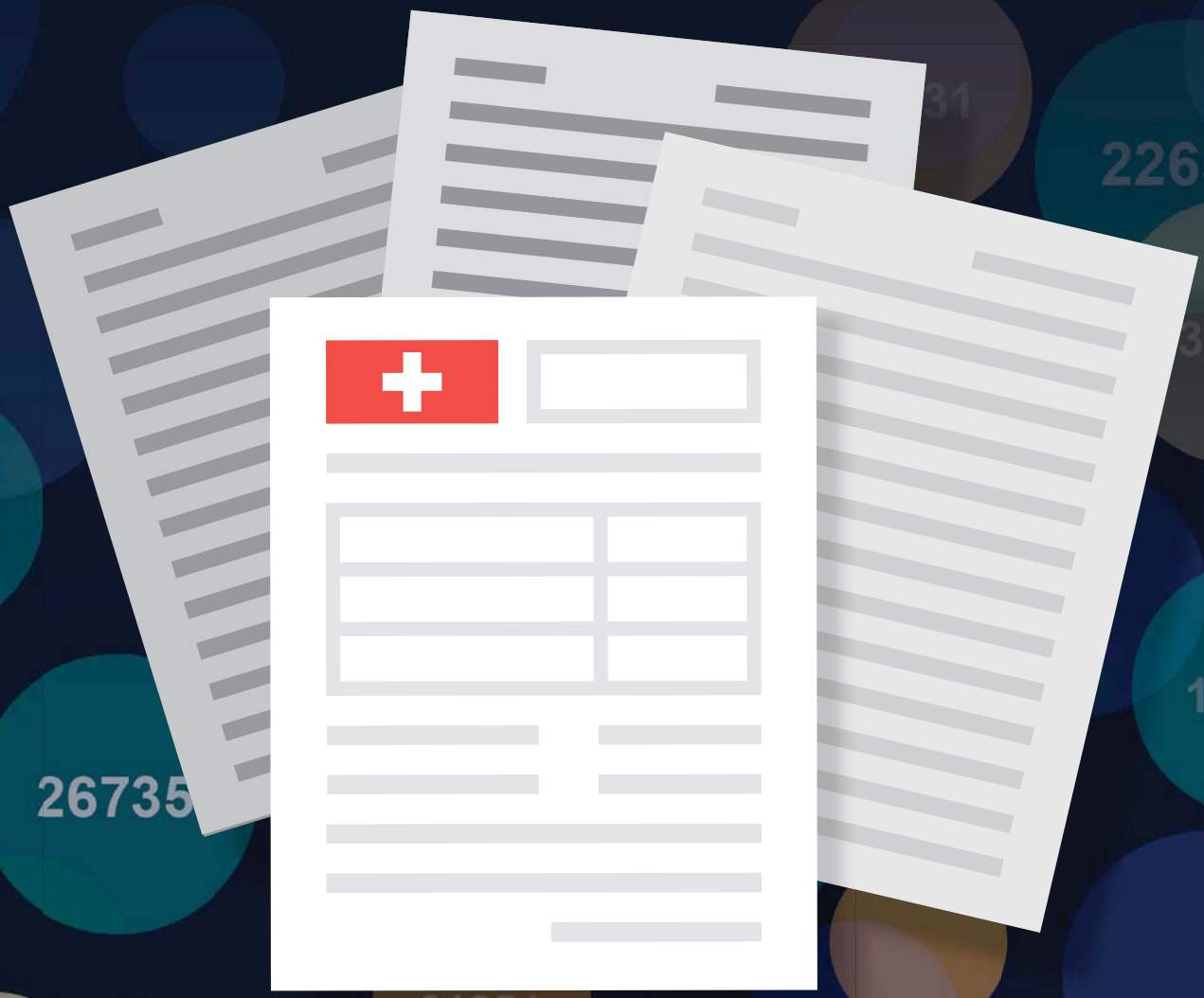
JustCoding

Clinical Scenario Workbook:

2018 CPT® Edition



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JustCoding

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Introduction

JustCoding's Clinical Scenario Workbook: 2018 CPT® Edition contains 52 sample clinical cases to provide hands-on reinforcement of coding concepts. The cases range in difficulty, length, and medical specialty. They are designed to simulate real-life coding processes for training and assessing new coders or keeping skills sharp for experienced staff.

Each case includes provider documentation or operative reports based on real clinical scenarios. Cases offer a variety of documentation styles to reflect inconsistencies between different electronic health record systems and providers.

After reviewing the cases, coders should report the most applicable ICD-10-CM diagnosis codes and all relevant CPT procedure codes. Answer keys are included at the end of each chapter with the correct codes to report for each case. The answer keys were created by HCPro's coding instructors and include:

- A list of reportable ICD-10-CM and CPT codes, as well as rationale for using those codes
- Applicable coding guidance, where appropriate, including references from the *ICD-10-CM Official Guidelines for Coding and Reporting*, the AHA's *Coding Clinic*, *CPT Assistant*, and the *NCCI Manual*
- Instructions for looking up ICD-10-CM codes and certain CPT codes in the coding manuals
- Notation of which ICD-10-CM codes are assigned to hierarchical condition categories (HCC) to help familiarize coders with diagnoses that factor into risk adjustment

All codes and guidance are up to date as of January 1, 2018. The ICD-10-CM and CPT code sets as well as any guidance are subject to changes. These cases therefore should not be used as a guide for coding any real claims.

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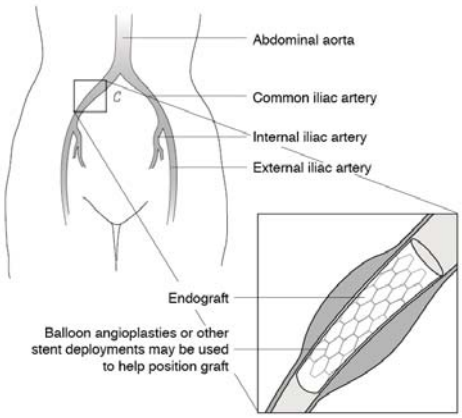
Cardiovascular System Scenarios

Case 1: Abdominal Aortic Aneurysm Repair

FIGURE 1.1 **Endovascular graft placement**



Provider documentation:

Preoperative diagnosis:

Abdominal aortic aneurysm (AAA)

Postoperative diagnosis:

AAA, right renal artery stenosis

Operation performed:

1. Endovascular repair of abdominal aortic aneurysm using fenestrated endograft system, Cook Z-Fen stent graft system

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2. Reduction of a sliding inguinal hernia
3. Balloon angioplasty of right renal artery

Anesthesia:

General

Complications:

None

Procedure:

The patient was brought to the operative room. He underwent general anesthesia. The abdomen and lower extremities were prepped and draped in sterile fashion. Both femoral vessels were exposed through transverse bilateral inguinal incisions. There was a fairly large sliding hernia in the inguinal area with the hernia sac extending over the common femoral artery. Both femoral vessels were then exposed and circumferentially controlled proximally and distally. Both sides were then cannulated in retrograde fashion. There was a significant amount of tortuosity involving the iliac arteries.

We advanced a 6-French sheath on the left side, which was chosen as the contralateral side for delivery purposes. A Lunderquist stiff wire was advanced, allowing the iliac system to straighten out. At this time, we placed a 20-French Cook sheath in the left iliac system without difficulty. We proceeded to cannulate the hub of the 20-French sheath on the left side and successfully cannulated both renal arteries, placing a Rosen wire into the left renal artery without difficulty. There was stenosis at the origin of the right renal artery. This was cannulated and balloon angioplasty performed of the origin of the right renal artery using a 5 × 20 mm Viatrac balloon. In a similar fashion, Rosen wire was left in the right renal artery for marking purposes.

The main body of the device was chosen and had been designed using the patient's CT scan. There were two small fenestrations for each renal vessel with a scallop for the superior mesenteric artery. The graft diameter was 30 mm and it was two main body stents. This was oriented and successfully advanced. The device was then deployed using aligning markers. We then cannulated the distal aspect of the proximal graft and were able to successfully cannulate each of the small renal fenestrations extending out into the renal vessels with Glidewires.

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Six-French Ansel flex sheaths were then advanced into the origin of both renal arteries. ICast 6 ×22 stents were then advanced into the origin of both renal vessels. Two stent links were left in the main body of the device. At this time, each renal stent was successfully deployed. A 10 × 20 mm angioplasty balloon was then used to complete the deployment at the very proximal end and anchor the stent in place.

The distal body was chosen and advanced via the right iliac artery. This was advanced with approximately one stent extending distally and successfully deployed down to the contralateral gate. The contralateral gate was successfully cannulated from the left iliac artery. We then completed our left iliac deployment using a 74 × 20 mm iliac limb. At this time, on the ipsilateral right side, the final two stents of the distal body were deployed, and we completed the deployment of the right iliac system using a 56 × 20 mm iliac stent. The Coda balloon was used for the junction between the components. At this time, a completion angiogram was performed. The superior mesenteric artery was patent as were both renal stents and renal perfusion. We angioplastied just distal to the renal stent deployment.

At this time, sheaths and wires were withdrawn. The arteriotomies were closed using 5-0 Prolene suture. The large hernia on the right inguinal area was reduced, and we used a mesh Bard plug placed and secured it anteriorly with Prolene suture. Each inguinal wound was then irrigated and closed with 2-0 Vicryl, 3-0 Vircyl and 4-0 Monocryl subcuticular stitch. The patient was extubated in the operating room and transported to the recovery room in satisfactory condition. Total fluoroscopy time was 80.7 minutes. Total recorded Visipaque was 130 mL full strength.

Codes:

CPT:

ICD-10-CM:

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