OB/GYN – Scenario #1

Narrative Title: PCS 1  
Narrative Desc: Pregnancy w/previous C-section

<table>
<thead>
<tr>
<th>Patient Info:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>29</td>
</tr>
<tr>
<td>Height:</td>
<td>64</td>
</tr>
<tr>
<td>BP:</td>
<td>138/75</td>
</tr>
<tr>
<td>Resp-rate:</td>
<td>16</td>
</tr>
<tr>
<td>Gender:</td>
<td>Female</td>
</tr>
<tr>
<td>Weight:</td>
<td>155</td>
</tr>
<tr>
<td>Pulse:</td>
<td>70</td>
</tr>
<tr>
<td>Temp:</td>
<td>98.7</td>
</tr>
</tbody>
</table>

Chief Complaint: Patient is in the office today for her 6th month check up.

Past Med. History: Patient has had a previous C-Section 2 years ago. She is gravida 2, para 1, abortions 0.

Office Visit Notes: Patient is in today for her 6th month visit. She has had a previous C-Section and we are monitoring her closely as the fetus appears larger than her last baby and she has gained 30 pounds during this pregnancy. We are concerned with the strain on the uterus at the previous C-Section site. She had a classic C-Section, due to the breech presentation of the fetus. There have not been any signs of uterine distress at this time. Will continue to monitor as pregnancy progresses.

Drugs: None

The following ICD-9 Code(s) were chosen:

- 654.23  
- V23.9  
- 656.63

The following ICD-10 Code(s) were chosen:

- 034.21  
- O09.91  
- 036.6201

- 026.02  
- Z3A.24  
- CM-026.849
Patient Info:

- **Age:** 42
- **Height:** 64
- **BP:** 145/82
- **Resp-rate:** 16
- **Gender:** Female
- **Weight:** 160
- **Pulse:** 75
- **Temp:** 98.6

Chief Complaint: Patient is in the office today for her 7th month check up.

Past Med. History: Patient has had a previous delivery 2 years ago. She is gravida 2, para 1, abortions 0.

Office Visit Notes: This 42, elderly multigravida patient is seen today for her 7th month check-up. Fetal heart tones are strong and running 150 beats per minute. Patient experiences occasional heartburn and leg cramps. Weight gain has been only 15 pounds to date. BP is elevated but not of concern. Urine is clear and negative for protein, no signs of pedal edema. Will continue routine visits.

Drugs: None

The following ICD-9 Code(s) were chosen:
- V23.82
- V22.1
- 659.63

The following ICD-10 Code(s) were chosen:
- O09.523
- 9.523
- CMZ34.80
- CM009.523
## OB/GYN – Scenario #3

**Narrative Title: GCA 2**

**Narrative Desc: General Cancer**

### Patient Info:

<table>
<thead>
<tr>
<th>Age: 51</th>
<th>Height: 63</th>
<th>BP: 138/70</th>
<th>Resp-rate: 16</th>
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</thead>
<tbody>
<tr>
<td>Gender: Female</td>
<td>Weight: 126</td>
<td>Pulse: 70</td>
<td>Temp: 98.7</td>
</tr>
</tbody>
</table>

### Chief Complaint:

Patient being discharged from hospital following treatment of generalized symptoms related to her cancer.

### Past Med. History:

Patient was diagnosed with cancer 1 month ago. To date primary site has not been identified.

### Office Visit Notes:

Patient was admitted for general symptoms and weakness related to her cancer. She is being discharged home with instructions for diet, vitamin supplements and exercise as tolerated. The patient will continue with her chemotherapy regimen.

### Drugs:

None

### The following ICD-9 Code(s) were chosen:

- 780.79
- 995.29
- 239.9
- 199.0

### The following ICD-10 Code(s) were chosen:

- R53.0
- T50.905A
- D49.9
- R53.1
- C80.1
OB/GYN – Scenario #4
Narrative Title: PRE 1
Narrative Desc: Pre-Surgical Exam

Patient Info:

<table>
<thead>
<tr>
<th>Age</th>
<th>Height</th>
<th>BP</th>
<th>Resp-rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>66</td>
<td>140/80</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Gender</th>
<th>Weight</th>
<th>Pulse</th>
<th>Temp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>185</td>
<td>75</td>
<td>98.6</td>
</tr>
</tbody>
</table>

Chief Complaint: Patient being seen today for pre-surgical exam and bloodwork.

Past Med. History: This patient is para 4, gravida 4 and has heavy menstrual periods for the past 3 years. She is a non-smoker.

Office Visit Notes: Patient being seen in the office today for blood work prior to the surgery planned for Tuesday of next week. I reviewed the specific surgery, potential outcomes and post-operative restrictions she will have after the hysterectomy. Due to the patient's weight and elevated BP I discussed dietary restrictions and encouraged her to work on losing weight after the surgery. Patient states that she has the listing of medications that she is to avoid prior to surgery.

Drugs: None

The following ICD-9 Code(s) were chosen:

- V72.63
- V65.3
- 626.2
- 401.9
- V72.84

The following ICD-10 Code(s) were chosen:

- Z01.818
- Z01.812
- I11.9
- Z71.3
- N92.1
OB/GYN – Scenario #5
Narrative Title: MGN 1
Narrative Desc: Meningococcal vaccine

Patient Info:

<table>
<thead>
<tr>
<th>Age</th>
<th>Height</th>
<th>BP</th>
<th>Resp-rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
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<tr>
<td>Gender</td>
<td>Weight</td>
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</tr>
<tr>
<td>Female</td>
<td>110</td>
<td>72</td>
<td>98.6</td>
</tr>
</tbody>
</table>

Chief Complaint: Patient is being seen for Meningitis vaccine.

Past Med. History: Patient has had no remarkable history of illnesses or surgeries and has been seen at this office before. She is up to date on all other immunizations.

Office Visit Notes: Patient and her mother are requesting the Meningococcal vaccine since she will be working as a camp counselor and living in close proximity to several different groups of campers. Vaccine given in left upper arm per patient's request. Patient and mother received information as to possible adverse effects and instruction to call office if any of these conditions should occur.

Drugs: Meningococcal vaccine

The following ICD-9 Code(s) were chosen: V05.9, V01.84

The following ICD-10 Code(s) were chosen: Z23
OB/GYN – Scenario #6
Narrative Title: HPV 1
Narrative Desc: Human Papilloma Virus

Patient Info:

<table>
<thead>
<tr>
<th>Age</th>
<th>Height</th>
<th>BP</th>
<th>Resp-rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
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<tr>
<td>Gender: Female</td>
<td>Weight: 110</td>
<td>Pulse: 72</td>
<td>Temp: 98.6</td>
</tr>
</tbody>
</table>

Chief Complaint: Patient requesting to receive the HPV vaccine, Gardasil.

Past Med. History: Patient is a 1 pack/day smoker. She has a family history of cervical cancer. No other significant medical history.

Office Visit Notes: Patient is requesting the HPV vaccine. She says that she is concerned with her family history and feels this vaccination will provide her with added protection from getting cervical cancer. Patient states she has not been sexually active. Explained that the vaccination does not protect the patient from sexually transmitted diseases and that it is effective in preventing certain virus strains of HPV. Explained to Patient Gardasil helps protect against 2 types of HPV that cause about 75% of cervical cancer cases, and 2 more types that cause about 90% of genital warts cases. Explained that she is still at risk for getting cervical cancer and will need to be vigilant about getting regular PAP smears. Explained possible adverse effects, and that she will need to return for 2 more doses. Patient states she understands and requests the immunization. Gardasil given in the upper right arm. Patient instructed to call the office if she has any negative reactions to the immunization. Patient also encouraged to quit smoking and provided with information on programs available to help her quit. Patient to schedule appointments for 2 months and for 8 months (6 months after the second dose is administered).

Drugs: HPV Vaccine

The following ICD-9 Code(s) were chosen:

- V04.89
- V16.49
- 90649

The following ICD-10 Code(s) were chosen:

- Z23
- Z80.49
Patient Info:

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<th>Age</th>
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<th>Resp-rate</th>
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</thead>
<tbody>
<tr>
<td>41</td>
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<td>128/78</td>
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<th>Gender</th>
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<tbody>
<tr>
<td>Female</td>
<td>145</td>
<td>76</td>
<td>98.6</td>
</tr>
</tbody>
</table>

Chief Complaint: Patient seen in office for annual exam and complained of bleeding with bowel movements.

Past Med. History: Patient has a negative history and her only medication is a daily Multivitamin.

Office Visit Notes: This patient is known to me. She states that she has noticed that for the past 2 weeks, she sees blood on the toilet paper when she wipes. She denies that the blood appears to be in the stool itself. She states that she has suffered some constipation lately. Upon exam, there appears to be a first degree hemorrhoid. There is no protrusion outside of the anus and no active bleeding currently. Advised patient on a high fiber diet, to drink plenty of water and to try and get daily exercise. Advised patient to try OTC Preparation H and if there is not any improvement in symptoms in 1 - 2 weeks, to return to the office for follow-up.

Drugs: Preparation H

The following ICD-9 Code(s) were chosen:

V72.31  455.0  455.6
455.3  564.00

The following ICD-10 Code(s) were chosen:

Z01.411  K64.0  K59.00
CM-K64.4
Patient Info:

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<th>Resp-rate</th>
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</thead>
<tbody>
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<td>62</td>
<td>122/70</td>
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<table>
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<th>Weight</th>
<th>Pulse</th>
<th>Temp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>125</td>
<td>70</td>
<td>98.7</td>
</tr>
</tbody>
</table>

Chief Complaint: Patient came in today requesting a tetanus booster.

Past Med. History: Patient is known to me and has a very healthy lifestyle. She obtains her annual check-up from me and per Patient, sees no other physician. She has no previous surgeries.

Office Visit Notes: Patient requested and received a tetanus booster. No other service was provided today.

Drugs: Tetanus booster

The following ICD-9 Code(s) were chosen:
- V03.7
- V06.5

The following ICD-10 Code(s) were chosen:
- Z23
- CM-Z23
Patient Info:

<table>
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<tr>
<th>Age</th>
<th>Height</th>
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<th>Resp-rate</th>
</tr>
</thead>
<tbody>
<tr>
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<td>65</td>
<td>114/78</td>
<td>18</td>
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</tbody>
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<table>
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<th>Weight</th>
<th>Pulse</th>
<th>Temp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>125</td>
<td>72</td>
<td>98.6</td>
</tr>
</tbody>
</table>

Chief Complaint: Patient is here for her annual Pap smear and exam.

Past Med. History: Patient has no significant medical history other than taking Seasonique for birth control, all immunizations are current.

Office Visit Notes: This is a new patient here for her annual Pap smear and exam. Slides were taken from the cervix and examined under a microscope. Unspecified abnormal cytologic findings were found. These findings were discussed with the patient and it was recommended to have a colposcopy scheduled for further analysis. The procedure will be scheduled in the next 2 weeks and patient will be contact of the exact date and time.

Drugs: Seasonique

The following ICD-9 Code(s) were chosen: V72.31 795.09

The following ICD-10 Code(s) were chosen: Z01.411 R87.820
OB/GYN – Scenario #10
Narrative Title: ACV 1
Narrative Desc: Other abnormal cytological findings on specimens from vagina

**Patient Info:**

<table>
<thead>
<tr>
<th>Age</th>
<th>Height</th>
<th>BP</th>
<th>Resp-rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>67</td>
<td>140/78</td>
<td>20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Weight</th>
<th>Pulse</th>
<th>Temp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>180</td>
<td>82</td>
<td>98.6</td>
</tr>
</tbody>
</table>

**Chief Complaint:** Patient is here for a colposcopy.

**Past Med. History:** Patient takes Crestor 10 mg daily and Zestril 30 mg daily for HTN. Patient had TAH 2 years ago for fibroids.

**Office Visit Notes:** This patient is known to me. Her specimens from the vagina showed ACG or atypical glandular cells of undetermined significance. She is here today for colposcopy and biopsy of the affected area of the vagina. The procedure was performed and she tolerated it well. Ibuprofen was prescribed for discomfort and patient was told to monitor for signs of excessive bleeding or increased pain. Patient to report any symptoms related to her procedure today to me.

**Drugs:** Crestor, Zestril, ibuprofen

**The following ICD-9 Code(s) were chosen:**

795.1

**The following ICD-10 Code(s) were chosen:**

R87.628
OB/GYN – Scenario #11
Narrative Title: IMP 1
Narrative Desc: Irregular Menstrual Period

<table>
<thead>
<tr>
<th>Patient Info:</th>
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<tbody>
<tr>
<td>Age: 17</td>
<td>Height: 64</td>
<td>BP: 120/70</td>
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</tr>
<tr>
<td>Gender: Female</td>
<td>Weight: 120</td>
<td>Pulse: 70</td>
<td>Temp: 98.6</td>
</tr>
</tbody>
</table>

**Chief Complaint:** Patient has been having irregular periods, with the variation of time between cycles ranging from 10 to 20 days.

**Past Med. History:** Patient is up to date on immunizations. She has no surgical history and has been having regular check ups at this office with no other known medical condition. Her periods started when she was 12, with a regular 28 day cycle. Within last 6 months they have been irregular with 38 to 58 days in-between cycles.

**Office Visit Notes:** Patient came to the office as she is concerned about the irregularity of her cycle. We discussed possible reasons, but there has not been any significant change to her weight (<5lbs) over the past year, she is not anorexic or bulimic; she has not increased her exercise and is not on any sports teams at school. However she is stressed and under pressure to maintain her GPA to be accepted at Harvard, so she has been spending a lot of time studying and has had irregular sleep patterns. Pregnancy test was negative. Ordered blood work to check on hormone levels. Instructed pt to return to the office after her next cycle and we will discuss the outcome of the blood work. She should discuss with her mother the possibility of birth control as a way to regulate her periods.

**Drugs:** None

<table>
<thead>
<tr>
<th>The following ICD-9 Code(s) were chosen:</th>
<th>The following ICD-10 Code(s) were chosen:</th>
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<tbody>
<tr>
<td>626.4</td>
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<td>V72.41</td>
<td>Z32.02</td>
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<td>CMN92.6</td>
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</table>
OB/GYN – Scenario #12
Narrative Title: UTI 3
Narrative Desc: Urinary Tract Infection

Patient Info:

<table>
<thead>
<tr>
<th>Age: 44</th>
<th>Height: 67</th>
<th>BP: 135/72</th>
<th>Resp-rate: 16</th>
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</thead>
<tbody>
<tr>
<td>Gender: Female</td>
<td>Weight: 165</td>
<td>Pulse: 70</td>
<td>Temp: 100.2</td>
</tr>
</tbody>
</table>

Chief Complaint: Patient complains of pain and burning with urination

Past Med. History: Patient has no significant medical history and is current on all immunizations

Office Visit Notes: This Patient is known to me. She presents to the office today for complaints of pain and burning with urination. Obtained a mid-stream clean catch urine sample. Sample showed two to five leukocytes and positive bacteria count of about 15 bacteria per high-power microscopic field and Patient had a temperature of 100.2. Patient was prescribed Bactrim DS, 1 tab twice daily for 14 days for the treatment of her urinary tract infection. Patient was also encouraged to drink plenty of fluids, especially cranberry juice. Patient to return to the office if no improvement in symptoms.

Drugs: Bactrim

The following ICD-9 Code(s) were chosen:
599

The following ICD-10 Code(s) were chosen:
N39.0
CMN39.0
OB/GYN – Scenario #13
Narrative Title: PRH-1
Narrative Desc: Pregnancy with poor reproductive history

Patient Info:

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Gender: Female</td>
<td>Weight: 165</td>
<td>Pulse: 84</td>
<td>Temp: 98.6</td>
</tr>
</tbody>
</table>

Chief Complaint: Pre-natal visit - 28th week check

Past Med. History: History of stillbirth (2011) at 34 weeks gestation due to prolapsed umbilical cord.

Office Visit Notes: Patient here for 28th week check. Patient states she’s been having trouble sleeping and has noticed her breasts are leaking. She is also very anxious that she’ll have the same problem as with her last pregnancy. Noted weight is up 4 lbs since last visit. Exam - breasts beginning to secrete colostrum, fetal heart tones strong, regular 140 bpm, fundal height is 30 cm, no pedal/ankle edema noted. Urine and 3 hr GTT normal. Patient encouraged to monitor baby activity and report any signs of decreased fetal activity. Patient assured pregnancy is going well and that the baby is developing normally. Patient has a home fetal monitor and has been instructed on its use. Patient to return to the office in 2 weeks.

Drugs: None

The following ICD-9 Code(s) were chosen:

- V23.5
- V22.1
- V23.5

The following ICD-10 Code(s) were chosen:

- O09.293
- Z34.80
- CM009.291
OB/GYN – Scenario #14
Narrative Title: RGE 1
Narrative Desc: Routine GYN Exam

Patient Info:

<table>
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<tr>
<th>Age</th>
<th>Height</th>
<th>BP</th>
<th>Resp-rate</th>
</tr>
</thead>
<tbody>
<tr>
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<thead>
<tr>
<th>Gender</th>
<th>Weight</th>
<th>Pulse</th>
<th>Temp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>192</td>
<td>78</td>
<td>98.2</td>
</tr>
</tbody>
</table>

Chief Complaint: Patient here for annual exam


Office Visit Notes: Patient here for annual exam. PAP from last year showed no abnormalities, will repeat in 2 years if asymptomatic. No complaints of abnormal bleeding, menses still regular cycle about every 32 days. Breast exam normal no lumps palpated, Patient states no noted changes to breasts. No complaints of pre-menopausal symptoms. Ordered dietary counseling for Patient due to diabetes and family history of heart disease as well as metabolism changes related to menopause and aging.

Drugs: None

The following ICD-9 Code(s) were chosen:
V72.31

The following ICD-10 Code(s) were chosen:
Z01.419
OB/GYN – Scenario #15
Narrative Title: TLA-1
Narrative Desc: Other threatened labor, Antepartum

Patient Info:

<table>
<thead>
<tr>
<th>Age</th>
<th>Height</th>
<th>BP</th>
<th>Resp-rate</th>
</tr>
</thead>
<tbody>
<tr>
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<th>Gender</th>
<th>Weight</th>
<th>Pulse</th>
<th>Temp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>158</td>
<td>92</td>
<td>98.6</td>
</tr>
</tbody>
</table>

Chief Complaint: Patient complained of spotting and abdominal cramps

Past Med. History: 34 weeks gestation, no family history of preterm births no other significant medical history.

Office Visit Notes: Patient here with complaining of abdominal cramping and vaginal spotting which started yesterday evening. Patient very anxious and tearful. She is a lab technician at the local hospital and states she has been working overtime and has been spending a lot of time on her feet. She rarely has time to stop to eat and knows that she is not been drinking enough water. Exam - fetal heart tones strong and regular, 140 bpm. Fundal height 36 inches. Braxton Hicks contractions present. Vaginal exam shows cervix 60% effaced, with a small amount of bleeding noted, no dilation. Fetal non-stress test done in office showing a reactive non-stress result indicating that blood flow (and oxygen) to the fetus is adequate. Patient instructed to stay on bed rest for the next week, no work until symptoms subside. Told to increase fluid intake to minimum of 64 ounces/day, limit caffeine. Patient to take calcium and magnesium supplements, 1500 mg calcium/day and 750 mg magnesium/day. Continue with pre-natal vitamins. Encouraged to take luke-warm baths to relax. Reassured that tests indicate that the baby is doing well and that working long hours and not keeping hydrated may have caused the spotting and contractions. Follow up visit next week. Patient instructed to call if symptoms progress, pain gets worse, has an increase in contractions or if she notices any type of vaginal discharge.

Drugs: None

The following ICD-9 Code(s) were chosen: 644.03

The following ICD-10 Code(s) were chosen: O60.03
OB/GYN – Scenario #16
Narrative Title: COW-1
Narrative Desc: Other complications of obstetrical surgical wounds

<table>
<thead>
<tr>
<th>Patient Info:</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
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<td>BP:</td>
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<tr>
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<td>Weight:</td>
<td>146</td>
<td>Pulse:</td>
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<tr>
<td></td>
<td></td>
<td>Resp-rate:</td>
<td>12</td>
<td>Temp:</td>
</tr>
</tbody>
</table>

Chief Complaint: Moderate pain at episiotomy site, post delivery check

Past Med. History: Para 1 gravida 1, 10 days post delivery, 2nd degree midline episiotomy. No other significant medical history.

Office Visit Notes: Patient 10 days post delivery. Mom and baby doing well. Exam - breasts full, Patient states nipples are sore, no signs of mastitis or cracking, baby nursing well. Episiotomy healing well, redness and swelling present, no drainage. Rectovaginal exam does not show any signs of fistula formation or rectal injury. Stitches intact and well approximated. Patient states she has burning with urination. Instructed to squirt warm water on the perineal area during urination to ease discomfort and to continue with Sitz baths with antiseptic solutions. Ice packs as needed to reduce swelling. Patient to continue to take prescribed Keflex until gone. Follow up in office in 4 weeks. Patient to notify office if she experiences any vaginal bleeding, increased pain, foul odor or drainage from incision site or if she experiences any problems with breasts/breast feeding.

Drugs: Keflex

The following ICD-9 Code(s) were chosen:
- V24.2
- V58.89

The following ICD-10 Code(s) were chosen:
- T88.8XXD
- Z39.2