h prn nausea.

Discharge Instructions: Activities: Ad lib. Diet: General, as tolerated.

Allergies: None known.

HISTORY AND PHYSICAL

Admitted: 4/28

Identification/Chief Complaint:

A 68-year-old female with primary peritoneal epithelioid carcinoma who is admitted for her sixth cycle of chemotherapy.

History of Present Illness:

The patient was in her usual good health until October, when she developed a sensation of lower abdominal pressure and fullness, with "gas pain" episodically. These increased in intensity to the point of pain, arising in the left flank and gradually moving to the left side and the midline. She noted abdominal distention in late November and presented to her private physician. At that time, a CT scan was obtained, which demonstrated a pelvic mass with evidence of mesenteric involvement. She was referred to this hospital and in December underwent laparotomy, with a finding of what officially appeared to be Stage III ovarian epithelial carcinoma. Upon histologic review of the specimen, the tumor was felt to be a primary peritoneal epithelioid carcinoma, and the patient was referred for chemotherapy. She began treatment with cis-platinum 75 mg/m² intravenously in combination with cyclophosphamide 750 mg/m². She received her first chemotherapy administration 1/7 and a second cycle 1/27. A third cycle was administered on 2/17, and a fourth cycle was administered on 3/8. She completed a fifth cycle of chemotherapy three weeks prior to this admission and has remained clinically well. Her CA-125 level has fallen from an initial 2,243 on 1/4 to a level of 118 by 2/17, and a level of 7 at the time of her most recent chemotherapy admission.

Since her last discharge, the patient has been feeling generally well until approximately one week prior to admission, when she developed ear pain. This was evaluated by a local physician and has subsequently been resolved. She denies recent fevers, chills, or sweats, and has been undertaking her usual activities of daily living. Her appetite has been good, and her bowel habits have been regular.

Allergies: None known.

Medications:

On admission, cimetidine 300 mg p.o. qhs, Percocet 1-2 tablets p.o. q 4 h prn pain, heparin sulfate 5,000 units subcutaneously q 12 hr, Colace 100 mg p.o. b.i.d.

Past Medical History:

The patient underwent a total abdominal hysterectomy in the 1960s for uterine fibromas. She underwent a cholecystectomy in 1988 and has undergone cesarean section once in the past. She is gravida II, para II. At the time of her laparotomy in 1990, she was found to have thrombosis of femoral vessel and has been maintained on subcutaneous heparin since that time. A Greenfield filter was placed at the time of laparotomy.

Social History:

The patient is married with two children and resides in the area. She previously smoked tobacco, but has not done so for many years. She does not consume alcohol.

Family History: The patient's family history is negative for neoplastic diseases.

Review of Systems:

Neurologic

The patient denies history of head trauma, seizure disorder, or focal neurologic deficits.

Cardiac

The patient denies prior myocardial infarction, exertional dyspnea, or palpitation.

Gastrointestinal

The patient denies a history of hepatitis, inflammatory bowel disease, or melena.

Endocrine

The patient denies history of hypertension, diabetes mellitus, or thyroid disorder.

Physical Examination

General Appearance:

The patient is a short female, who is awake, alert, and fully oriented in no acute distress.

Vital Signs: Blood pressure 120/75, respirations 18, pulse 88, and regular, temperature 36.8¼Celsius.

HEENT Head: Normocephalic and atraumatic.

Eyes:

Pupils equally round and reactive to light and accommodate. Extraocular muscles intact. Oropharynx without lesions.

Neck: Supple, without adenopathy.

Lungs: Clear to percussion and auscultation.

Cardiac: Point of maximal impulse nondisplaced. S1, S2 without gallop, rub, or murmur. Full pulses throughout.

Abdomen:

Active bowel sounds. Soft and nontender. No palpable organomegaly, no guarding or rebound.

No masses appreciated.

Pelvic: Deferred at this time.

Rectal: Deferred at this time.

Extremities: Without clubbing, cyanosis, or edema.

Neurologic: Mental status fully intact. Cranial nerves fully intact. Motor and sensory intact throughout.

Diagnostic Data: Pending at this time.

Impression:

The patient is a 68-year-old woman with primary peritoneal epithelioid carcinoma, who is now admitted for her sixth cycle of chemotherapy. She has demonstrated a continuing decline in her CA-125, which is suggestive of a good response to chemotherapy following a suboptimal debulking procedure.

Plan:

The patient will receive cyclophosphamide 750 mg/m² and cis-platinum 75 mg/m² following intravenous fluid hydration. She will be closely followed with respect to her electrolyte and fluid balance, and diuretics will be administered as indicated. Antiemetics will be given liberally, and she will be monitored for toxicity throughout her hospital stay. Consultation will be undertaken with the Gynecologic Oncology Service to assess the patient as a candidate for a second laparotomy.

PROGRESS NOTES

4/28: Brief Admission Note

This is the sixth medical oncology admission for this 68-year-old woman with primary peritoneal epithelial carcinoma, who presents for her sixth cycle of chemotherapy following suboptimal debulking in December. She has shown a steady decline in her CA-125 level and has remained clinically well since surgery.

4/28: Chemotherapy Notes:

CYCLE #6 CTX-CDDP

HT = 62.5"; WT = 67 kg; BSA = 1.7 m²

*Cis-platinum 75 mg/m² = 127 mg IVPB x 1 dose

*Cytoxan 750 mg/m² = 1270 mg IVPB x 1 dose

Antiemetics and careful hydration to be administered.

4/29: Medical Oncology:

S: Feeling well, no complaints, no nausea or vomiting. No tinnitus or paresthesias.

O: BP 162/96, R 18, P 92, T 36.8¼Celsius

Lungs: Clear

Cor: Regular rhythm and rate

Abd: Active bowel sounds, soft, nontender

Labs: 134 / 103 / 15 / 109 mg = 1.7

4.5 / 24 / 0.9 /

A: Peritoneal epithelial carcinoma - S/P cycle #6

Chemotherapy tolerated well

P: Discharge home today. Return 2-3 weeks to GYN/ONC and MED/ONC for follow-up with CT and CA-125.

PHYSICIAN'S ORDERS

4/28:

1. Admit to Medical Oncology
2. Diagnosis: Primary epithelial peritoneal carcinoma
3. Allergies: None known
4. Condition = good
5. Diet = general
6. Vitals = q shift
7. Activities = up ad lib
8. IV fluids = 0.9% NaCl + 10 mEq/lit KCl + 8 mEq/lit MgSO₄
9. Bolus fluids: 500 cc NS over 2 hrs just prior to CDDP and 500 cc NS over 2 hrs just after CDDP
10. Antiemetics:
 - A. Decadron 20 mg IV 1 hr prior to CDDP
 - B. Zofran 14 mg IV 3/4 hr prior to CDDP
 - C. Ativan 1 mg IV 3/4 hr prior to CDDP then Zofran 14 mg 3 hrs, 7 hrs then q 4 hrs prn N/V
 - D. Ativan 1 mg IV q 4 h prn
11. Chemotherapy:
 - * Cis-platinum 127 mg in 250 cc NS IVPB over 1 hr on 4/28
 - * Cytosan 1270 mg in 250 cc fluid IVPB over 1 hr on 4/28
12. If urine output is less than fluid intake by \pm 400 cc over 4 hours, give Lasix 20 mg IV push and KCl 20 mEq IV over 2 hours.
13. Nursing:

Strict I&O, please notify MD for temp >101.5, HR >120 or <50, BP >200/110 or <90/48
14. Medications:

Compazine 10 mg IV q 6 hr prn
Timoptic eye drops once per day
Mylanta II 30 cc p.o. q 4 h prn
Heparin Na⁺ 5000 units subcut bid
Tylenol 650 mg p.o. q 4 h prn
Procardia 10 mg p.o. q 6 h prn BP diastolic >100 mmHg
Halcion 0.25 mg p.o. q hs prn

4/29:

10:30 a.m.

Discharge home today.

DIRECTIONS:

Be sure to enter all medical record codes in the manner provided in the sample, paying special attention to the decimal placement for each code. A decimal point (.) has been provided as a guide for entering each ICD-9-CM code. Do not write in the column with the decimal point. You may lose credit if the digits of the code are correct, but the decimal point has been incorrectly placed or if your answer is not legible.

NO CREDIT WILL BE GIVEN FOR CODES WRITTEN OUTSIDE THE BOXES

DIAGNOSES
 PDX _____
 DX2 _____
 DX3 _____
 DX4 _____
 DX5 _____
 DX6 _____
 DX7 _____
 DX8 _____
 DX9 _____
 DX10 _____

ICD-9-CM						
	1	2	3	.	4	5
	6	7	8	.	9	
E	9	0	0	.	1	
	V	1	0	.	0	1
				.		
				.		
				.		
				.		
				.		
				.		

PROCEDURES
 PP1 _____
 PR2 _____
 PR3 _____
 PR4 _____
 PR5 _____
 PR6 _____
 PR7 _____

ICD-9-CM				
1	2	.	3	4
5	6	.	7	
8	9	.	0	
		.		
		.		
		.		
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CCS EXAMINATION ANSWER SHEET (INPATIENT)

DIAGNOSIS

Principal DX _____

ICD-9-CM CODES

	V	5	8	.	1	
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DX2 _____
 DX3 _____
 DX4 _____
 DX5 _____
 DX6 _____
 DX7 _____
 DX8 _____
 DX9 _____
 DX10 _____

	1	5	8	.	9	
	3	8	9	.	9	
E	9	3	3	.	1	
	V	1	2	.	5	1
	V	5	8	.	6	1
				.		
				.		
				.		
				.		

PROCEDURES

PP1 _____
 PR2 _____
 PR3 _____
 PR4 _____
 PR5 _____
 PR6 _____

ICD-9-CM CODES

9	9	.	2	5
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		.		
		.		
		.		
		.		

Case No. 2

AMBULATORY CARE FACE SHEET

Admit Date: 7/8 @ 20:22

Discharge Date/Time: 7/9 @ 10:10

Sex: M

Age: 47

Disposition: Home

Admitting Diagnosis: Possible esophageal foreign body.

Discharge Diagnosis: Esophageal foreign body.

Procedures: EGD with foreign body removal.

CONSULTATION

Date of Consultation: 7/8

This is a 47-year-old male who was in his usual state of health until early this evening when he developed an acute episode of odynophagia and a sensation of a foreign body in the proximal esophagus. This occurred after the patient had several bites of fish. The patient was evaluated with C-spine films and soft-tissue films, but no definite foreign body was seen. The soft tissue was noted to be normal. The patient, however, continued to have a sensation of a foreign body in the proximal esophagus and was complaining of upper esophageal pain. He has no past history of dysphagia, tobacco abuse, peptic ulcer disease, or reflux history. The patient has no past history of lye or corrosive substance ingestion. He denies any fever, chills, or shortness of breath.

Past Medical History:

Allergies: No known drug allergies.

Medications: None.

Surgeries: Repair of a laceration to the forehead 10 months ago.

Medical History: History of hepatitis.

Family History: Noncontributory.

Review of Systems: No medical abnormalities.

Physical Examination:

Vital Signs: BP 130/80, P 92, T 98.5

General:

This is a well-developed and well-nourished anxious black male in mild distress. Head and neck are normocephalic, atraumatic. Sclerae clear. The oropharynx is clear. The neck is supple with free range of motion and no thyromegaly. The trachea is midline and mobile. There is no crepitus noted. Lungs are clear bilaterally. Heart is regular rate and rhythm. Abdomen is soft and nontender with bowel sounds active in all four quadrants. There are no hepatosplenomegaly or masses noted. Rectal is deferred. Musculoskeletal with free range of motion. Neurologic with no focal deficits.

Impression:

Foreign body in upper esophagus or possible laceration of this area. We will plan for upper endoscopy to rule out an acute obstruction and, if necessary, remove the foreign body.

OPRATIVE REPORT**Date of Procedure: 7/8****Procedure:** Esophagogastroduodenoscopy with foreign body removal.**Preoperative Medication:** Demerol 50 mg IV, Versed 3 mg IV, Cetacaine spray**Preoperative Diagnosis:**

1. Esophageal foreign body.
2. Odynophagia.

Postoperative Diagnosis:

Status-post foreign body removal.

Clinical Note: This is a 47-year-old black male who experienced acute odynophagia after initially eating a meal consisting of fish. The patient felt a foreign-body-like sensation in his proximal esophagus and presented to the emergency room. He was evaluated with lateral, C-spine films, and soft-tissue films without any evidence of perforation. The patient is now referred for evaluation for his proximal esophagus.

Findings: After obtaining informed consent, the patient was endoscoped in the emergency room. He was premedicated with Demerol and Versed without any complications. Under direct visualization, an Olympus Q20 endoscope was introduced orally, and the esophagus was intubated without any difficulty. The hypopharynx was carefully reviewed, and no abnormalities were noted. There were no foreign bodies or lacerations to the hypopharynx. The proximal esophagus was normal. No active bleeding was noted. The endoscope was farther advanced into the esophagus, where careful review of the mucosa revealed no foreign bodies and no obstructions. The distal esophagus did, however, show a very small fish bone, which was removed without any complications. The endoscope was advanced into the stomach, where partially digested food was noted. The endoscope was then removed. The patient tolerated the procedure well, and his post-procedure vital signs are stable.

Recommendations:

1. Clear liquids for 24 hours.
2. Follow-up with me in the office in the morning.

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Procedure Performed:

Soft-tissue neck. There is a curvilinear density in the region of the base of the tongue that could conceivably represent a small bone. The airway is intact throughout. No other abnormalities are visible.

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Admit to Endoscopy Department.

Obtain consent for procedure, signed and witnessed.

Start IV of 55 cc D5W or NS TO KVO or heparin lock.

Preoperative Medications: Versed 3 mg IVP, Demerol 50 mg IVP, apply pulse oximeter.

