Coder Summary:

DRG: 091 Other disorders of nervous system w MCC

Admitting Diagnosis:

G93.41 Metabolic encephalopathy

Principal Diagnosis:

G93.41 Metabolic encephalopathy

Secondary Diagnoses:

N17.9 Acute kidney failure, unspecified (CC)
M19.90 Unspecified osteoarthritis, unspecified site
E66.01 Morbid (severe) obesity due to excess calories
S52.501A Unsp fracture of the lower end of right radius, init (HAC)
E46 Unspecified protein-calorie malnutrition (CC)
N39.0 Urinary tract infection, site not specified (CC)
Z68.41 Body mass index (BMI) 40.0-44.9, adult (CC)
E86.0 Dehydration
110 Essential (primary) hypertension
M25.531 Pain in right wrist
F41.9 Anxiety disorder, unspecified
F43.21 Adjustment disorder with depressed mood
M85.80 Oth disrd of bone density and structure, unspecified site
E89.0 Postprocedural hypothyroidism
G89.11 Acute pain due to trauma
E78.5 Hyperlipidemia, unspecified
F09 Unsp mental disorder due to known physiological condition
R53.1 Weakness
T40.605A Adverse effect of unspecified narcotics, initial encounter
Z96.653 Presence of artificial knee joint, bilateral
Z88.2 Allergy status to sulfonamides status

Pre-Admission Screening

Etiology: G93.41-metabolic encephalopathy

Date of screening: 7/01/25

75-year-old female, with history of a fall two weeks ago resulting in a fractured wrist, has been treated conservatively. Over the past 10 days she has been taking pain medication and the family has noted increasing confusion and increased difficulty ambulating, more dependence on others for ADLs. Patient diagnosed with multifactorial encephalopathy, acute renal failure, severe dehydration, hypokalemia, UTI, and mild bradycardia. Pt treated with fluids, potassium, antibiotics and change from narcotic pain meds to non-narcotic. Beta blocker was restarted at a lower dose, and Lisinopril and hydrochlorothiazide were held pending improvement in renal function. Acute rehab was recommended in order to facilitate

improvement in functional mobility and self care skills in an effort to decrease the likelihood of further falls and readmission to the hospital and for safe transition back to her home and prior level of function.

Comorbidities: HTN, dyslipidemia, anxiety, osteoarthritis, osteopenia, acute pain due to trauma, history of migraines, hysterectomy, bladder suspension, bilateral total knee replacements, ORIF of left arm, morbid obesity (BMI of 41), UTI, unspec. Protein-calorie malnutrition

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ADMISSION MOTOR SCORE: 35

History and Physical

7/6/25

HISTORY OF PRESENT ILLNESS:

I was told by the nurse at the Rehab Unit that we were asked to see the patient when she was at the Rehab. Apparently, the patient was discharged by [Dr V-] from [Hospital C] to [Rehab] on 07/01/2025 We were not notified that the patient was going to [Rehab] and hence nobody saw the patient since then until today when I was notified by the nurse that there is an order from [Dr L-] on 07/06/2025 to change the attending name to [Dr V-]. The patient was admitted to [Hospital C] and was discharged on 07/01/2025 with a discharge diagnosis at the time being of metabolic encephalopathy, likely secondary to narcotic pain medication/dehydration/UTI. she was admitted to rehab on 07/01/2025 and as per the charting and the nurses, the patient has been doing well at the rehab, except that she was complaining of some fatigue.

When I saw the patient, she mentioned that she has gained some weight in the last couple of weeks. She has a history of hyperthyroidism from what she was explaining and had radioactive iodine treatment done many years ago. Since then, she has had iatrogenic hypothyroidism and has been on Synthroid. Her last TSH check was in January this year as per her and it was normal. Normally, her TSH levels run fine as per her. During the last admission to [Hospital C], she forgot to tell us about the Synthroid and she has not taken Synthroid in about 2 weeks and today, the TSH level is more than 50. She has been complaining of some cold intolerance also last few days.

PAST MEDICAL HISTORY:

Hypertension. hyperlipidemia. hypothyroidism. anxiety, osteoarthritis, osteopenia, migraine headaches.

PAST SURGICAL HISTORY:

Hysterectomy, bladder suspension surgery, right total knee replacement, left total knee replacement, left arm open reduction and internal fixation for injury, tonsillectomy.

ALLERGIES:

SULFA.

SOCIAL HISTORY:

Denies smoking, alcohol or recreational drug use. She is a retired elementary teacher. She walks with a walker at baseline.

FAMILY HISTORY:

Denies any significant medical problems in her parents. They both lived into their 80s.

REVIEW OF SYSTEMS:
positive for just fatigue, cold intolerance, pain in the arm is controlled. All other systems reviewed and are negative except as mentioned.

OUTPATIENT MEDICATIONS:
Reviewed, please see the attached med rec.

PHYSICAL EXAMINATION:
Vitals: Temperature 97.3 Fahrenheit, pulse 61, respiratory rate 18, oxygen saturation 95, blood pressure 146/63. General appearance: No apparent distress. Head and neck: Pupils equally reacting to light and accommodation. Extraocular movements intact. Neck is supple, no jugular venous distention. Chest: Clear to auscultation and percussion, no rales or rhonchi. Abdomen: Soft, nontender, nondistended. positive bowel sounds. Extremities: No cyanosis, clubbing. Right arm in a cast. No joint effusions. Skin: Warm and moist.

LABORATORY DATA AND INVESTIGATIONS:
Potassium 3.7. TSH 17.9, magnesium 1.9.

ASSESSMENT AND PLAN:
1. Status post right distal radius fracture, managed nonoperatively in a short arm cast, for which the patient is admitted to Rehab for rehabilitation purposes. Continue physical therapy and occupational therapy. The patient is being seen by Rehab doctor. Pain is well controlled.
2. History of hypothyroidism. The patient has not taken Synthroid in 2 weeks. TSH level is very high. We will check a free T4 level. Restart her home dose of Synthroid and make adjustments to her steroids as needed.
3. Hypertension. Continue with outpatient medications.
4. Hyperlipidemia. Continue with outpatient medications.
5. History of anxiety disorder.

We will continue to see the patient while she stays at the rehab.

Consultation Report – Physical Medicine and Rehab
ADMISSION DATE: 07/01/2025
CHIEF COMPLAINT:
Generalized weakness and pain in her right wrist.

HISTORY 0F PRESENT ILLNESS:
This patient is a very pleasant 75-year-old female with past medical history significant for hypertension, dyslipidemia, anxiety, osteoarthritis, osteopenia, history of migraine headaches, who had a fall 2 weeks prior to her original admission to [Hospital C], which is currently 06/28/2025, had a right wrist fracture and is managed nonoperatively and conservatively with a short arm cast. The patient had been given Norco for her pain control. The family recently found her to be very confused and not behaving like herself and was admitted for further evaluation and workup, which demonstrated hypovolemia, dehydration and narcotics-induced altered mental status. The patient was determined to have metabolic encephalopathy secondary to the above.
This has resulted in nontraumatic brain dysfunction. The patient was subsequently admitted to the Acute

Rehab unit for comprehensive inpatient therapy as the patient is having difficulty ambulating and performing self-care tasks.

PAST MEDICAL HISTORY:
Hypertension, dyslipidemia, anxiety, osteoarthritis, osteopenia and history of migraine headaches.

PAST SURGICAL HISTORY:
Hysterectomy, bladder suspension, right TKA, left TKA, left arm ORIF, tonsillectomy.

FAMILY HISTORY:
Reviewed and noncontributory to present illness.

SOCIAL HISTORY:
Denies any tobacco, alcohol or illicit drug use, was previously an elementary school teacher, is now retired. Currently, lives alone, has friends who assist her at times during the day, and she is living in a single-story home, no steps to enter and has a narrow standup shower. The patient has a front-wheeled walker, straight cane and wheelchair at home.

PREVIOUS LEVEL OF FUNCTION:
The patient was previously independent for all ADLs and mobility.

CURRENT LEVEL OF FUNCTION:
The patient currently requires moderate assistance for transfers and is only able to ambulate 40 feet with constant cues using a rolling walker, total assistance.

REVIEW OF SYSTEMS:
The patient denies any fevers, chills, nausea, vomiting. Otherwise, 14-point review of systems is negative.

ALLERGIES:
SULFA.

MEDICATIONS:
Please see medication reconciliation for complete listing of admission medications, which are significant for gabapentin, duloxetine, Lidoderm patch, tramadol, albuterol.

PHYSICAL EXAMINATION:
Vital signs: Temperature 96.3, pulse 64, respirations 17, BP 141/66, 02 sats 99 on room air. General: Alert and oriented x 3, in no apparent distress. Head and neck: Normocephalic, atraumatic. PERRLA, EOMI. Mucous membranes moist. Chest: Lungs are clear to auscultation bilaterally, no rhonchi, no wheezing. Cardiovascular: S1, S2 present. Regular rate and rhythm, no murmurs, gallops, rubs. Abdomen: Protuberant, normal active bowel sounds throughout all 4 quadrants. Soft, nontender, nondistended, no hepatosplenomegaly. Extremities: Right upper extremity noted to be in a short arm cast. Mild tenderness to palpation to her digits; however, no sensation is lost. Brisk capillary refill to the right upper extremity. Remainder of extremities demonstrate full passive range of motion without any significant pain.
Skin: No rashes, no skin breakdown, no bruising. Neurologic: Cranial nerves intact. Coordination is diminished bilaterally. Sensation intact to light touch in all dermatomes. Strength is 5/5 strength for left upper extremity. Right upper extremity has 4/5 strength throughout all muscle groups tested and

bilateral lower extremities demonstrate 4/5 hip strength, 4/5 quads and hamstrings, 5/5 gastrocnemius complex and EHL. pathologic reflexes are negative. DTRs are 1+.

LABORATORY DATA:

Albumin of 2.9, BUN of 8, magnesium of 1.4, prealbumin of 15, H&H of 12.9 and 37.1. Normal white blood cell and platelet count.

IMAGING:

X-rays of the hip on 06/28/2025 did not demonstrate any acute fracture or dislocation and demonstrated mild degenerative changes in the hips. Imaging was reviewed by me independently and I agree with the radiologist's interpretation.

ASSESSMENT AND PLAN:

This patient is a very pleasant 75-year-old female with nontraumatic brain dysfunction secondary to metabolic encephalopathy as a result of a significant amount of dehydration and narcotics-induced altered mental status, which was being used for right wrist pain status post mechanical fall resulting in a distal radius fracture, currently managed with a short arm cast. The patient was previously independent for all ADLs and mobility; however, now is having difficulty ambulating and performing self-care tasks and is therefore admitted to the Acute Rehab Unit for comprehensive inpatient therapy aimed at restoring functional independence to this patient with a goal of returning home to family.

1. The patient is appropriate for the Acute Rehab Unit as the patient has demonstrated progress in therapies, is able to tolerate 3 hours of daily therapy, and the patient will require close medical followup to prevent any complications. The patient is not safe to discharge home or to skilled nursing setting as the patient's multiple medical comorbidities require daily followup and medical management, and the patient is at risk for falls, complications and readmission. physiatrist will see the patient daily 5 to 7 days weekly for coordination of care with consulting physicians to ensure adequate pain
   control to allow participation in therapies and provide leadership for the multidisciplinary rehabilitation team as well as development of an individualized rehabilitation program.
2. The patient will continue on all transfer medications to include Tylenol and Lidoderm patch for pain control as well as Neurontin. The patient will be on heparin for DVT prophylaxis. Internal medicine will continue to follow and manage the patient's chronic comorbid disorders
3. PT was consulted to evaluate and treat the patient for goal of improving lower extremity strength, balance, transfers and ambulation. PT will see the patient daily for 60 to 90 minutes per day, 5 to 6 days a week for duration of stay.
4. Occupational Therapy was to evaluate and treat the patient for goals of improving upper extremity strength, coordination, active assisted range of motion, ADLs, training associated adaptive equipment and caregiver training. OT will see the patient daily for 60 to 90 minutes per day, 5 to 6 days a week for duration of stay.
5. Speech therapy is consulted to evaluate and treat the patient for goals of improved cognition. Speech Therapy will see the patient daily for 60 minutes per day, 5 to 6 days a week for duration of stay.
6. Rehabilitation nursing will be available to the patient 24 hours daily for medication education, maintaining skin integrity, restoration of autonomous control of bowel and bladder management, provide caregiver training and neuro rehabilitative assistance.
7. Psychology is consulted to evaluate cognitive function, screen for depression and supportive counseling for serious illness and loss of autonomy.
8. Nutrition is consulted to provide recommendations for total calorie and fluid needs as well as

supplementation for protein malnutrition.

9. Social work will evaluate the patient for review of resource eligibility for community based assistance, DME procurement and discharge planning.

POTENTIAL REHABILITATION COMPLICATIONS:

1. Fall risk for which bed alarm will be used as well as encouraging the patient to call for help prior to getting out of bed and transfers.
2. The patient is at risk for *DVT,* for which she will continue on heparin as well as progressive mobility with therapies.

REHABILITATION POTENTIAL:

Good for return home with family at supervision for ADLs and ambulation.

ESTIMATED LENGTH OF STAY:

13 days.

Team Conference Notes:

No speech ordered at this time.

Psychology consult 7/2/25 Today, patient is alert and oriented x4. Fair historian. Denies history of depression, but has experienced panic attacks about once a month. She was using a walker prior this admission but she reported that for the past several months she has been falling out of bed and had placed her mattress on the floor to protect herself.

Progress Note: 7/5/25

Subjective: Patient has loose stools. No skin issues.
Lab data: No new labs since H&P.
Impression and Plan:

1) NTBI-metabolic encephalopathy
2) s/p R wrist fx—non-operative-6/28/25
3) HTN-lisinopril
4) Anxiety-cymbalta
5) UTI-cipro
6) DVT prophylaxis-ASA, progressive mobility, TEDS

Discharge Summary: 7/13/25

Date of admission: 7/01/25
Discharge diagnoses:

- Debility needing skilled rehab services
- Pain control with ongoing debility with right wrist fracture
- Uncontrolled hypothyroidism with elevated TSH in 70s
- History of hypertension and resolved metabolic encephalopathy, dyslipidemia

Discharge to skilled nursing facility.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER: PRINCIPAL:

BEST PRACTICES

OPPORTUNITIES

QUERY POTENTIAL?

IF SO PROVIDE A QUERY

Coder Summary:

DRG: 552 Medical back problems *wlo* MCC

Admitting Diagnosis:

M48.06 Spinal stenosis, lumbar region

Principal Diagnosis:

M48.06 Spinal stenosis, lumbar region (DRG)

Secondary Diagnoses:

K31.84 Gastroparesis

K86.1 Other chronic pancreatitis (CC)

E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unsp

I10 Essential (primary) hypertension

M54.89 Other dorsalgia

D57.3 Sickle-cell trait

Pre-Admission Screening

Etiology: Spinal stenosis. Left lumbar hemilaminectomy and posterolateral fusion of L2 through S1.

Date of screening: 5/10/25

Patient is a 47-year-old patient with history of lumbar stenosis, L3-L4 and L4-L5 hemilaminectomy and posterolateral fusion of L2 through S1. Patient had left lower extremity weakness after her surgery and was put on Decadron treatment. During subacute stay, patient was trying to get out of the bed, had difficulty moving her LLE and fell on the floor sustaining trauma to the head. She denied loss of consciousness. Patient admitted to IRF due to impaired ambulation and ADL's secondary to lumbar stenosis L3-L3 and L4-L5 with radiculopathy. The patient subsequently developed post op fluid collection with worsening in her lower left extremity function.

PMHx: HTN, DM, HLD, anxiety, fibromyalgia, seronegative RA, questionable Crohn's disease, alpha thalassemia, morbid obesity (BMI of 42), chronic lower back spinal stenosis, gastroparesis syndrome, diabetic peripheral neuropathy, chronic pancreatitis, chronic ischemic colitis, bilateral CTs, right should rotator cuff injury.

ADMISSION MOTOR SCORE: 41

History and Physical

Chief Complaint

LES weakness

History of Present Illness
[Patient] is a 47-year-old patient with h/o of lumbar stenosis, L3-L4 and L4-L5, and radiculopathy. This patient underwent left L3-L4 and L4-L5 hemilaminectomy and posterolateral fusion of L2 through S1 by [Dr M-]on 4/4/25. The patient had left lower extremity weakness after her surgery and was put on Decadron treatment by neurosurgery. She had a follow up *CT* scan of the lumbar spine on 4/5/25 that showed no significant changes. The patient was discharged to a subacute facility to continue her comprehensive rehabilitation. Per the EMR, the patient reported that on 4/13/25 she was trying to get out of the bed, had difficulty moving her LLE and fell on the floor sustaining trauma to the head. She denied loss of consciousness. According to the facility, the patient was taking Valium and Percocet and was drowsy when she was trying to get out of bed. The patient had a CAT scan of the head in the Emergency Room on 4/13/25 that showed no intracranial bleeding, and the CAT scan of the lumbar spine showed post-surgical changes; no acute event.

The patient was admitted to [FACILITY] for IPR on 4/15/25 due to impaired ambulation and ADL's secondary to lumbar stenosis L3-L4 and L4-L5 with radiculopathy. The patient subsequently developed post operative fluid collection w/ worsening in her LLE function. Per the EMR, the patient underwent MRI lumbar spine which revealed large fluid collection. ID was following for possible infection. Pt went for aspiration of fluid collection by IR on 4/25/25. Cx after IR drainage negative to date. The patient requested a second neurosurgical opinion, per the EMR, and [Dr L-] was consulted. A myelogram was recommended by [Dr L-].

Per the neurosurgery note, the myelogram showed persistent compression and stenosis at L3-L4 and L4-L5, but no blockage of the dye. The MRI cervical spine showed cervical spondylosis and a C1-C2 arthropathy with mild signal changes in the cord on the right side.

The patient was transferred to [Hospital B] on 5/2/25 for further workup and management. LE Doppler on 5/3/25 was negative for DVT.

On 5/4/25, the patient underwent wound exploration and debridement with drainage of the fluid collection and sampling for microbiology and bilateral midline laminectomy L3-L5 with decompression of the thecal sac, bilateral foraminotomies and decompression of the nerve roots with [Dr L-].

PMR was consulted on 5/5/25 for IPR needs.

Currently, pt is reporting constipation. No BM x 5 days. Vol void without difficulty. Reports no change in lower ext sensation, feels cont to be diminished. Denies spasticity. Decrease sharp/shooting pain to back and bilateral lower ext.

Active PRN Medications:

oxyCODONE (oxyCODONE immediate release) 15mg = 1 Tab By Mouth Q4

Histories

Past Medical History:

Active
Hypertensive disorder
Sickle-cell thalassemia without crisis
Gastroparesis syndrome
Backache
herniated disk
Diabetic peripheral neuropathy
Sickle cell trait
Chronic pancreatitis
Chronic ischemic colitis
Resolved
DIABETES MELLITUS : Resolved.
Fibromyalgia : Resolved.
Family History: OM and HTN

Procedure history:

Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive on 04/3/2025. Fusion of 2 or more Lumbar Vertebral Joints with Interbody Fusion Device, Posterior Approach, Posterior Column, Open Approach on 04/04/2025.
Fusion of Lumbar Vertebral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach on 05/04/2025. Fusion of Lumbosacral Joint with Autologous Tissue Substitute, Posterior Approach, Posterior Column, Open Approach on 05/04/2025

Social History

This patient is single and will be living with brother upon discharge from [FACILITY] in an apartment. Pt reports unsure if there are steps and brother recently found this apartment. Pt denies h/o smoking cigarettes, etoh. Positive h/o of marijuana.

Education- College with Liberal Arts degree
Employment- Not working. Previously worked as a stationary engineer for that city of {CITY}

Premorbid Functional Status:

Eating: Independent.
Grooming: Independent.
Bathing Upper: Independent.
Bathing Lower: Independent.
Dressing Upper: Independent.
Dressing Lower: Independent.
Toileting: Independent.
Bed Mobility: Independent.
Transfers Bed to and from Chair: Independent.

Transfers: Toilet: Independent.
Transfers: Tub/Shower: Independent.
Ambulation (Home): Independent.

Pt able to lift both arms above 90 without difficulty.
Neg babinski/Neg clonus/neq hoffman bilaterally
Proprioception Intact bilateral thumbs/Absent
bilateral Toes
DTR's upper ext bilateral 2's throughout and lower ext
diminished throughout
Upper and lower ext easy to range

Light Touch and Pin Prick Sensation- Intact sensation except has impaired sensation bilateral lower exts. Still has numbness in perineal areas and buttocks

MMT_
Right- C5 -5/5, C6-5/5, C7-5/5, C8-5/5,Tl-5/5, L2- 3-/5, L3- 3/5, L4- 3/5,
L5-1/5, 51- 3/5
Left- C5- 5/5, C6-5/5, C7-5/5, C8-5/5,Tl-5/5, L2- 1/5, L3-1/5, L4-0/5, LS-
0/5, 51-0/5

Quality and Safety
Quality and Safety: Core Measures Indwelling Urethral Catheter Indication (Patient does not have an indwelling urethral catheter), and Central Venous Catheter Indication (Patient does not have a central venous catheter).

Review / Management
Results review: Lab results
05/10/2025 06:40 EDT

Sodium
Potassium
Chloride
Carbon Dioxide
Anion Gap
Glucose
Urea Nitrogen (BUN)
Creatinine
Calcium
GFR for African Amer
GFR for Other Races
WBC
RBC
Hemoglobin
Hematocrit
MCV
MCH
MCHC
Red Cell Distribution Width (RDW)
Platelets
Mean Platelet Volume (MPV)
Nucleated RBCs
D Dimer
139 mMol/L
4.4 mMol/L
106 mMol/L
28 mMol/L
5 mMol/L
85 mg/dL
10 mg/dL
0.60 mg/dL
9.0 mg/dL
>120 mL/min/1.73 m2
108 mL/min/1.73 m2
9.2 K/CUMM
3.49 M/CUMM LOW
8.7 gm/dL LOW
27.4 lOW
78.5 Fl LOW
24.9 pg LOW
31.8 LOW
16.6 HI

323 K/CUMM
10.8 FL
0.00 K/CUMM
2.26 mg/L FEU HI History and Physical

Impression and Plan

[Patient] readmitted to [Hospital] after recent left L3-L4/ L4-L5 hemilaminectomy on April 4, 2025. Patient was discharged to [Facility]. During her stay at the facility, she experienced a fall. She complained of lower extremity weakness. She was admitted to [Hospital] for closer monitoring, pain control and further diagnostic testing. No findings noted. Pt admitted to to [FACILITY] on 4/15/25 for IPR. During course c/o of severe low back/left leg pain with continued weakness. Pt seen and evaluated by [Dr L-] from [Practice]. Imaging revealed continued
severe lumbar stenosis L3 -LS. Pt OX with Post- Laminectomy Syndrome. - Pt is now s/p L3-S laminectomy and b/l medial facetectomy for decompression on *5/4/25* by [Dr L-] [Patient] still remains below baseline and requires IPR rehab prior to returning home.

*Impaired ambulation and ADL's secondary to Lumbar stenosis with radiculopathy. Lumbar stenosis, L3-L4 and L4-L5.
Pt is s/p left L3-L4/l4-LS hemilaminectomy on April 4, 2025. performed by [Dr O-],

*New Post-laminectomy syndrome due Severe L3-L5 lumbar stenosis- s/p L3-5 laminectomy and b/l medial facetectomy for decompression on *5/4/25* by [Dr L-]
left LE still very weak
-FT: patient to be seen by PT S-6x/week for 1.5-2,5 hours per day.
-OT: patient to be seen by OT 5-6x/week for 1.5-2,5 hours per day.
- Rehabilitation Nursing, Recreational Therapy, Neuro-Psych for adjustment to disability, Social Work, PMR
physician supv
No back brace, Pain is better controlled now so expect to have better participation in therapies.

*Bladder Mang- pt reports voiding. Will order bladder scan's. If pvr's greater than 150 or no void greater
than 6 hours, pt will require sterile IC cath,

*Bowel Mang/constipation- No x 5 day will place pt on bowel program- colace 100mg 1 tab po bid, senna
8.6mg 2 tab po qhs, and dulcolax supp 10mg PR
Will order abdominal X-ray on 5/11 to assess severity of fecal stasis.

*DM with gastroparesis- Pt is not on OM meds, Controlled by Diet. Monitor CBG's, and low dose Insulin
SSI. Will consult [Dr W-] from IM,
4/16: hgb A1C 6.1

* Leukocytosis
Most probably from steroid. Monitor. Afebrile
WBC 9.2 on 5/10.

*HTN-BP in the low 100's. Not on BP meds. [Dr W-] 1M consulted

*HLP- Cont with Zocor 10 mg daily. check Lipid profile on 4/16
4/16: lipid profile WNL except low HDL (34) and elevated triglyceride (225)
IM consult

*Sickle Cell trait/ Borderline Anemic-
Labs on 4/16- Iron -72/TIBC-264/Iron St- 28/Ferritin- 305
Not consistent with Iron def. Will Monitor Hb/HCT

H/O Anxiety- Mood is currently stable. Will consult Neuropsychology to teach relaxation tech.

*IBS/Crohn's dz - Pt is not on Medication. Will monitor
Currently, no abdominal pain, no diarrhea and no hematochezia. The patient to follow with the gastroenterology clinic as outpatient.

*Rt shoulder rotator cuff injury- Pt has limited ROM but improved since previous admission
US of bilateral shoulder to assess for rotator cuff injury- Outpatient

·Smoking Cessation- Pt is non-smoker

*Bilateral lower ext swelling- Doppler neg for *DVT* in bilateral LEs on 4/15 and 5/10

*GI/DVT prophylaxis- Protonix 40mg daily/ Heparin 5000U every 8 hours

*Pain Control/Diabetic peripheral neuropathy- Lyrica 300mg po BID/Cymbalta 60mg qhs/ oxycodone 15mg immediate release 1 tab po every 4 hours prn pain
tylenol 1,000 mg q8 hours Pt was seen by Pain service at [Hospital]. If needed, will reconsult pain service. Currently pain is better controlled

*Immunization- Pt has received both the Influenza vaccine/Pneumovaccine Fall of 2015

"'Asses nutritional status - BMI- 29 (Not morbid obese) Nutrition Consult, 4/16: Albumin 3.1 and prealb 19.9. Will recheck Pre-alb, and albumin

Consults
[Dr W-] from IM
[Dr T-] from NP

Expected function at the time of discharge- Mod I with ADL's and Mod 1 with w/c propulsion
Prognosis- Good for rehab goals
Disposition- Home with brother
ELOS-2 weeks

Stable for IPR: Yes.
Medical Plan
DVT prophylaxis: Heparin 5,000U every 8 hours.
Estimated length of stay: 3 to 4 weeks.
Disposition: home with family.

Documentation Reviewed: I have reviewed the Preadmission Screen.
Functional status documented at preadmission: I agree with the patient's current functional status as documented in the preadmission screening.
Risk for complications: I agree with the risk for clinical complications documented in the preadmission screening.
Medical conditions: The plan of treatment is documented above in the history and physical.
Patient participation in therapy: The patient can participate in, and will benefit from an intense therapy program at least 3 hours per day / 5 days per week. Therapies/services include:, Physical therapy, Occupational therapy, Orthotics, Rehabilitation Nursing, Psychology, Case Management, Therapeutic Recreation, Dietician.

Created by Attestation
Teaching Attestation
Teaching Attestation

Attestation/ Supervisor Note: Attestation to History and physical, Participation (management reviewed and discussed, seen and exam with PA. report was edited. Still no functional active movement in the left LE but there is active movement in right hip flexor and quads and 0s in AD, Posterior PF and big toe extensor. heart-regular; lungs- no rales, no wheeze. Abdomen - soft, good bowel sounds. See detailed MMT and sensory testing above., Spent 2 hrs, reviewing medical records, discussing with consult team, evaluating patient and coordinating care.), I agree with findings & plan,
Age: 46 years Sex: Female
Associated Diagnoses: None
Author: [DR O-]

Internal Medicine Consult H&P

Chief Complaint
The patient is a 46 years old Female weighing
79.6 kg 215 lb.

CC: medical co-
management

Date of Service:
05/11/2023.

History of Present Illness
46 yof w/ pmh significant for sickle cell thallesemia, HTN, OM and lumbar stenosis, l3-l4 and l4-L5 w/ radiculopathy admitted 4/4/2025 for a left L3-L4 and L4-L5 hemilaminectomy and posterolateral fusion of L2 through S1. Post op course complicated by left lower extremity weakness and was put on Decadron treatment by neurosurgery. She had a follow up CT scan of the lumbar spine on 4/5/25 that showed no Significant changes. The patient was discharged to a subacute facility to continue her comprehensive rehabilitation. On 4/13/25 she was trying to get out of the bed, had difficulty moving her LLE and fell on the floor sustaining trauma to the head. She denied loss of consciousness. Head CT in ED on 4/13/25 showed no intracranial
bleeding, and the CAT scan of the lumbar spine showed post-surgical changes; no acute event.
She was admitted to [FACILITY] for IPR on 4/15/25 due to impaired ambulation. pt developed post operative fluid collection w/ worsening in her LLE function. MRI lumbar spine showed revealed large fluid collection. ID was following for possible infection. Pt went for aspiration of fluid collection by IR on 4/25/25 Neurosurgery requested myelogram which showed persistent compression and stenosis at L3-L4 and L4-L5. pt transferred to {Hospital} 5/2 and underwent wound exploration and debridement with drainage of the fluid collection and sampling for microbiology and bilateral midline laminectomy L3-L5 with decompression of the thecal sac on
5/4. Currently denies cp/sob, no nausea/vomiting. Tol po diet. Consulted for medical co-management.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

PRINCIPAL:

BEST PRACTICES

OPPORTUNITIES

QUERY POTENTIAL?

IF SO PROVIDE A QUERY

REHAB Etiologic DX: Postictal State with Left non dominant hemiparesis
Date of Admission: 02/07/2025

Coding Abstract

ICD10 | ICD9 | QH | SC | DX | PX | HC

Admit DX: 0 | G81.94 | HEMIPL UNS AFFECT LT NONDOM SIDE

	Ok	E	DX	POA	CC	S	M	#	HAC	HCC	RA	Description	R	I	N	C
1	☑		R26.9	Y		S	M	0				UNS ABNORMALITIES GAIT & MOI	R			
2	☑		I48.20	Y	cc	S2	M1	0		HCC	RA	CHRONIC ATRIAL FIBRILLATION U	R	I		
3	☑		G93.40	Y	cc	S3	M3	0			RA	ENCEPHALOPATHY UNSPECIFIED	R			
4	☑		I49.5	Y		S2	M2	0		HCC	RA	SICK SINUS SYNDROME	R	I		
5	☑	⚠	E11.22	Y		1	M2	0		HCC	RA	TYPE 2 DM W/DIABETIC CKD	R	I		
6	☑		E11.42	Y		1	M2	0		HCC	RA	TYPE 2 DM W/DIABETIC POLYNEU	R	I		
7	☑		E11.51	Y		1	M2	0		HCC	RA	TYPE 2 DM DIAB P ANGIOPATH NO	R	I		
8	☑		G31.84	Y		1	M1	0			RA	MILD COGNITIVE IMPAIRMENT SC	R	I		
9	☑		G40.909	Y		1	1	0		HCC	RA	EPILEPSY UNS NOT INTRACT W/O	R			
10	☑	⚠	N18.30	Y		1	1	0		HCC		CHRN KIDNEY DISEASE STG 3 UN	R	I		
11	☑		E78.5	Y		1	1	0			RA	HYPERLIPIDEMIA UNSPECIFIED	R	I		
12	☑	⚠	H53.40	Y		1	1	0			RA	UNSPECIFIED VISUAL FIELD DEFI	R			
13	☑	⚠	I12.9	Y		1	1	0			RA	HTN CKD W/STAGE 1-4 CKD/UNS	R	I		
14	☑		H35.30	Y		1	1	0			RA	UNSPECIFIED MACULAR DEGENE	R			
15	☑		R68.89	Y		1	1	0				OTHER GENERAL SYMPTOMS AN	R			
16	☑		Z86.73	1		1	1	0				PERS HX TIA & CI NO RESID DEFI	R	I		
17	☑		Z79.01	1		1	1	0				LONG TERM CURRNT USE ANTIC	R	I	N	
18	☑		Z95.0	1		1	1	0				PRESENCE OF CARDIAC PACEMA	R	I		

ADMISSION MOTOR SCORE - 29

HISTORY AND PHYSICAL

Assessment

Problem list

Post-ictal state. (02.1)
S/P seizures on 01/27/2025
Multiple prior strokes.
Hx of prior seizure disorder.
S/P right craniotomy for intracerebral hematoma evacuation. (2020)
Left hemiparesis.
Balance impairment.

Cognitive impairment.
Right visual field deficit.
Chronic AF.
Hx of sinus node dysfunction.
Cardiac pacemaker in place.
PAD.
HTN.
HLD.
DM.
Diabetic PN.
CKD III.
Macular degeneration.

70-year-old right-handed man presented to the ED at Medical Center on 01/27/2025 after awakening with left-sided weakness, sensory loss, and visual deficit, and falling out of bed. There was no LOC; unknown whether he hit his head. EMS witnessed 2 seizures en route to the hospital. BP was 203/103. He was admitted to the hospital. He was seen for neurology by Dr. Smith. Assessment was simple partial status epilepticus and chronic bilateral occipitoparietal stroke with petechial hemorrhages. He noted that focal seizures stopped after 4 mg of Ativan were given. He was treated with Keppra and Vimpat. He was continued on Coumadin, ASA, and statin. He was agitated and combative. He was treated with Seroquel and Haldol. He subsequently became cooperative. He was found to have right posterior tibial artery occlusion. He was seen for vascular surgery by Dr. Who on 01/28, and diagnosed peripheral arterial occlusive disease. SLP on 01/28 noted the patient passed a 3-oz water challenge. They suspected bolus efficiency deficit due to edentia. Recommended minced/moist diet consistency with thin liquids. They noted left neglect and field cut, and motor planning deficits, and deficits across higher order cognitive domains. There are no subsequent SLP notes. I discussed the case with Dr. Smith, who reports that his diagnosis is postictal state plus hospital delirium, but no new stroke. He was transferred here to the rehab unit this afternoon.

CURRENT FUNCTION PER PREADMISSION SCREEN:

Eating min A, grooming/hygiene min A, upper body dressing max A, lower body dressing min A, bed mobility CGA, sit-stand min A, transfer min A, ambulation 160 feet with FWW min-mod A, memory mod A, expression independent. Sitting balance was 4 and standing balance 1+.

Review of Systems

He says he feels "great". He admits to a little chronic numbness in his feet. Balance is off. Loss of vision to the right, chronic, but denies any recent change in vision. Admits to short-term memory impairment. His wife notes other cognitive impairment as well. He denies weakness, dizziness, nausea, dysphagia, cough, dyspnea, chest pain, abdominal pain, dyspepsia, symptoms or difficulty with urination or BMs, headache, musculoskeletal pain, or depression.

PLOF:

He could walk by himself up to about 300 yards at a time using a single-point cane. He needed assistance at times for ADLs. He was not driving. His wife manages his medications and finances.

Histories

Past Medical History

Multiple CVAs, including ICH.
Chronic atrial fibrillation.
On Coumadin at home.
Sinus node dysfunction.
HTN.
HLD.
DM.
Diabetic PN.
Diabetic retinopathy.
CKD III.
Hepatitis D in 1986
Orthostatic dizziness.
Previous seizures.
MRSA.
Macular degeneration.
Valley fever.

Ophthalmologist:
Dr. K

Cardiologist:
Patient and wife do not recall the name of his current cardiologist.

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Procedure history

Right craniotomy/intracerebral hematoma evacuation.
TKR.
Left carpal tunnel surgery.
Cardiac pacemaker placement in 2021.

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Family History

Cardiac arrest
Mother
Diabetes mellitus type 2
Mother
Father
Acute myocardial infarction
Mother
Hypertension
Mother
Alzheimer's disease
Brother
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Social History

Retired pipeline worker and then airbag assembly worker.
High school graduate + 2 years of college.
Lives with wife and son.
Wife is able-bodied and available full-time.
Son works.

Habits:

He smoked about ½ pack of cigarettes a day from around age 18 to 36.
He denies EtOH or illicit drugs.
He does about 10 minutes of exercise at a counter, e.g. squats and running in place, about 3 times a week.

Objective

Tape
vancomycin

Medications: Medications

ACTIVE MEDS

aspirin (aspirin 81 mg oral tablet, chewable) 81 mg 1 tab PO DAILY
gabapentin 600 mg 2 cap PO TID
insulin glargine (insulin glargine-yfgn) 15 units 0.15 mL SubCutaneous Q24h-interval
lacosamide 100 mg 2 tab Oral BID
levETIRAcetam (Keppra) 500 mg 1 tab PO BID
lisinopril 5 mg 1 tab PO QHS
pravastatin 40 mg 1 tab PO QHS
warfarin (Coumadin) 2 mg 1 tab Oral Daily
QUEtiapine (SEROquel) 50 mg 2 tab Oral BID PRN: Agitation
docusate-senna 1 tab Oral BID PRN: Constipation
glucagon 1 mg 1 mL IntraMuscular On Call PRN: Blood Glucose
glucose (Dextrose 50%) 25 Gm 50 mL IV Push On Call PRN: Blood Glucose
glucose 15 Gm Oral On Call PRN: Blood Glucose
glucose 30 Gm Oral On Call PRN: Blood Glucose
insulin lispro (Correction Dose HumaLOG) Bedtime correction scale SubCutaneous QBedtime PRN: Blood Glucose
insulin lispro (Correction Dose HumaLOG) Low resistance correction scale SubCutaneous TID before meals PRN: Blood Glucose

Vital Signs: Last vitals

VITALS

Height/Weight : HEIGHT/WEIGHT

02/07/2025	19:06 MST	BMI (Pt Care)	29.26
02/07/2025	18:20 MST	Height	188 cm
		Weight	103.4 kg

5 **Physical Examination**

General: NAD. Alert. Pleasant. Cooperative.

HEENT: PERL, cloudy. Pharynx appears normal. Edentulous, with full upper and lower dentures in place, 1 missing front tooth on the upper denture.

Neck: Functional ROM, pain-free, without dizziness.

Chest: Lungs are clear to auscultation.

Heart: Regular rate and rhythm currently. No murmur is heard.

Abdomen: Bowel sounds present. Soft, nontender. No masses or organomegaly are palpated.

Extremities: No peripheral edema. No calf tenderness. Negative Homans bilaterally. Hands are warm, left foot fairly warm, right foot a little cooler; without cyanosis or pallor. Capillary refill is about 3 seconds in great toes bilaterally. Unable to definitely palpate DP or PT pulses.

Neuro: Speech is intact. Follows directions accurately. Oriented to year and month, off by 1 day on the date; oriented to city, Medical Center, and with a slight hint able to state rehab unit. Repeats 3 words immediately and recalls all of them after 3 minutes. Names the current and 2 past presidents, but not the prior one. Number of nickels in $1.50 is correct. Subtracts 5 of 5 serial 7s correctly. Proverb interpretation is inadequate. EOMI. Complete right VFD. Face is approximately symmetric. Opens/closes both eyes adequately. Tongue is midline. Sensation to light touch is present and localizable in bilateral hands and legs, but absent in the toes bilaterally. Position sense is correct in bilateral thumbs but absent in bilateral toes. Manual muscle testing in RUE is 5; LUE is 4+ to 5; proximal BLEs are 5; ankle DF and PF are 4- bilaterally. Finger tapping is intact on the right and slightly slow on the left. Toe tapping is limited and slow bilaterally. Finger-to-nose is a little slow with right hand, and slower/mildly clumsy with the left hand. Heel-to-shin is somewhat clumsy with the right foot, but worse with the left foot.

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Plan:

Admitted for acute inpt rehab due to postictal state.
No significant discrepancy between current medical/functional status and that noted in PAS.
DC destination: Home with full-time family assistance.
DC goal: Mod I to CGA range of fct for ADLs and household mobility.
ELOS: 1 wk - subject to change pending therapy evals.
Appropriate for AIRF as opposed to lower level of care in view of postictal state with significant functional impairment and comorbidities listed above.
Needs multidisciplinary rehab: PT, OT, and ST each 1 h/d 5 d/wk with shorter weekend sessions, and rehab nsg.
Rehab will include gait and tfr training, WC mobility, ADL training, cognitive remediation, and ther ex for strength, coordination, balance, ROM and endurance.
Expected to fully participate in intensive rehab, make significant progress, and be able to DC home as planned.
DME: TBD.
Caregiver training for family prior to DC.
Risk of falls - fall precautions.
Rehab nsg to monitor B&B fct; check PVR bladder volume; intervention if indicated.
Rehab nsg to monitor skin integrity; intervention as indicated.
Medical mgmt per IM.
Risk of recurrent seizure -continue seizure precautions; continue antiepileptic medications.
Risk of embolic stroke - continue ASA and Coumadin.
Risk of VTE - continue Coumadin.
Coumadin dosing per pharmacist.
Monitoring/mgmt of HTN and DM to ensure good control.
He is to follow up with Dr. Toe for neurology in 1 to 2 months.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

PRINCIPAL:

BEST PRACTICES

OPPORTUNITIES

QUERY POTENTIAL?

IF SO PROVIDE A QUERY