Coder Summary:
DRG: 057 Degenerative nervous system disorders *wlo* MCC

Admitting Diagnosis:
I69.351 Hemiplegia following cerebral infrc aff right dominant side

Principal Diagnosis:
I69.351 Hemiplegia following cerebral infrc aff right dominant side
POA: Yes, present at the time of inpatient admission

Secondary Diagnoses:
G40.409 generalized epilepsy, not intractable, *wlo* stat epi
I25.10 Athscl heart disease of native coronary artery *wlo* ang pctrs
I25.2 Old myocardial infarction
Z86.718 Personal history of other venous thrombosis and embolism
M13.0 Polyarthritis, unspecified
N31.9 Neuromuscular dysfunction of bladder, unspecified
J44.9 Chronic obstructive pulmonary disease, unspecified
R13.10 Dysphagia, unspecified
M71.551 Other bursitis, not elsewhere classified, right hip
Z74.09 Other reduced mobility
M54.01 Panniculitis aff regions of neck/bk, occipt-atlan-ax region
R53.81 Other malaise
K28.9 Gastrojejunal ulcer, unsp as acute or chr, *wlo* hemor or perf
Z68.27 Body mass index (BMI) 27.0-27.9, adult
K13.70 Unspecified lesions of oral mucosa
R62.7 Adult failure to thrive
R63.0 Anorexia
I10 Essential (primary) hypertension

Pre-Admission Screening:
IGC: 17.9 Other Medically complex conditions

Etiology: A. Ulcer of the GE junction, B. lower lobe atelectasis, C. seizures

Date of screening: 5/25/25

87 y/o male has been going to the VA for services. He presented to the ED with right hip pain which was going on for one day. Pain was consistent and sharp in nature. He has also had retrosternal chest pain, nonspecific. Characterized as if he has heaviness and tightness in the chest and the degree was moderate. Patient was constantly complaining of pain in the

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right knee, admitted to acute rehab prior but on day one vomited brown residue. Patient diagnosed with ileus and transferred back to medical floor before returning here. Ileus now appears to be resolved but now presents with atelectasis.

Patient has a history of CVA with left hemiplegia, epilepsy, lumbar and cervical spine surgery,

TURP of prostate, insertion of coronary stents, coronary angioplasty, HTN, CAD and was admitted for cardiac workup.

Venous doppler exam shows evidence of venous thromboses and obstruction of distal segment of the right jugular vein.

ADMISSION GG SCORE: 29

History and Physical
5/26/25

DATE OF BIRTH: 04/11/1936

HISTORY OF PRESENT ILLNESS: This is an 86-year-old male who has a history of smoking and who recently was admitted with hip pain, chest pain and has been worked up. Patient also developed some partial abdominal discomfort with nausea, but which cleared up. Patient has a known history of atrial fibrillation, cerebrovascular accident, epilepsy, hypertensive disorder, coronary artery disease and MI. Patient also had a back surgery of the cervical and lumbar spine and a TURP for prostate and coronary stent and hemorrhoidectomy.

He is mainly admitted here for rehab for his PT, occupational for strengthening.

ALLERGIES: No known allergy.

PAST MEDICAL HISTORY: History of atrial fibrillation, CVA, epilepsy, hypertension, myocardial infarction.

PAST SURGICAL HISTORY: The patient has a past surgical history of back and neck surgery, history of TURP, history of coronary artery catheterization with stent placement and history of hemorrhoidectomy.

SOCIAL HISTORY: The patient has a 60-year remote history of smoking, now stopped.

Patient has a former ETOH use, but now stopped.

HOME MEDICATIONS: See the MR in detail for the medications he has been for multiple problems. As mentioned, patient is taking: 10 mg, vitamin D3, clonidine, Colace, Cardura, Lovenox, Proscar, gabapentin, levofloxacin, lisinopril, metoprolol and a few p.r.n. medicine.

PHYSICAL EXAMINATION:

GENERAL: This is a well-developed, well-nourished male.

VITAL SIGNS: Temperature is 100, heart rate is 88, respirations 18, blood pressure 144 systolic, diastolic 82, 02 sat 96%.

CONSTITUTIONAL: No weight loss. No fever, chills, abdominal issues are now resolved.

ENT: No hearing loss. No blurred vision, no double vision.

Sclerae are clear, not yellow. Not hard of hearing.

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SKIN: No rash, no itching.
HEART: No chest pain. No chest pressure, no complaint. 81, 82 normal. No 83, no gallop.
ABDOMEN: Soft, bowel sounds present. No nausea, no vomiting or diarrhea. No muscle guarding. No phlegmon.
CHEST: Bilaterally symmetrical.
LUNGS: Congested with COPD, long history of smoking, but no shortness of breath, no diaphoresis.
GENITOURINARY: The patient has no hematuria, dysuria and now is clearing up, history of TURP.
NEUROLOGICAL: No headache, no dizziness, no syncope.
MUSCULOSKELETAL: Generalized weakness in the legs for which PT/OT has been requested and his Hematology: No anemia.
LYMPHATIC: No enlarged lymph nodes.
PSYCHIATRIC: No history of depression, looks fine.
Patient admitted to rehab. PT/OT evaluation and treatment by Dr. A- and he is participating in that.

Currently, the patient remains hemodynamically stable, I plan to keep him here until he gets well.

DIAGNOSTIC IMPRESSION: Generalized weakness, difficulty in ambulation, recent history of atrial fibrillation, atelectasis, cerebrovascular accident, epilepsy, hypertensive disorder, coronary artery disease, MI and venous thrombosis, ileus, some anorexia. Patient is tolerating food well but does not complete meals. PT/OT, has continued. Currently, the patient is stable and Dr. A- will continue the course of rehabilitation and is participating in the exercise program.

Signature Dr. B, Hospitalists

Physical Medicine and Rehabilitation Consult

Date of Admission: 5/26/25

Reason for Consult: Comprehensive rehabilitation for clinical evidence of CVA with R hemiparesis, and neurogenic bladder
Chief Complaint: new right hemiparesis

HISTORY OF PRESENT ILLNESS:
87 you. WM admitted to ABC Hospital on 5/19/25 for atypical chest pain. Cardiology ordered stress test which was normal. His hospital course further complicated by seizure d/o with subtherapeutic AED level, right extremities pain associated with weakness (HCT w/o acute pathology), urinary retention (on Tamsulosin & Foley), and pseudogout involving the right knee (non-operative).

Currently he is having persistent deficits with: Right hemiparesis, neurogenic bladder, debility, impaired ADLs, and impaired mobility. He reports having generalized right extremity pain/soreness (non-specific), worst with movements, better with Norco and rest, and associated with weakness, swelling and RUE hyperesthesia.

Prior to patient's hospitalization, pt was independent with all ADLs and intermittently using RW

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for house mobility. He has wheelchair for community as needed. Patient now with functional deficits and was thought to be a good candidate for comprehensive inpatient rehabilitation at REHAB Center.

PAST MEDICAL HISTORY:
HTN
Epilepsy
Urinary retention CAD
CVA HLD
Afib MI

Current Medications:
aspirin (aspirin chewable) 81 mg= 1 tab, Chewed, Daily
atorvastatin 10 mg= 1 tab, Oral, Q Bedtime
cholecalciferol (Vitamin 03 (cholecalciferol)) 800 int_units = 2 tab, Oral, Daily
doxazosin (Cardura) 4 mg = 1 tab, Oral, Q Evening enoxaparin (Lovenox) 40 mg = 0.4 mL, Subcut, Daily finasteride (Proscar) 5 mg = 1 tab, Oral, Q Bedtime folic acid 1 mg = 1 tab, Oral, Daily
lactulose 20 g = 30 mL, Oral, Daily
lamotrigine (LaMICtal) 100 mg= 1 tab, Oral, BID
lisinopril 10 mg = 1 tab, Oral, Daily
metoprolol 12.5 mg= 0.5 tab, Oral, Q12hr
mirtazapine (Remeron) 30 mg = 2 tab, Oral, Q Bedtime pantoprazole (Protonix) 40 mg = 1-tab, Oral, Daily Phenobarbital (Luminal) 32.4 mg = 1 tab, Oral, QAM PHENobarbital (Luminal) 64. 8 mg = 2 tabs, Oral, Q Bedtime
phenytoin (Dilantin extended release) 100 mg= 1 cap, Oral, BID
potassium chloride (KCl) 10 mEq = 1 tab, Oral, BID
mg = 1 cap, Oral, Q Bedtime
PRN: (6)
acetaminophen (Tylenol) 650 mg = 2 tab, Oral, Q4hr
acetaminophen-Hydrocodone (Norco 325 mg-10 mg oral tablet) 1 tab, Oral, Q4hr
polyethylene glycol 3350 (MiraLAX) 17 g = 1packet(s), Oral, Daily
simethicone (Millicom) 80 mg= 1 tab, Chewed, As Directed

Studies done at acute hospitalization:

IMAGING:
5/20/25: Lexiscan with Myoview myocardial perfusion imaging study.
CONCLUSION: Normal. There were no reported symptoms or diagnostic EKG changes during Lexiscan infusion. There is normal LV systolic function with no inducible ischemia

Head CT 5/19/25
IMPRESSION:
No acute intracranial abnormality.
Findings suggestive of small vessel ischemic disease, although nonspecific

CT Knee W/O Contrast Right (05/25/25)

IMPRESSION:
No acute fractures detected. Moderate-sized joint effusion. Osteoarthritic changes and

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findings suggestive of calcium pyrophosphate deposition disease

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Orthopedic Consultation

DATE OF CONSULTATION: 06/02/2025
CONSULTING PHYSICIAN: Dr. S-
REASON FOR CONSULTATION: Right hip pain.
HISTORY OF PRESENT ILLNESS: Patient is an 86-year-old male with multiple medical problems who has been admitted for hip and chest pain, managed inpatient and eventually was transferred to inpatient rehab. However, he had difficulty with ambulating this morning due to his hip pain. Pain is noted to be lateral and posterior along the hip. Patient is unable to weight bear or lift himself. When the symptoms continued to persist, orthopedic was consulted for evaluation.
PAST MEDICAL HISTORY: Notable for atrial fibrillation, CVA, epilepsy, hypertension, previous MI.

PAST SURGICAL HISTORY: Notable for spine surgery along the cervical and lumbar spine, history of transurethral resection of the prostate, stent placement and hemorrhoidectomy.
MEDICATIONS: Please refer to Medical Record.
ALLERGIES TO MEDICATIONS: INCLUDE AMOXICILLIN AND CLARITHROMYCIN.

REVIEW OF SYSTEMS:
PHYSICAL EXAMINATION:
GENERAL: Reveals a well-appearing male. He is alert and oriented x 3.
HEENT: Per internal medicine note.
CHEST: Per internal medicine note.
ABDOMEN: Per internal medicine note.
EXTREMITIES: Examination is most notable for pain along the right lateral hip with tenderness to palpation and patient with difficulty with flexion of the hip joint and flexion of the knee while supine. Patient has good dorsalis pedis pulse and has limited motor function along his ankle.
X-rays of the hip were taken, reviewed and notable for minimal osteoarthritis, but no significant fractures or deformities.

ASSESSMENT: Patient is an 86-year-old male with right hip greater trochanteric bursitis, but also possible right sciatic nerve symptoms. I have discussed with the attending physician. He does have a history of GI ulceration and was recommended that he avoid any oral anti-inflammatories or oral steroids. Thus, I have discussed with the patient a corticosteroid injection along his right greater trochanter bursa. The details of procedure and risk and benefits discussed with patient, and he wished to proceed with the procedure.

PROCEDURE NOTE: Under sterile condition, the right greater trochanter was injected with combination of 8 mL of 1% Xylocaine and 1 mL of Solu-Medrol. Patient tolerated the procedure well.

DIAGNOSES:
CVA, acute, ischemic by physical exam.

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Ileus
Pseudogout
Right hemiparesis
Right extremity pain
Seizure disorder, followed by Dr. B.
Neurogenic bladder, on Foley.

PLAN: Patient will continue with weightbearing as tolerated once he improves. Thank you for this consultation.

Discharge Summary: 6/8/25

Pain in right hip joint keeps increasing despite strong pain medication dosage. Currently with protein calorie malnutrition and diagnosis of failure to thrive, as he refuses to eat. Patient has decided to go home.

Impression: Generalized weakness and deconditioning, right hip pain with difficulty in ambulation. Patient was on PT with improvement but slowly dwindled down due to poor appetite, history of aFIB, hx of CVA, hx of epilepsy.

Discharge to home with family. Follow up with outpatient PT in 1 week.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

COMMENTS:

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