PART I: CERTIFIED CODING SPECIALIST-PHYSICIAN (CCS-P) MOCK EXAM

The CCS-P exam is a level of coding certificate through the American Health Information Management Association (AHIMA). Detailed information on the exam including content, question format, testing sites, etc. can be found at the AHIMA website (http://www.ahima.org/certification/ccsp.asp). Information on this certification exam is provided at the site and in the Candidate Handbook, which can be downloaded from the site. Content areas of the exam are referred to as domains. Currently, CCS-P domains include: Health Information Documentation, ICD-9-CM coding, CPT and HCPCS Level II coding, Reimbursement, Data Quality and Analysis, Information and Communication Technologies, and Compliance and Regulatory Issues. The first portion of the CCS-P exam consists of 60 questions in multiple-choice format. Provided in this appendix is a mock 60-question exam for coding practice.

1. Andres Mink underwent a colonoscopy, performed by Dr. Hershey, in the ambulatory surgery unit of a local hospital. When submitting the claim for this service, which coding manual(s) would be used to assign diagnosis and procedure codes?
   a. HCPCS
   b. ICD-9-CM and HCPCS
   c. ICD-9-CM
   d. ICD-0-3

2. The coding supervisor at a local hospital reviews a report that contains information about codes assigned by a new coder. The new coder is responsible for assigning codes to emergency department and ambulatory surgery unit charts. The coding supervisor was particularly concerned about information presented in the table below. Based on information in this table, which statement below is valid? The new coder:

   a. assigned first-listed diagnosis codes incorrectly from the ICD-9-CM coding manual.
   b. entered incorrect discharge dates and medical record numbers for the patients.
   c. incorrectly assigned codes for the first-listed diagnosis instead of the principal diagnoses.
   d. should have used the CPT coding manual to assign all first-listed procedure codes.

3. Which publication is released quarterly by the American Hospital Association and identifies issues and/or questions regarding ICD-9-CM coding guidelines?
   a. Coding Clinic
   b. CPT Assistant
   c. JAHIMA
   d. The Coding Edge

4. During the review of 10 records, it was noted that the following data was documented: (1) living arrangements prior to admission to home health care, (2) integumentary status, (3) activities of
daily living (ADL) status, and (4) pain status. Which data set is used to capture this type of information?

a. HEDIS  
b. OASIS  
c. ORYX  
d. UHDDS

5. The following information about patient John R. Wakefield was abstracted from his record and entered into a database. Which data set is used to capture this type of information?

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<th>Date of Birth:</th>
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<td>Time of Admission:</td>
<td>11:55 p.m.</td>
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<td>Method of Arrival:</td>
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<td>Provider NPI:</td>
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<tr>
<td>ED Procedures:</td>
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<td>3:35 a.m.</td>
</tr>
<tr>
<td>Disposition:</td>
<td>Home</td>
</tr>
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</table>

a. DEEDS  
b. MDS  
c. UACDS  
d. UHDDS

6. Which is a function of physician orders?

a. They document the provider's instructions for follow-up care and are then given to the patient or the patient's caregiver.  
c. They document the patient's current and past health status.  
d. They document the physician's instructions to other parties involved in providing care to a patient.

7. Which document would be excluded from the patient record for an elective inpatient surgery admission?

a. Allergies and ROS report  
b. Anesthesia record  
c. Discharge summary  
d. EMT care sheet

8. Based on the information provided in the note (below), documented in John Cali's patient record, in what type of health care facility is Mr. Cali being treated?

**Medication History**: Tylenol for headaches, Claritin for allergies, and Atenolol 50 mg for hypertension.

**05/06/YYYY** Mr. Cali was given 2 Tylenol capsules for complaint of headache. He was given water to take with this over-the-counter medication. Patient was observed while taking medication. Patient was then escorted back to the common area for planned group activity.
9. Which does the fifth digit of a pregnancy code identify?
   a. episode of care
   b. length of pregnancy
   c. outcome of delivery
   d. type of complication or no complication

10. A patient received scheduled chemotherapy treatment for lung cancer in the hospital outpatient department. The patient underwent removal of a malignant lung nodule four weeks ago. Which of the following diagnosis codes would be reported on the insurance claim?
    162.9 Malignant neoplasm of bronchus and lung, unspecified
    V58.1 Encounter for antineoplastic chemotherapy and immunotherapy
    V10.11 Personal history of malignant neoplasm bronchus and lung
    a. All of the diagnosis codes would be reported, in the order listed, on the claim.
    b. Code 162.9 would be reported as the only diagnosis code on the insurance claim.
    c. Code V10.11 would be reported as the first-listed diagnosis code on the insurance claim.
    d. Code V58.1 would be reported as the first-listed diagnosis code on the claim, followed by code 162.9.

11. For a patient with a documented fracture and dislocation at the same anatomical site, which is coded?
    a. dislocation only
    b. fracture and dislocation
    c. fracture only
    d. Query the physician as to which is clinically significant.

12. A 45-year-old female patient presents to the physician with a rash, right lower leg. The patient reports that she has had the rash for over six months, with no change upon application of over-the-counter topical medications. The physician examines the patient and determines that the patient has a fungal rash. Due to the history of this rash, the physician prescribes an anti-fungal medication to be taken by mouth. The patient takes the medication for three days, as prescribed, and returns to the office complaining of severe dizziness. She is found to be hypotensive upon examination during this visit. She is instructed to stop taking the oral antifungal medication, and she is given a prescription for an antifungal topical cream. The diagnosis of hypotension would be coded as a(n):
    a. adverse effect
    b. overdose
    c. poisoning
    d. toxic effect

13. For “extent of burn” ICD-9-CM category code 948, the fifth digit assignment indicates the total amount of the patient’s body that experienced:
    a. burns.
    b. no burns.
    c. second-degree burns.
    d. third-degree burns.

14. A patient presents for treatment of a bullet wound, upper leg, through the femoral shaft. The bullet passed through the skin of the leg and is lodged in bone, resulting in a fracture. This type of fracture is classified as a(n):
    a. compound closed fracture
    b. missile closed fracture
    c. missile open fracture
    d. open greenstick fracture
15. Five-year-old patient Michael Walker underwent a reduction of a tarsal dislocation that included manipulation without anesthesia. After reduction, the physician applied a short-leg cast. CPT codes 28540 and 29405-51 were reported on the insurance claim for this encounter. Based upon review of the CPT codes and description below, which statement is correct?

28540 Closed treatment of tarsal bone dislocation without anesthesia
29405-51 Application of short leg cast

a. Code 29405-51 is included in code 28540 and should not be reported separately.
b. Code 29405-51 should be reported as the first-listed procedure.
c. Codes 28540 and 29405-51 should be reported on the claim, in that order.
d. Modifier -51 should not be reported with code 28540 or code 29405.

16. A 25-year-old patient is seen in the emergency department (ED) with a complaint of RUQ abdominal pain. The patient underwent a cholecystectomy eight weeks ago. The patient states that the current location of her pain is the same as precholecystectomy surgery. The ED final diagnosis is status post cholecystectomy due to chronic cholelithiasis. The coder should:

a. assign a code for chronic cholelithiasis as an active condition.
b. code the patient's reported symptom of RUQ abdominal pain.
c. query the physician to ask if the patient has postcholecystectomy syndrome.
d. report a V code as the first-listed diagnosis code.

17. Intrathecal drugs are administered into the:

a. brain.

b. CSF.

c. nerve(s).

d. PNS.

18. Lipomas, fibromas, and adenomas are classified as:

a. benign.

b. cancer in situ.

c. malignant.

d. uncertain behavior.

19. To determine a comprehensive exam level for an evaluation and management service under the 1995 E/M coding guidelines, review the patient record to locate documentation of:

a. 5 organ systems, 3 body areas, and a complete ROS.

b. 8 body areas.

c. 8 organ systems.

d. 8 organ systems and body areas.

20. The classification of a patient into a Home Health Resource Group (HHRG) is based on information collected from the ________ data collection tool.

a. HCPCS

b. OASIS

c. RAVEN

d. RBRVS

21. In the ICD-9-CM coding system, an esophageal stricture due to a burn sustained from a house fire two years ago would be classified as a/an:

a. abnormal reaction.

b. current injury.

c. late effect.

d. mechanical complication.

22. Which of the following data sets is used by ambulatory care facilities?

a. MDS

b. OASIS

c. UACDS

d. UHDDS

23. During the incision and drainage of a deep abscess, the physician documented that the incision penetrated the fascia. To report the appropriate code, review the CPT Surgery subsection.
   a. general
   b. integumentary
   c. musculoskeletal
   d. operating microscope

24. What is the difference between the DEEDS data set and the EMEDS data set?
   a. The DEEDS data set focuses on data collection for a specific emergency department encounter, while the EMEDS data set is collected to build a health history.
   b. The DEEDS data set focuses on the collection of data to build a health history, while the EMEDS data set is collected for a specific emergency department encounter.
   c. The DEEDS data set is collected for emergency department visits, while the EMEDS data set is collected for physician office visits.
   d. The EMEDS data set is used to collect data on ambulatory encounters (e.g., outpatient surgery); while the DEEDS data set is used to collect data about emergency department visits.

25. A local safety council has requested statistics about the number of head injuries that occurred as a result of motorcycle accidents during the past year. Which coding system would be used to collect that data?
   a. HCPCS Level II
   b. ICD-9-CM
   c. Level I of HCPCS
   d. Standard Nomenclature of Injuries

26. The placement of radioactive sources into a tumor-bearing area to generate high-intensity radiation is called:
   a. brachytherapy.
   b. external beam radiation.
   c. proton beam treatment.
   d. stereotactic radiation treatment.

27. A patient underwent bypass surgery for life-threatening coronary artery disease. With the aid of extracorporeal circulation, the right internal mammary artery was grafted onto the left anterior descending artery. Saphenous vein grafts were grafted from the aorta to the diagonal, right coronary artery and the posterior descending artery. ICD-9-CM procedure codes would be reported for:
   a. aortocoronary bypass of four coronary arteries.
   b. aortocoronary bypass of three coronary arteries.
   c. single internal mammary artery bypass and aortocoronary artery bypass of three vessels.
   d. single internal mammary artery bypass, aortocoronary bypass of three vessels, and extracorporeal circulation.

28. A condition is documented as both acute and chronic in the patient record, and upon review of the ICD-9-CM Index to Diseases, the coder notices two separate subterms. In this situation, the coder should assign:
   a. a code for the acute condition only.
   b. a code for the chronic condition only.
   c. codes for both the acute and chronic conditions, and sequence the acute condition first.
   d. codes for both the acute and chronic conditions, and sequence the chronic condition first.

29. Which ICD-9-CM code listed below could be reported as a first-listed diagnosis code?
   a. E867 (Accidental poisoning by gas distributed by pipeline)
   b. M9010/0 (Fibroadenoma NOS)
   c. V27.2 (Outcome of delivery, twins, both live born)
   d. V30.00 (Single live born, born in hospital)

30. A patient admitted to a local hospital for outpatient hernia repair surgery also has a low potassium level. Intravenous potassium was ordered by the attending physician and was administered to the patient. The
attending physician did not include hypokalemia as a discharge diagnosis on the face sheet. Which action should the coder take?

a. Assign a diagnosis code for hernia only.
b. Code the hypokalemia as confirmed.
c. Query the physician about the documented low potassium level.
d. Report the low potassium level as an abnormal blood chemistry test.

31. ICD-9-CM code category 402 (Hypertensive Heart Disease), is reported for the diagnosis of:

a. cardiomegaly with hypertension.
b. congestive heart failure; hypertension.
c. hypertensive cardiovascular disease with congestive heart failure.
d. left heart failure with benign hypertension.

32. Which data set was designed to gather data about Medicare beneficiaries who receive home health services?

a. HEDIS  
b. OASIS  
c. ORYX  
d. UHDDS

33. A patient presents to the emergency department after having been in a three-car motor vehicle accident (MVA) on a local expressway. The patient is in and out of conscious and has an open femoral fracture with a possible arterial injury. The attending physician, who is also the head of the trauma service, examines the patient and documents the progress note below. Based on documentation in the progress note and the 1995 coding guidelines of E/M service, which level of evaluation and management services would be reported?

Patient is a 42-year-old male involved in a motor vehicle accident, who sustained an open femoral fracture. There is severe bleeding and possible femoral artery injury. Patient is scheduled for immediate surgical repair. Patient is not able to provide any medical history since he is in and out of conscious. Once he is stable for transport, he will be taken to operating room. No family members are present in the hospital at this time. Patient identification was retrieved from his wallet. Patient was alone in his vehicle.

a. Level 1  
b. Level 3  
c. Level 4  
d. Level 5

34. The following progress note is documented for an established patient’s office visit. Based on 1995 E/M coding guidelines, what is the level of exam that is documented for this visit?

Mary Reynolds was seen complaining of painful and swollen right elbow. Patient reports no recent injury. Mary was shoveling snow over the weekend for herself and four of her elderly neighbors. She also reports low back pain. The patient took Tylenol and Motrin in an attempt to relieve the pain. These medications did not seem to help.

S Right elbow and low back pain
O Slightly limited ROM in right elbow. Left elbow ROM normal. A small amount of swelling posterior elbow, back with limited ROM. Neurological reflexes are normal x 4. There is no bruising or redness of the skin noted for the areas of the arms or lower back. The entire trunk was examined for skin lesions. No bruising or lesions of the skin were found.
A Strain lower back and right elbow.
P Muscle relaxants for strains of back and elbow and x-ray of right elbow to rule out effusion or soft tissue damage.

a. Comprehensive  
b. Detailed  
c. Expanded Problem Focused  
d. Problem Focused
35. The use of a transverse incision or horizontal slicing to remove epidermal and dermal lesions is called:
   a. debridement.
   b. excision.
   c. laser removal.
   d. shaving.

36. A patient swallowed part of a toy and is having difficulty breathing. The toy is found to be lodged in the patient’s bronchus. The patient is scheduled for outpatient endoscopy to remove the foreign object. Which procedure would be used to retrieve this object?
   a. flexible bronchoscopy
   b. laryngoscopy
   c. open tube bronchoscopy
   d. thoracoscopy

37. Which is excluded from CPT’s definition of a surgical package?
   a. digital block anesthesia
   b. E/M visit to surgeon the day before surgery
   c. incision and drainage of wound abscess in office during global period
   d. patient evaluation in recovery room

38. In which section of the CPT coding manual is the lightning bolt symbol used?
   a. Anesthesia
   b. Surgery
   c. Medicine
   d. Pathology and Laboratory

39. A surgeon performed an intranasal lesion excision using a laser on the right and left nares of a patient. Code 30117, Excision or destruction (e.g., laser), intranasal lesion, internal approach, is reported. Which modifier should be added to code 30117?
   a. None
   b. -50
   c. -51
   d. -59

40. Which are the contributory components associated with evaluation and management system CPT codes?
   a. Counseling, Coordination of Care, and the Nature of the Presenting Problem
   b. Critical Care Time and Nature of the Presenting Problem
   c. History, Examination, and Medical Decision Making
   d. Time and Nature of the Presenting Problem

41. Which is the format of a HCPCS Level II modifier?
   a. 2-digit alphabetic or 2-digit alphanumeric
   b. 2-digit numeric
   c. 3-digit alphabetic or 3-digit alphanumeric
   d. 3-digit numeric

42. Regarding qualifying circumstance CPT codes, which statement is true? Qualifying circumstance codes are reported:
   a. as a stand-alone code for anesthesia services.
   b. for all anesthesia services provided.
   c. for all surgical procedures, inpatient and outpatient.
   d. only when they apply to that patient or situation.

43. Which code below is a CPT category II code?
   a. 0089T
   b. 1035F
   c. 20555
   d. 99100
44. In which subsection of the CPT evaluation and management section is time not a descriptive component?
   a. Consultation, hospital, initial
   b. Custodial Care Services
   c. Emergency Department Services
   d. Office Visits, new patient

45. A 66-year-old patient underwent coronary artery bypass graft (CABG) surgery for which a pump oxygenator was used. During the procedure, an anesthesiologist placed a Swan-Ganz catheter. Per CPT anesthesia guidelines, a code for the placement of the Swan-Ganz catheter is:
   a. not reported because the CABG procedure was performed under conscious sedation, for which no anesthesia code is required.
   b. reported as a qualifying circumstance based on the patient’s age.
   c. reported separately because placement of a Swan-Ganz catheter is not included in the anesthesia code.
   d. unnecessary because placement of a Swan-Ganz catheter is included in the anesthesia code.

46. Which is administered to a patient after exposure to a disease to help prevent the patient from becoming infected?
   a. antigen
   b. immune globulin
   c. toxoid
   d. vaccine

47. In order for a physician office to submit a claim for reimbursement of clinical lab testing, a ______ waiver is required.
   a. CLIA
   b. CMS
   c. OIG
   d. State

48. Which abbreviation or acronym below is used when discussing Medicare’s latest initiative to ensure provider compliance and to combat overpayment and underpayment of claims?
   a. CoP
   b. NCCI
   c. POA
   d. RAC

49. Which is used to analyze coding quality?
   a. chargemaster review
   b. chart audits
   c. evaluation and management
   d. review of systems

50. Which CPT term is used to describe lab tests that are commonly performed together?
   a. allergy codes
   b. CLIA codes
   c. panel codes
   d. quantitative codes

51. Which type of drug testing determines how much of a specific substance is present in the sample?
   a. qualitative
   b. quantitative
   c. suppression
   d. toxiod

52. To correctly report a skin lesion removal, which information is reviewed in the patient record?
   a. layer of lesion depth and size of lesion
   b. lesion morphology, anesthesia used, and location of lesion
   c. location and method of removal
   d. location, size of lesion, method of removal, and lesion morphology
53. Wound repair that requires debridement and extensive undermining would be classified as:
   a. complex repair.
   b. destruction with debridement.
   c. intermediate repair.
   d. simple repair.

54. Which lesion would warrant Mohs Micrographic Surgery?
   a. basal cell carcinoma
   b. fibroadenoma
   c. lipoma
   d. seborrheic keratosis

55. A surgical service that is considered an integral part of one or more other surgical events would be classified as a(n):
   a. add-on code.
   b. global package.
   c. separate procedure.
   d. unlisted procedure.

56. When discussing CPT category III codes, which statement below is false?
   a. Category III codes are temporary codes.
   b. Category III codes are used if applicable instead of an unlisted Category I code.
   c. Category III codes are used to collect data on performance measurement.
   d. Category III may not conform to the requirements for Category I codes.

57. Which modifier is not approved for use in ambulatory surgery units (ASU)?
   a. -25
   b. -50
   c. -51
   d. -59

58. Which CPT appendix could be useful when updating a physician office’s superbill?
   a. Appendix A
   b. Appendix B
   c. Appendix C
   d. Appendix D

59. A patient presents to a physician office with a complaint of a rash and a sore finger. The patient is examined with documentation of constitutional, integumentary, musculoskeletal, and lymphatic systems. After the patient is examined, the physician performs drainage of his subungual hematoma. The patient is provided a prescription for medication for his rash. Per CPT coding guidelines, a code from:
   a. both the evaluation and management (E/M) and integumentary subsections would be reported, with modifier -25 added to the E/M code.
   b. the evaluation and management and integumentary subsections would be reported, with modifier -25 added to the integumentary code.
   c. the evaluation and management subsection would be the only code reported.
   d. the integumentary subsection would be the only code reported.

60. Genetic testing code modifiers are located in ______ of the CPT coding manual.
   a. Appendix A
   b. Appendix I
   c. the Medicine Section
   d. the Pathology and Laboratory Section
PART II: CODING PATIENT CASES

Instructions
Assign ICD-9-CM and CPT codes to the following types of outpatient cases:

a. Hospital (e.g., outpatient treatment)  c. Operating room (e.g., operative report)
b. Emergency department  d. Physician office/clinic setting

Note:

• Assign diagnosis codes in accordance with ICD-9-CM coding conventions and instructional notations and the “Basic Coding Guidelines for Outpatient Services.” Do not assign ICD-9-CM external cause (E-codes) or morphology codes. Do not assign ICD-9-CM volume 3 procedure codes.
• Assign procedure and service codes in accordance with CPT coding guidelines and notes. Do not assign CPT Category II or Category III codes. Do not assign modifiers.
• Evaluation and management (E/M) levels are included in each case that requires assignment of CPT E/M codes. It is not necessary to determine the level of history, examination, or medical decision making.

Hospital

1. HOSPITAL OUTPATIENT PATHOLOGY REPORT
   SPECIMEN RECEIVED: Right ear cholesteatoma.
   CLINICAL HISTORY: Congenital cholesteatoma, right middle ear.
   GROSS DESCRIPTION: Received in formalin labeled “right ear cholesteatoma” are multiple fragments of pink-tan material. The specimen is filtered and forms an aggregate 0.8 × 0.5 × 0.2 cm. The specimen is entirely submitted.
   FINAL PATHOLOGICAL DIAGNOSIS: Right ear cholesteatoma. Laminated keratinized debris and detached strips of keratinizing squamous epithelium consistent with cholesteatoma.
   ICD: ___________________________
   CPT: __________________________

2. HOSPITAL OUTPATIENT RESPIRATORY THERAPY VISIT
   REASON: Chronic emphysema.
   PROCEDURE: Patient received total vital capacity procedure for measurement of the largest volume of air he could expire from his lungs. Measurement of the amount of air inhaled and exhaled was calculated according to the patient’s body size to determine lung capacity. Results indicated five liters, which is an excellent result for this patient.
   ICD: __________________________
   CPT: __________________________

3. HOSPITAL OUTPATIENT DIALYSIS CENTER VISIT
   REASON: Chronic kidney disease, Stage I.
   PROCEDURE: Hemoperfusion was performed to remove toxins from the patient’s blood and to maintain fluid and electrolyte balance due to kidneys’ dysfunction. Venipuncture was performed to draw the patient’s blood, and hemoperfusion was performed through activated charcoal. As part of the hemoperfusion procedure, blood was transfused back into the patient using a needle and catheter.
   ICD: __________________________
   CPT: __________________________

4. HOSPITAL OUTPATIENT AUDIOLOGY DEPARTMENT VISIT
   REASON: Failed hearing screening at patient’s elementary school as part of annual screening.
   Patient underwent hearing test, pure tone, air only. Earphones were placed on the patient, who was asked to respond to tones of different pitches and intensities. This limited study
resulted in appropriate responses from the patient. No further testing is needed. Patient’s hearing is normal.

ICD:________________________________________________________

CPT:________________________________________________________

**Emergency Department**

5. EMERGENCY DEPARTMENT VISIT

**Note:**

*Patient received level 1 evaluation and management service.*

HISTORY: This 64-year-old female presents to the emergency department stating that for the past few days she has had a fever and chills, has been extremely nauseas, and has had a poor appetite. Today, the patient became very tired and weak, ached all over, and had one episode of vomiting. The patient complains of no abdominal pains. Patient did say her last solid bowel movement was approx 3–4 days ago. PHYSICAL EXAMINATION: This 64-year-old female was alert, appeared acutely ill. HEENT: Patient’s mucus membranes are very dry. Neck is supple. Lungs are clear. Heart regular rate and rhythm with a 3 out of 6 high-pitched murmur heard over the entire chest. Abdomen is soft, non-tender. Bowel sounds are somewhat remarkable. There is no evidence of any ankle edema.

LABORATORY DATA: All within normal limits.

DIAGNOSIS: Viral syndrome with acute gastroenteritis and dehydration.

ICD:________________________________________________________

CPT:________________________________________________________

6. EMERGENCY DEPARTMENT VISIT

**Note:**

*Patient received level 2 evaluation and management service.*

CHIEF COMPLAINT: Fourteen-year-old male presents to the emergency department stating, “I cut my head.”

HISTORY OF PRESENT ILLNESS: This 14-year-old male fell off his bike, injuring his head and sustaining a laceration that measures 4 cm and extended through the scalp to the skull. No step-off point was palpated.

REVIEW OF SYSTEMS: Patient denies dizziness, blurred vision, or headache. Bleeding from the laceration has ceased. Patient is experiencing pain at the laceration site and of the right elbow. Slight swelling of the laceration site is noted. Patient denies loss of consciousness.

PHYSICAL EXAMINATION: Exam of HEENT revealed the ears to be clear bilaterally. EYES: Pupils were equal and reactive. Funduscopic exam was normal. THROAT: The posterior pharynx was clear. NECK: Supple. Exam of the shoulders, chest, abdomen, hips, and lower and upper extremities was unremarkable with the exception of a small abrasion of the right elbow.

PROCEDURE: Under sterile technique, five simple 4-0 prolene sutures were inserted in the scalp after the area was anesthetized with local anesthetic. The area was then dressed with a topical spray dressing and the patient was discharged after a skull x-ray revealed no apparent evidence of fracture. However, the formal report is pending. Patient was given a head injury patient education form and advised to take aspirin or Tylenol only for pain. He is scheduled to be seen by the family physician on Tuesday for suture removal.

DIAGNOSES: Scalp laceration, 4 cm. Abrasion, of right arm.

ICD:________________________________________________________

CPT:________________________________________________________

7. EMERGENCY DEPARTMENT VISIT

**Note:**

*Patient received level 3 evaluation and management service.*

**HISTORY:** This 37-year-old white female was seen in the emergency department today with a chief complaint of abdominal pain, nausea, vomiting, chills, and fever. The patient had started with pain in her abdomen on Saturday afternoon and this has not subsided much. She had fever of 103 at home, and at the present time her temperature is 104.

**REVIEW OF SYSTEMS:** She has had abdominal pain on both sides. It hurts her sometimes to walk. She has had a lot of frequency and urgency of urination but she states that it does not hurt her to urinate.

**LABORATORY DATA:** Her white blood count was 17,000 with a preponderance of polys. Her urine shows a lot of white cells, too numerous to count, albuminuria and some blood.

**PHYSICAL EXAMINATION:** Blood pressure 118/66, pulse 136, respirations 20, and temperature 104. The chest is clear to auscultation and percussion. Breath sounds are normal. No rales are heard. Heart reveals that the apex beats in the fifth interspace. A sinus tachycardia is present. No murmurs are heard. The abdomen is soft, but it is tender throughout both sides, a little more so on the right side. However, it is as bad in the right upper quadrant as it is in the right lower quadrant and quite a bit supra-pubically. There was no rebound, no referred tenderness. Rectal examination revealed quite a bit of tenderness when the bladder was palpated but otherwise no particular tenderness in the pelvis. The peritoneum is quite excoriated, probably due to infected and very concentrated urine.

**PLAN:** The patient was hydrated and started on antibiotics, administered medication for the temperature elevation, and a culture and sensitivity of the urine was ordered. She is scheduled to return for recheck tomorrow at 9 a.m.

**IMPRESSION:** Urinary tract infection.

**ICD:**

**CPT:**

8. EMERGENCY DEPARTMENT VISIT

**Note:**

*Patient received level 3 evaluation and management service.*

This patient is a 20-year-old male who presents to the emergency department with a history of depression and apparently is under the care of his psychiatrist, Dr. Drake. Patient threatened to shoot himself in the abdomen twice on Sunday and, in fact, he carried out that suicidal ideation by having a loaded gun that was cocked and ready to fire. Since that time, he has continued to be depressed and was brought here, to the Crosby Medical Center ED, today by police. Apparently, the patient cried all the way over to the ED and then became very quiet here. When questioned he was tearful, claimed he had no intention of harming himself today but he wanted to see Dr. Drake. This patient is an alert but depressed-appearing white male who is tearful and sullen and answers mostly by shaking his head “yes” or “no” or not at all. Dr. Doug was called and he will be admitting the patient to the Karr Valley Psychiatric Hospital.

**ASSESSMENT:** Recurrent depression. Suicide attempt.

**PLAN:** Transfer to Karr Valley Psychiatric Hospital for inpatient admission.

**ICD:**

**CPT:**

Operating Room

9. OPERATIVE REPORT
PREOPERATIVE DIAGNOSIS: Basal cell carcinoma, skin of left jaw line, 12 mm
POSTOPERATIVE DIAGNOSIS: Basal cell carcinoma, skin of left jaw line, 12 mm
OPERATION: Excision of 1.2 cm lesion, skin of left jaw line, and closure with Rhomboid flap.
ANESTHESIA: Local 1% Lidocaine with 1:100,000 Epinephrine.
INDICATIONS FOR PROCEDURE: This patient is a pleasant gentleman who was seen in my office with a lesion on his jaw line. This was felt to be a basal cell carcinoma. We discussed removal and he wished to pursue it. He was made aware of the risks of bleeding, infection, scarring, and recurrence and wished to proceed.
PROCEDURE: The area of planned incision was outlined with a marking pen, infiltrated with local anesthetic, prepped with Betadine solution and sterile drapes applied. An incision was made around the lesion in a Rhomboid pattern, carried through skin and subcutaneous tissue and the lesion was removed. It was tagged with a suture at the 12 o'clock position. A Rhomboid flap was planned, elevated and transposed into the defect. It was inset with interrupted buried 6-0 PDS sutures in simple interrupted running 6-0 Prolene sutures. It was dressed with Bacitracin and he tolerated it well.

ICD: 
CPT: 

10. OPERATIVE REPORT
PREOPERATIVE DIAGNOSIS: Cervical dysplasia via Papanicolaou smears and colposcopy.
POSTOPERATIVE DIAGNOSIS: Cervical dysplasia via Papanicolaou smears and colposcopy.
OPERATION: Cold cone biopsy of cervix. Fractional dilatation and curettage of uterus.
ANESTHESIA: General
CLINICAL POINTS AND DIAGNOSIS: The patient is a 48-year-old, white female who has had cervical dysplasia on Papanicolaou smears approximately 4-5 times in the last year. She had colposcopy done 6/12/02 which showed mild atypia. The recent Papanicolaou smears, however, have also shown dysplasia. The patient is currently taking no medications.
PROCEDURE: The patient was taken to the operating room and after preoperative medication she was prepped and draped in the dorsolithotomy position. Pelvic examination revealed the uterus essentially normal size, shape, symmetry, anterior in position and movable, with a mild amount of descensus present. The adnexal regions felt clear. A weighted speculum was placed in the posterior vagina. The anterior lip of the cervix was grasped with a single tooth tenaculum and the endometrial cavity sounded to a depth of approximately 4 ½ inches. Cold cone biopsy of the cervix was then performed using a #11 blade. A specimen was sent in 2–3 pieces to Pathology for examination. The endocervix was then dilated with Hegar dilators and the endocervix was curetted, specimen sent separately to Pathology for examination. The endometrial cavity was separately curetted, the specimen sent separately to Pathology for examination. The uterine cavity seemed essentially normal in size, shape and symmetry at the time of dilatation and curettage. Bleeding points on the exocervix and endocervix were then cauterized with the Bovie unit and the cervix was bilaterally ligated with #0 chromic catgut.
Blood loss was approximately 100 cc. The tenaculum marks on the exocervix were also cauterized with the Bovie unit. The patient tolerated the procedure well and was sent to the recovery room in good condition.

ICD: 
CPT: 

11. OPERATIVE REPORT
POSTOPERATIVE DIAGNOSIS: Bicompartmental osteoarthritis, left knee, with meniscal tear. Baker’s cyst.
OPERATION: Arthroscopy, left knee with chondroplasty of bicompartamental osteoarthritis. Arthroscopic partial left posterior horn medial meniscectomy.

INDICATIONS: The patient is a 38-year-old man with bilateral knee arthritis. Both are equally symptomatic. The left has been evaluated with an MRI identifying a 4.7 × 1.3 × 1.3 Baker’s cyst with osteoarthritis changes and possible meniscal pathology. It was suggested that he undergo the above operative procedure to decrease knee pain as he continued with pain despite anti-inflammatories, isometric exercises, and knee braces. Risks in the procedure including infection, phlebitis, neurovascular or tendon injury, anesthetic complications, failure of the procedure amongst others were discussed and accepted.

PROCEDURE: The patient was brought to the operating room and given a general anesthetic. He was given prophylactic Ancef 1 gm push. A 34 inch tourniquet was placed proximally and the extremity was exsanguinated and the tourniquet elevated to 350 mmHg. An Acufex knee holder was used. The knee was scrubbed, prepped and draped in routine sterile fashion.

Prints were taken of the intra-articular anatomy, one set of which was provided to the family. The scope was passed through the anterolateral portal to the patellofemoral joint. There was a definite synovial effusion. There was no purulence to it.

The patellofemoral joint showed evidence of osteoarthritis. This was characterized by outer bridge 3, nearly grade 4, changes, particularly on the fovea of the femur. The patella tracked normally, but there was a near full thickness loss. There was an irregular crevice in the fovea. The scope was then passed into the medial compartment where osteoarthritis was noted as well. This was characterized by outer bridge 3 changes over most of the medial femoral condyle. It was associated with the complex medial meniscal tear, including a radial tear, horizontal cleavage, and structurally mucoid tissue. Anterior cruciate ligament was normal and the lateral compartment was normal. It was felt the procedure of choice would be partial medial meniscectomy and chondroplasty.

Chondroplasty was performed with a 3.5 aggressive razor cut power tool. Any structurally loose articular cartilage on the patellofemoral and medial compartment were addressed. This was not an abrasion chondroplasty procedure. The partial meniscectomy was performed by morselizing the degenerative torn posterior mid-third junction site. It was taken back to a firm red-white level and further smoothed with the use of a power tool. There was a near complete meniscectomy, particularly at the junction of the posterior mid-third. Satisfied with the procedure, the wound was closed.

Closure was done repairing the skin portals with 4-0 Monocryl. It was felt that by addressing the intra-articular pathology, the synovial fluid would be hopefully alleviated, and the Baker’s cyst would return back to a normal configuration and not require a separate operative procedure. He was told this would be expected 80 percent plus of the time. A pressure dressing was applied. There was normal capillary refill, so the patient was transferred to the Recovery Room in stable condition.

ICD:____________________________________
CPT:____________________________________

12. OPERATIVE REPORT
PREOPERATIVE DIAGNOSIS: Sebaceous cyst, superior natal cleft.
POSTOPERATIVE DIAGNOSIS: Sebaceous cyst, superior natal cleft.
OPERATION: Excision of sebaceous cyst, superior natal cleft.
ANESTHESIA: IV Versed and 1% lidocaine.
COMPLICATIONS: None.
SPECIMENS: Clustered sebaceous cyst of superior natal cleft.
DRAINS: None.
INDICATIONS: The patient is a 74-year-old white female with a clustered group of approximately 5–6 sebaceous cysts of the superior and left side of her natal cleft causing disability and pain when the patient attempted to sit. This overall measured approximately 4 × 4 cm grouping.
PROCEDURE: After placement of all appropriate monitoring devices, the patient was in prone position. The natal cleft was prepped and draped in the usual sterile fashion. IV Versed was administered.
One percent Lidocaine field block was accomplished in, over, and around the natal cleft area of the sebaceous cysts, which were then excised through a longitudinal elliptical incision measuring approximately $4 \times 3$ cm. The skin and subcutaneous tissue and cyst was then excised using sharp dissection. Electrocautery for hemostasis until the area was circumferentially excised in their entirety. The specimen was handed off for pathologic examination. The wound was then closed using interrupted sutures of 3-0 nylon. Sterile dressing was then placed. The patient tolerated the procedure well and was taken to the recovery room in satisfactory condition. All sponge and instrument counts reported correct at the end of the case.

Physician Office Clinic

13. PHYSICIAN OFFICE SURGERY

Patient returns to the office for scheduled office surgery to remove an irritated 0.6 cm nevus, face, which is located on the right side of her nose.

Previous history reveals this 59-year-old woman has enlarging nevus of her face, which is chronically irritated by her glasses. It does not bleed. No personal or family history of skin cancer. Past medical history reveals high cholesterol, mitral valve prolapse. She does not smoke. She is unemployed. Current medications include Atenolol, Lipitor, multi-vitamins, cranberry juice, calcium, and low-dose aspirin. She has no known allergies. Physical examination reveals patient has fair skin. There is a 0.6 cm pale fleshy nevus on the right side of the nose where the glasses ride.

PREOPERATIVE DIAGNOSIS: Irritated 0.6 cm nevus, face.

POSTOPERATIVE DIAGNOSIS: Irritated 0.6 cm nevus, face.

PROCEDURE: Excision of one lesion, face (right side of nose), 0.6 cm, with simple closure.

The patient’s face was prepped and draped in the usual sterile fashion. One percent Lidocaine field block was accomplished in, over, and around the right side of the patient’s nose. The 0.6 cm nevus was then excised without incident. The specimen was prepared off transportation to the hospital for pathologic examination. The wound was closed using interrupted sutures of 3-0 nylon. Sterile dressing was placed. The patient tolerated the procedure well.

The patient was told to leave the bandage in place and avoid getting water or soap on that area. Patient will return to the office in one week for recheck at which time bandage will be replaced.

14. PHYSICIAN OFFICE VISIT

Note:

Patient received level 3 evaluation and management service.

CHIEF COMPLAINT: Patient presents to the office today with diagnosis of hyperparathyroidism.

HISTORY OF PRESENT ILLNESS: This is an established patient who has had multiple episodes of kidney stones. Work up of this problem revealed hypercalcemia with increased PTH level. The patient had a recent sestamibi scan performed, which showed a parathyroid adenoma in the right lower pole area. The patient was sent for evaluation for a possible parathyroidectomy.

PAST MEDICAL HISTORY: No known allergies. Negative history of alcohol or tobacco use. Current medications include Fosamax once per week. No past surgical history. Past illnesses include kidney stones, automobile trauma, and cardiac arrhythmia (occasional PVCs).

LABORATORY DATA: I reviewed the sestamibi films with the patient in my office and showed him that there is a clearly evident abnormal parathyroid gland in the right lower pole area of the neck.

ASSESSMENT: Hyperparathyroidism secondary to a single parathyroid adenoma.

PLAN: We plan to do a neck exploration with parathyroidectomy. Prescription for Darvocet-N 100 q4h pm with 1 refill (for post-op pain) given to patient. Risks, benefits, alternatives, and potential complications have been discussed with patient and/or family and informed consent obtained for procedure/sedation. Patient's medical risk for this procedure at this time is acceptable.

ICD: __________________________

CPT: __________________________

15. PHYSICIAN OFFICE CARDIOLOGY CONSULTATION

Note:

Patient received level 3 evaluation and management service.

A pleasant 69-year-old female presents to the cardiologist's office with past medical history of coronary artery disease requiring coronary artery bypass graft surgery in 1998, hypertension, and who was previously admitted to the hospital with symptoms of chest pain and diaphoresis, suggestive of angina.


REVIEW OF SYSTEMS: Negative for syncope or presyncope. No orthopnea or paroxysmal nocturnal dyspnea. History is negative for cerebrovascular accident. Cardiac history, as mentioned above. No history suggestive of claudication. No nausea, vomiting, diarrhea, or frequency. All systems were reviewed, and pertinent findings are as noted.

PHYSICAL EXAMINATION: Demonstrates a blood pressure of 147/76, pulse rate of 69, respiratory rate of 16. Afebrile. There is no jugular venous distension. Normal carotid upstrokes. No audible bruits. Examination of the heart revealed S1, S2. No S3. S4 is heard. Lungs are clear. Abdomen is soft. Bowel sounds present. Extremities demonstrate no pedal edema. Three plus distal pulses are noted, which are symmetric and equal in volume bilaterally. Twelve-lead EKG demonstrated sinus rhythm with T-wave inversions in the anterolateral leads. Compared to prior EKGs, these are not new changes.

LABORATORY DATA: Troponin is normal. Potassium is 3.6. BUN is 11, and creatinine is 0.8.


PLAN: Serial troponins are recommended to exclude myocardial infarction. We will add nitro patch to current regimen at 0.2 mg/hr. Will discharge to home. There is no evidence of myocardial infarction based on cardiac enzymes.

Thank you for allowing us to participate in the care of this patient, and we will follow her with you.

ICD: __________________________

CPT: __________________________

16. URGENT CARE CENTER VISIT

Note:

Patient received level 2 evaluation and management service.

HISTORY: This 65-year-old man was seen today for his first visit at the urgent care center because of his complaint of pain in the left foot. This has been present since about May. He was in Alabama and
went to the clinic there where he was diagnosed as having congestive heart failure, which caused swelling of his left lower extremity. This may also be compounded by the fact that he previously had a vein removed for a coronary artery bypass. He describes the pain as being primarily in his heel rather than in his ankle or lower leg. He was also previously seen by the ambulatory care clinic at the local hospital, where it was thought that he has vascular insufficiency of the left leg and foot.

PHYSICAL EXAMINATION: Lower extremities are normal, as far as weight-bearing is concerned. Both legs are warm. There are no skin changes. He has 1+ pulses in both feet, both dorsalis pedis and posterior tibial.

ASSESSMENT: X-rays were reviewed. He has a calcaneal spur on his left heel, which is likely the cause of his pain. He is being referred to the Podiatry Service and has a scheduled appointment on September 4 for evaluation. As he was leaving the clinic, he complained of pain in his knees, particularly at night, and x-rays of his knees were ordered. He likely has degenerative joint disease in his knees as a cause of his pain.

PLAN: He will be seen in two weeks for evaluation of his knee x-rays.

IMPRESSION: Calcaneal spur, left heel.

ICD: 

CPT: 