PATIENT MEDICAL RECORD — SUMMARY CHART

Patient Demographics

Field	Value
Name	Priya Sharma
DOB	November 8, 1958 (Age 67)
Sex	Female
MRN	EMP-2025-09184
Insurance	Cigna Healthcare — CIG-KL8-442091557
PCP	Dr. Lisa Park, MD — Midtown Internal Medicine
Cardiologist	Dr. William Hayes, MD — Empire Cardiology Associates

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Chief Complaint

"I've been getting short of breath climbing the stairs to my apartment for the past month. I never had this problem before."

History of Present Illness (HPI)

Ms. Sharma is a 67-year-old female referred by her PCP for cardiology evaluation of **new-onset exertional dyspnea** over the past 4-6 weeks. She reports progressive breathlessness with moderate exertion (climbing 2 flights of stairs, walking 3+ blocks) that was not present 3 months ago. She denies chest pain, palpitations, orthopnea, PND, or lower extremity edema. No recent illness, fever, or cough.

Functional decline: Previously walked 1 mile daily without difficulty. Now limited to 2-3 blocks before needing to rest.

Cardiac risk factors: Hypertension (20 years), hyperlipidemia, coronary artery disease (coronary calcium score 280 Agatston units, 2023), family history of MI (father, age 62). Never smoker.

Physical Examination (March 12, 2026)

Vitals: BP 148/86, HR 82, RR 18, SpO2 96% on room air, BMI 27.8

Cardiovascular:

- Regular rate and rhythm
- **Grade II/VI systolic murmur best heard at the right upper sternal border, radiating to the carotids — NEW (not documented on any prior exam)**
- No S3 or S4 gallop
- JVP not elevated
- No peripheral edema

Pulmonary: Clear to auscultation bilaterally, no wheezing or crackles

Assessment:

1. New-onset exertional dyspnea — etiology unclear, cardiac workup indicated
2. **New systolic murmur — concerning for aortic stenosis vs. flow murmur**
3. Known CAD — need to evaluate LV function
4. Hypertension — suboptimally controlled

Plan:

- Transthoracic echocardiogram to evaluate valvular function, LV systolic/diastolic function, and wall motion abnormalities
- BNP level
- Consider stress test based on echo results

Diagnostic Results

BNP (March 12, 2026)

Test	Result	Reference
BNP	285 pg/mL	<100 normal, 100-400 grey zone

ECG (March 12, 2026)

- Normal sinus rhythm, rate 80
- Left ventricular hypertrophy by voltage criteria
- No ST-T wave changes
- No Q waves

Echocardiogram (March 18, 2026) — PERFORMED, CLAIM DENIED

Findings:

- LV ejection fraction: 50% (low-normal, borderline)
- Mild concentric LV hypertrophy
- **Moderate aortic valve stenosis** (valve area 1.2 cm², mean gradient 28 mmHg, peak velocity 3.4 m/s)
- Mild aortic regurgitation
- Grade I diastolic dysfunction
- No pericardial effusion
- Normal RV size and function

Medications

Medication	Dose	Frequency
Amlodipine	10 mg	Daily
Losartan	100 mg	Daily
Atorvastatin	20 mg	QHS
Aspirin	81 mg	Daily

Relevant Past Medical History

- Hypertension (20 years)
- Hyperlipidemia
- CAD (calcium score 280, no prior MI, no stents, no CABG)
- Osteoarthritis, bilateral knees
- No history of heart failure, valve disease, or rheumatic fever
- No prior echocardiogram on record

Provider Notes

Dr. Hayes, March 12, 2026 (Ordering the echocardiogram):

> *New patient referral with new-onset exertional dyspnea and a new systolic murmur heard at RUSB radiating to carotids — classic location for aortic stenosis. Elevated BNP at 285. LVH on ECG. Echocardiogram is the standard first-line diagnostic for evaluating both the new murmur (suspected valvular disease) and LV function in the setting of dyspnea with elevated BNP. This is clearly indicated per ACC/AHA 2020 Valvular Heart Disease Guidelines and ACC Appropriate Use Criteria for Echocardiography.*

Dr. Hayes, March 20, 2026 (Post-echo follow-up):

> *Echo confirms moderate aortic stenosis (AVA 1.2 cm², Vmax 3.4 m/s) — this explains the murmur and likely contributes to the exertional dyspnea. Borderline EF at 50%. Will need serial monitoring q12 months. Referring for cardiothoracic surgery evaluation if symptoms progress.* ***The claim was denied due to a coding error — my billing team submitted I25.10 (CAD) as the primary diagnosis rather than the actual clinical indications (dyspnea, murmur, suspected valvular disease). I am instructing my billing coordinator to resubmit with corrected codes: R06.00, R01.1, and I35.0 (nonrheumatic aortic stenosis).***