Hydronephrosis - Case #1

Physician Report

EXAM: CT of the abdomen and pelvis without contrast.

CLINICAL HISTORY: Right flank pain.

Technique: Axial and coronal images of the abdomen and pelvis were obtained without contrast.

FINDINGS: Atelectasis at the lung bases. Evaluation of the organs of the abdomen and pelvis is limited without contrast. The spleen is stable in size. Adrenal glands, pancreas, gallbladder, and the liver are unremarkable. Bilateral renal stones. On the right, there is mild hydronephrosis. There is a 3 mm stone in the right ureterovesicular junction. No bowel obstruction. The appendix is normal. Shotty mesenteric and periportal lymph nodes. Urinary bladder is normal. No pelvic free fluid. The right testicle projects in the region of the spermatic cord, question undescended testicle. Osseous structures are stable with degenerative changes. No abdominal aortic aneurysm.

IMPRESSION: Mild right hydronephrosis secondary to a 3 mm stone in the ureterovesicular junction. Bilateral nephrolithiasis. The right testicle projects in the region of the spermatic cord, question undescended testicle.

Coding Summary

	ICD-9	ICD-10
Primary Dx	591 - Hydronephrosis 592.1 - Calculus of ureter	N13.2 - Hydronephrosis with renal and ureteral calculous obstruction

ICD-10 Guidance

4 potential ICD-10 codes exist under N13 - Hydronephrosis.

- Underlying condition (calculus)
- Location (ueterovesicular junction and kidneys)

Abdominal Pain - Case #2

Physician Report

EXAM: CT THROUGH THE ABDOMEN AND PELVIS:

CLINICAL HISTORY: Lower abdominal pain

TECHNIQUE: 5 mm axial images were obtained from the diaphragm to the symphysis pubis without oral or IV contrast.
FINDINGS: No abnormal calcifications are present in the kidneys, the ureters, or in the urinary bladder. There is no evidence of hydronephrosis or inflammatory changes. Limited examination without IV contrast of the abdominal organs is unremarkable.

IMPRESSION: There is no evidence of hydronephrosis or renal stones

Coding Summary

	ICD-9	ICD-10
Primary Dx	789.09 - Abdominal pain, other specified site	R10.30 - Lower abdominal pain, unspecified

ICD-10 Guidance

3 potential ICD-10 codes exist under R10 - Abdominal pain.

- Location (lower abdomen)

Diverticular Disease - Case #3

Physician Report

EXAM: CT ABD/PELVIS W&W/O CONTRAST

INDICATION: Abdominal pain, diverticulitis x1 month

TECHNIQUE: Helical CT of the abdomen and pelvis was performed prior to and following the administration of oral contrast and intravenous 94 mL Optiray 300 contrast. 5 mm axial and 2 mm coronally oriented images were obtained.

Lower thorax: Unremarkable.
Hepatobiliary: Mild hepatic steatosis. No focal liver lesion. No biliary ductal dilatation.
Gallbladder: Status post cholecystectomy.
Spleen: Unremarkable.
Pancreas: Unremarkable.
Kidneys: Unremarkable.
Adrenals: Unremarkable.
Lymph nodes: Unremarkable.
Vessels: Unremarkable.
Peritoneum/retroperitoneum: No free fluid or free air.
Pelvic organs/bladder: There is moderate prostatomegaly. The bladder is unremarkable.
Bowel: Moderate diverticulosis is seen. The focal wall thickening of the colon and pericolonic fat stranding associated with distal descending colonic/proximal sigmoid diverticulitis has improved, although these changes have not completely resolved compared to x/2013. No new colon abnormality is seen. The appendix is normal. No bowel obstruction is identified.
Bones/soft tissues: No destructive osseous lesions. A small fat containing right inguinal hernia is noted.

IMPRESSION: 1. Partial resolution of inflammation associated with left lower quadrant diverticulitis as described. No perforation or abscess is seen.
2. No new intra-abdominal abnormalities.

Coding Summary

	ICD-9	ICD-10
Primary Dx	562.11 - Diverticulitis of colon (without mention of hemorrhage)	K58.32 - Diverticulitis of large intestine without perforation or abscess without bleeding

ICD-10 Guidance

6 potential ICD-10 codes exist under K58 - Diverticulitis of Intestine.

- Location (descending colon and sigmoid)
- Complication (none mentioned)

Peptic Ulcer - Case #4

Physician Report

EXAM: Nuclear medicine GI bleeding scan at 2 hours.

CLINICAL HISTORY: Peptic ulcer.

Radiopharmaceutical: 24.8 mCi of 99m pertechnetate labeled RBCs.

FINDINGS: Scintigraphy evaluation of the abdomen and pelvis was performed over 60 minutes showing physiologic blood pool activity in the aorta and iliac arteries as well as physiologic activity in the liver, spleen, kidneys and bladder. One and 2 hour delayed images show no abnormal uptake in the in the colon.

IMPRESSION:
No evidence for GI bleed.

Coding Summary

	ICD-9	ICD-10
Primary Dx	533.90 - Peptic ulcer, unspecified site, unspecified as acute or chronic, without mention of hemorrhage, perforation, or obstruction	K27.9 - Peptic ulcer, site unspecified, unspecified as acute or chronic, without hemorrhage or perforation

ICD-10 Guidance

9 potential ICD-10 codes exist under K27 - Peptic ulcer site unspecified.

- Location (not specified)
- Complication (not specified)