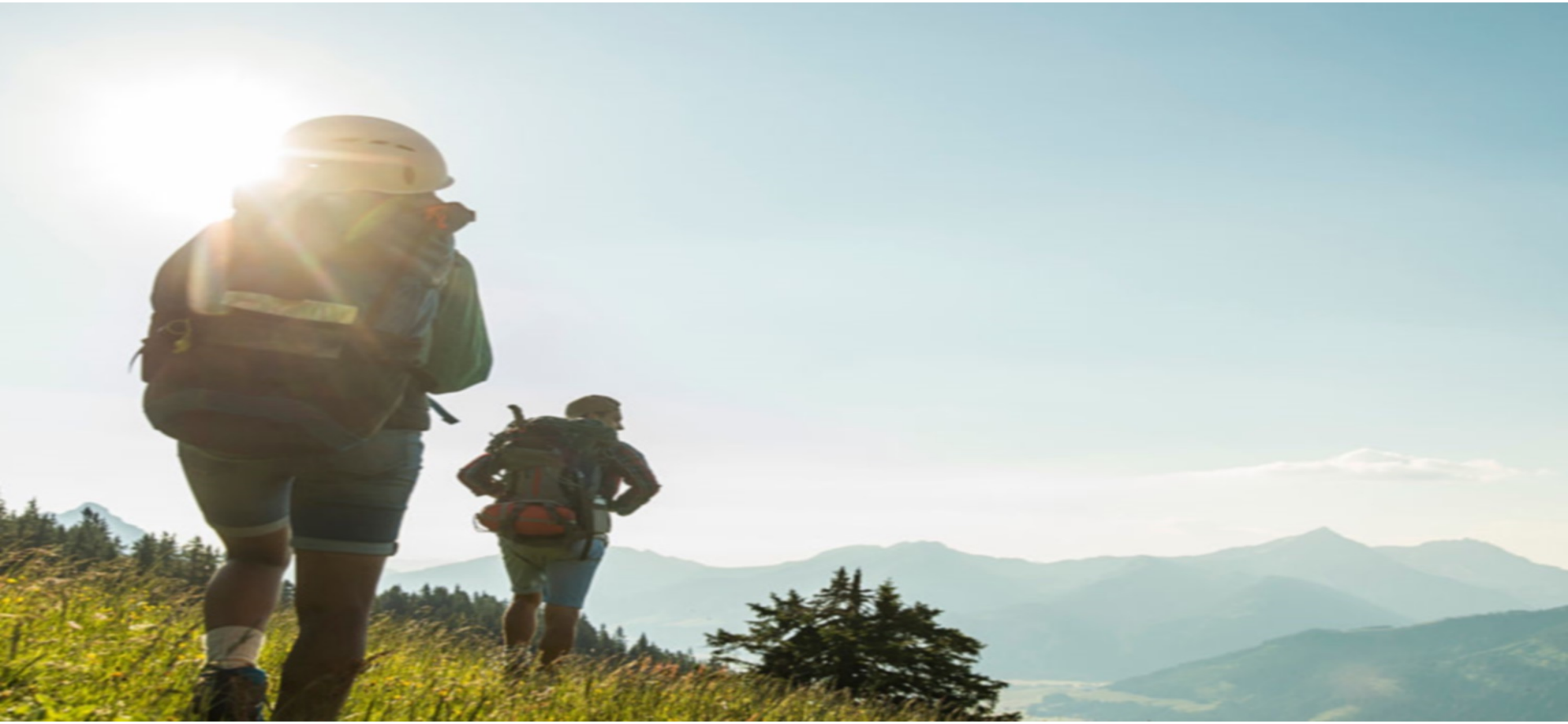
# Coding Examples
# COPD



# Six Elements of Medical Record Documentation

## 01 Reason for Appointment

- History of Present Illness

## 02 Examination

- General Appearance
- Eyes
- Heart
- Neurologic
- Extremities

## 03 Vital Signs

- Current Medication
- Past Medical History
- Social History
- Surgical History

## 04 Review of System

- General/Constitutional
- Ophthalmologic
- Respiratory
- Gastrointestinal
- Peripheral Vascular

## 05 Assessments

- Definitive diagnosis

## 06 Treatment

- Notes
- Refer to
- Reason for referral

# Correct Coding Examples

# Case #1 - Page 1 of 2

**Reason for Appointment**
Initial evaluation

**History of Present Illness**
General:
58 yo female with PMH of IBS, HTN, chronic bronchitis, and osteoporosis presents to clinic as new patient for annual physical exam. She complains of left lower leg pain that she has had worked up and been diagnosed with tendonitis and plantar fasciitis at XXXXXX hospital. She has no other complaints at this time.

**Examination**
General Appearance: alert, well hydrated, in no distress.
Head: normocephalic, atraumatic .
Oral Cavity: mucosa moist, no lesions .
Throat: clear, pharynx normal, uvula midline .
Neck/Thyroid: neck supple, full range of motion, no carotid bruit, no thyromegaly, no JVD .
Abdomen: bowel sounds present, soft, nontender, nondistended, no masses palpable, no hepatosplenomegaly .
Neurologic: AOx3, normal strength, tone and reflexes, sensory exam intact .
Extremities: full range of motion, no clubbing, cyanosis, or edema. Tenderness to palpation of lateral left lower leg up to lateral aspect of foot, worsened with applying pressure such as weight when walking. Gait is normal except for favoring of right side, no limp noted. Negative homan's sign.

**Vital Signs**

•Ht 62 in, Wt 164.5 lbs, BMI 30.08 Index, BP sitting:110/70, HR 78 /min, RR 17 /min, Temp 98.2 F, Pain scale 0 1-10, Ht-cm 157.48, Wt-kg 74.62.

**Current Medications**
Taking
Propranolol HCl 10 MG Tablet 1 tablet on an empty stomach Orally Once a day, Notes: Twice a day
Montelukast Sodium 10 MG Tablet 1 tablet Orally Once a day
Dicyclomine HCl 10 MG Capsule 2 capsules Orally TID
Vitamin D (Ergocalciferol) 1.25 MG (50000 UT) Capsule 1 capsule Orally
Cyclobenzaprine HCl 10 MG Tablet 1 tablet 1 to 2 hours before bedtime Orally Once a day
Alendronate Sodium 70 MG Tablet 1 tablet 30 minutes before the first food, beverage or medicine of the day with plain water Orally

**Past Medical History**
Chronic bronchitis.
Irritable bowel syndrome.
Hypertension.
Osteoporosis.

**Social History**
Tobacco Use:
How many cigarettes a day do you smoke? *11-20*
How soon after you wake up do you smoke your first cigarette? *31-60 minutes*
Are you interested in quitting? *Not ready to quit*

**Surgical History**
•No Surgical History documented.

# Case #1 – Page 2 of 2

## Review of Systems

General/Constitutional: Denies Change in appetite. Denies Fatigue. Denies Fever. Denies Headache. Denies Sleep disturbance. Denies Weight gain. Denies Weight loss. Denies Ear pain. Ringing in the ears denies. Snoring denies.

Respiratory: Denies Cough. Denies Shortness of breath. Denies Wheezing.

Cardiovascular: Denies Chest pain. Denies Chest pain with exertion. Denies Dyspnea on exertion. Denies Orthopnea. Denies Palpitations.

Gastrointestinal: Comments admits to reflux. Denies Abdominal pain. Denies Blood in stool. Denies Change in bowel habits. Denies Constipation. Denies Decreased appetite. Denies Diarrhea. Denies Vomiting.

Musculoskeletal: Comments admits to left leg pain laterally, including left foot laterally. Denies History of Gout. Denies Muscle aches. Denies Trauma to knee(s). Denies Trauma to ankle(s).

Neurologic: Denies Headache. Denies Memory loss. Denies Seizures. Denies Tingling/Numbness. Denies, Tremor.

**RECAP: Correct Coding**

HPI: **Documented the condition**

Current Medications: **Documented treatment**

Assessment: **Documented the condition is** present

Treatment: **Documented treatment plan**

## Assessments

1. Annual visit for general adult medical examination with abnormal findings - Z00.01 (Primary)
2. Irritable bowel syndrome without diarrhea – K58.9
3. Essential hypertension - I10
4. Chronic bronchitis, unspecified chronic bronchitis type - J42
5. Osteoporosis without current pathological fracture – M81
6. Obesity (BMI 30-39.9) - E66.9
7. Plantar fasciitis of left foot - M72.2

## Treatment

**1. Annual visit for general adult medical examination with abnormal findings**

LAB: BASIC METABOLIC PANEL (Ordered for 02/10/2020) LAB: CBC (INCLUDES DIFF/PLT) (Ordered for 02/10/2020)

**2. Irritable bowel syndrome without diarrhea –** referral to GI.

**3. Essential Hypertension- continue on propranolol.**

**4. Chronic bronchitis, unspecified chronic bronchitis type**

Refill Montelukast Sodium Tablet, 10 MG, 1 tablet, Orally, Once a day, 30 days, 30

**5. Osteoporosis-** continue alendronate.

6. **Obesity (BMI 30-39.9**

Notes: Discussed healthy diet and exercise habits to reduce BMI to within normal limits.

7. **Plantar fasciitis of left foot**

Notes: Patient agrees to sign for release of records to obtain workup and treatment that was ongoing from XXXX Hospital. Instructed patient on proper NSAID use and exercises, as well as appropriate footwear to alleviate symptoms.

# Case # 2 – Page 1 of 2

**Reason for Appointment**
Refill of medication- bronchitis/chol

**History of Present Illness**
General:
53 y/o male presents for med refills used for his chronic conditions which he is compliant with and w/o side effects.

**Examination**
General Appearance: alert; pleasant; in no acute distress; overweight.
Head: normocephalic; atraumatic; no scalp lesions.
Eyes: sclera non-icteric; conjunctiva clear.
Heart: regular rate and rhythm; S1/S2 normal; no murmurs/rubs/ gallops.
Lungs: clear to auscultation bilaterally anteriorly and posteriorly; no wheezes/rales/rhonchi.
Chest: able to speak in complete sentences; no retractions or accessory muscle use; symmetrical chest movement.
Back: no spinal deformities; normal posture and gait; full range of motion.
Musculoskeletal: normal-appearing and normal range of motion of all major joints/spine.
Skin: visible skin clear without rash/lesion noted.
Neurologic: alert and oriented; nonfocal.
Extremities: no edema/cyanosis.

**Vital Signs**
Ht 69 in, Wt 197.8 lbs, BMI 29.21 Index, BP 114/76 mm Hg, HR 63/min, RR 14 /min, Temp 97.7 F, Pain scale 0 1-10, Ht-cm 175.26, Wt-kg 89.72.

**Current Medications**
Ipratropium-Albuterol 0.5-2.5 (3) MG/3ML Solution 3 ml Inhalation every 6 hrs PRN
Albuterol Sulfate HFA 108 (90 Base) MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 6 hrs
Fenofibrate 54 MG Tablet 1 capsule with food Orally Once a day
Sildenafil Citrate 100 MG Tablet 1 tablet as needed Orally Once a day
Nebulizer Air Tube/Plugs - Miscellaneous as directed inhaled. every 6 hours
Nebulizer - Device as directed inhaled. every 6 hours

**Past Medical History**
Mixed Hypercholesterolemia And Hypertriglyceridemia.
Chronic bronchitis.
ED.

**Social History**
Tobacco Use:
Are you an other tobacco user? *No*
Tobacco Use/Smoking Are you a *nonsmoker*
Tobacco Exposure
Are you exposed to second hand smoking at home? *No*

**Surgical History**
Colonoscopy 12/12/2019

# Case #2 – Page 2 of 2

**Review of Systems**
Comments ROS negative except as documented in HPI.
Respiratory:
Comments ROS negative except as documented in HPI.
Breast:
Comments ROS negative except as documented in HPI.
Cardiovascular:
Comments ROS negative except as documented in HPI.
Gastrointestinal:
Comments ROS negative except as documented in HPI.
Hematology:
Comments ROS negative except as documented in HPI.
Musculoskeletal:
Comments ROS negative except as documented in HPI.
Peripheral Vascular:
Comments ROS negative except as documented in HPI.
Neurologic:
Comments ROS negative except as documented in HPI.
Psychiatric:
Comments ROS negative except as documented in HPI.

**RECAP: Correct Coding**
Current Medications: **Documented treatment**
Assessment: **Documented the condition is present**
Treatment: **Documented treatment plan**

**Assessments**
1. Chronic bronchitis - J42 (Primary)
2. Mixed hypercholesterolemia and hypertriglyceridemia - E78.2

**Treatment**

**1. Chronic bronchitis**

Refill Ipratropium-Albuterol Solution, 0.5-2.5 (3) MG/3ML, 3 ml,Inhalation, every 6 hrs PRN, 90 days, 360 Vial, Refills 3

Start Ventolin HFA Aerosol Solution, 108 (90 Base) MCG/ACT, 2 puffs every 4-6 hours as needed, 3, Refills 3; Notes: Clinically stable Continue pulmono mgmt.

**2. Mixed hypercholesterolemia and hypertriglyceridemia**

Refill Fenofibrate Tablet, 54 MG, 1 capsule with food, Orally, Once a day, 90 days, 90 Capsule, Refills 3

LAB: LIPID PANEL WITH REFLEX TO DIRECT LDL

LAB: COMPREHENSIVE METABOLIC PANEL

LAB: HEMOGLOBIN A1c

LAB: TSH

# Case #3 – Page 1 of 2

**Reason for Appointment**
"Management of covid 19 positive“

**History of Present Illness**

Patient male 59 yo with emphysema who accepted a virtual medical visit ( an audio video phone call), he was diagnosed positive for SARS-CoV-2 with symptoms of cough and sore throat and congestion.

**Examination**
General Appearance: alert, pleasant, well-hydrated, in no distress..
Eyes: both eyes, normal, extraocular movement intact (EOMI), sclera non-icteric.
Lungs: no wheezing heard, no coughing.
Musculoskeletal: normal appearing, normal ROM of all major joints during normal exam movements.
Neurologic: Cooperative with the interview, patient is speaking full sentences, no tremor noted.
Psych: Normal mood and affect, no anxious or depressive appearance

**Vital Signs**
Audio video phone call

**Current Medications**
Montelukast Sodium 10 MG Tablet 1 tablet Orally Once a day
Ventolin HFA 108 (90 Base) MCG/ACT Aerosol Solution 1 puff as needed Inhalation every 4 hrs
Mucinex Cough & Congest Child 2.5-5- 100 MG/5ML Liquid 10 ml as needed Orally every 4 hrs, stop date 07/15/2020 Not-Taking/PRN
ProAir HFA 108 (90 Base) MCG/ACT
Aerosol Solution 2 puffs as needed Inhalation every 6 hrs
Loratadine 10 MG Tablet 1 tablet Orally Once a day
Ibuprofen 800 MG Tablet 1 tablet with food or milk as needed Orally Three times a day, stop date 08/24/2020
Tylenol 8 Hour 650 MG Tablet Extended Release 2 tablets as needed.

**Past Medical History**
Asthma.
Emphysema.
Covid-19.

**Social History**
Are you a light tobacco smoker
Other Tobacco
Are you an other tobacco user? No

**Surgical History**
hernia

# Case #3 – Page 2 of 2

**Review of Systems**

General/Constitutional:

Denies Chills. Denies Fatigue.

Denies Fever.

Respiratory:

Denies Cough. Denies Hemoptysis.

Denies Shortness of breath. Denies Sputum production. Denies Wheezing.

Cardiovascular:

Denies Chest pain. Denies Dyspnea on exertion. Denies Fluid accumulation in the legs. Denies Palpitations.

Gastrointestinal:

Denies Abdominal pain. Denies Blood in stool. Denies Constipation.

Denies Diarrhea. Denies Hematemesis. Denies Nausea. Denies Rectal bleeding. Denies Vomiting.

Genitourinary:

Denies Blood in urine. Denies Difficulty urinating. Denies Frequent urination.

Musculoskeletal:

Denies Joint stiffness. Denies Muscle aches. Denies Painful joints.

**Assessments**

1. COVID-19 - U07.1 (Primary)
2. Pulmonary emphysema, unspecified type - J43.9
3. OSA (obstructive sleep apnea) - G47.33

**Treatment**

**1. COVID-19**
L AB: SARS CoV-2 Serology (COVID-19) Antibody (IgG)

**2. Pulmonary emphysema, unspecified type**
Cont. current meds. Montelukast & Proair; will Refer To: Pulmonologist

**3. OSA (obstructive sleep apnea)**
Referral To: Pulmonologist

**4. Others**

Notes: The patient was advised that the diagnosis is based solely upon the symptoms provided, and the diagnosis is limited due to a limited physical exam at this time. Patient verbalized understanding and agrees with the plan, and was given ample opportunity to ask questions. Patient has been educated on symptoms that require prompt in-person medical attention.

**RECAP: Correct Coding**
HPI: **Documented condition**
Current Medications: **Documented treatment**
Assessment: **Documented condition is present**
Treatment: **Documented treatment plan**

# Incorrect Coding Examples

# Case #4 – Page 1 of 2 (Added missed diagnosis)

**Reason for Appointment**

1. F/U after hospital discharge

**History of Present Illness**

General:

Patient comes for follow up after hospital discharge.

His Primary Care already knows the case and is aware of Hospitalization.

Patient is stable after Hospital Discharge, has follow up with pulmonary disease for his lrti/copd.

**Examination**

General Appearance: ill-appearing.
Head: normocephalic, atraumatic.
Oral Cavity: mucosa moist, no lesions.
Throat: no erythema, no exudate.
Neck/Thyroid: no cervical lymphadenopathy, soft, supple, no thyromegaly.
Heart: Regular rate and rhythm, normal S1 and S2, no murmurs/gallops/rubs.
Lungs: mild hypoventilation, scattered bilateral ronchi.
Abdomen: bowel sounds present, soft, nontender, nondistended

**Current Medications**

Taking

Albuterol Sulfate (2.5 MG/3ML) 0.083% Nebulization Solution 3 ml as needed Inhalation every 6 hrs

Anoro Ellipta 62.5-25 MCG/INH Aerosol Powder Breath activated 1 puff Inhalation Once a day

Sildenafil Citrate 20 MG Tablet 1 tablet Orally Three times a day

**Past Medical History**

Coronary disease.

COPD.

High cholesterol.

**Surgical History**

hip replacement 2 times 01/01/2000 hernia repair 01/01/1999

**Hospitalization/Major Diagnostic Procedure:**

Myocardial infarction 02-03/2018 Mention above

# CASE #4 – Page 2 of 2

**Review of Systems**

Respiratory: COPD admits. Patient complaining of shortness of breath, cough, sputum production.

**RECAP: Missed Diagnosis**
HPI: **Documented the condition**
ROS: **Documented the condition**
Assessment: **No mention of condition**
Treatment: **No documented treatment plan**

**Assessments**

1. Pulmonary hypertension - I27.20 (Primary)

2. Lower respiratory infection – J22

3. Chronic obstructive pulmonary disease with (acute) lower respiratory infection-J44.0 (*Diagnosis was added. Per coding guidelines "Code all conditions that coexist or affect patient's care")*

**Treatment**

**1. Pulmonary hypertension**

Start Sildenafil Citrate Tablet, 20 MG, 1 tablet, Orally, Three times a day, 30 day(s), 90, Refills 3

**2. Lower respiratory infection**

Start Azithromycin Tablet, 500 MG, as directed, Orally, daily, 7 days, 7 Tablet, Refills 0

Start Loratadine Tablet, 10 MG, 1 tablet, Orally, Once a day, 30 day(s), 30, Refills 3

# Case #5 – Page 1 of 2 (Added missed diagnosis)

**Reason for Appointment**

1. Right arm pain along with some numbness on the tip of the finger

2. Heartburns

3. Oral overgrowth

**History of Present Illness**

PT is here with cont right shoulder pain she states she fell in April she states she was seen in ER and it was dislocated, she did therapy as well. She states she cont with discomfort. She also has oral growth which she needs referral at this time. She is also having some GERD due to the meds that she was given for her shoulder pain.
Pt is a former cigarette smoker and quit 2010, 1 PKG/day since 20 y/o. Pt complains of recurrent phlegm and CXR done today 5/22/2020 show stable COPD. Pt denies cough or fever.

**Examination**

General Appearance: alert, well developed, in no acute distress.
Heart: no clicks, no murmurs, rubs, gallops, S1, S2 normal.
Neurologic: alert and oriented , gait normal.
PSYCH: anxious appearance, pt teary.
Shoulder/Upper arm: SHOULDER: right.
Inspection: no deformities , no dislocation , no muscle atrophy , no swelling or redness.
Palpation: no crepitations.
Range of Motion: full range of motion.
Strength: normal in biceps, triceps, deltoids, rotator cuff.

**Vital Signs**

Ht 61.42 in, Wt 159.0 lbs, BMI 29.63 Index, BP 128/92 mm Hg, HR 90/min, RR 18 /min, Temp 98.1 F, Pain scale 8 1-10, Ht-cm 156, Wt-kg 72.12.

**Current Medications**

Medication List reviewed and reconciled with the patient

Taking

ProAir HFA

Meloxicam 15 MG Tablet - stopped

**Past Medical History**

Hypertension.

COPD

**Surgical History**

Appendectomy 01/955 cholecystectomy 01/01/2000

Removal of mass in the breast 01/01/2012

Nodule remove from thyroid 01/2000

Endoscopy 01/2017

Colonoscopy as per pt. WNL

**Hospitalization/Major Diagnostic Procedure:**

Denies Past Hospitalization

# Case #5 – Page 2 of 2

**Review of Systems**

General/Constitutional:
Denies Change in appetite. Denies Chills. Denies Fatigue. Denies Fever. Denies Headache.
Ophthalmologic:
Denies Blurred vision, denies.
ENT:
Denies Blocked ear. Denies Decreased hearing. Denies Decreased sense of smell. Denies Difficulty swallowing. Denies Ear pain. Denies Sinus pain.
Cardiovascular:
Denies Chest pain. Denies Chest pain with exertion. Denies High blood pressure, denies. Denies Shortness of breath.
Gastrointestinal:
Denies Abdominal pain. Denies Constipation. Denies Decreased appetite. Denies Diarrhea. Admits Heartburn. Denies Nausea.
Genitourinary:
Denies Blood in urine. Denies Difficulty urinating. Denies Frequent urination. Denies Pain in lower back. Denies Painful urination.
Musculoskeletal:
Denies Back problems, denies. Denies Pain in shoulder(s). Denies Painful joints. Denies Weakness.
Neurologic:
Denies Balance difficulty. Denies Coordination. Denies Difficulty speaking. Denies Dizziness. Denies Gait abnormality. Denies Headache. Denies Irritability. Denies Loss of strength. Denies Low back pain. Denies Memory loss.

**Assessments**

1. Oral mucocele - K13.79 (Primary)
2. Pain in right shoulder - M25.511
3. Other chronic pain - G89.29
4. Gastroesophageal reflux disease without esophagitis - K21.9
5. Chronic obstructive pulmonary disease, unspecified - J44.9 (*Diagnosis was added. Per coding guidelines "Code all conditions that coexist or affect patient's care")*

**Treatment**

1. Oral mucocele
Referral To: Maxillofacial Surgery Reason: oral mucocele

**2. Pain in right shoulder**
Referral To: Physical Therapist Reason: Chronic right shoulder pain

**3. Gastroesophageal reflux disease without esophagitis**
Start Esomeprazole Magnesium Capsule Delayed Release, 40 MG, 1 capsule, Orally, Once a day, 30 day(s), 30 Capsule, Refills 6

**4. Anxiety**
Notes: ALPRAZOLAM 1 mg RX given 15 tablets no refills.
Clinical Notes: EFORCE checked last RX 4/29 for 30 days.

**RECAP: Missed Diagnosis**
HPI: **Documented the condition**
Current Medications: **Documented treatment**
Assessment: **No mention of condition**
Treatment: **No documented treatment plan**

# Quick Tips (ICD-10- CM)

COPD is a chronic inflammatory lung disease that causes obstructed flow of air from the lungs. The disease is progressive in nature and typically will worsen over time. The most common cause of COPD is smoking tobacco. COPD is increasingly being used to document lung disease. The coder must review the record for further specificity of the disease. Emphysema and chronic bronchitis are the two main conditions of COPD. COPD can also be further clarified to be with acute exacerbation. *(https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679)*

In coding, if patients have COPD and asthma documented, without any further specificity of the type of asthma, only COPD would be reported. Per the instructional notes under Category J44, Other chronic obstructive pulmonary disease, code also type of asthma, if applicable (J45-). Unspecified asthma isn't a specific type of asthma, so no additional code would be assigned for unspecified asthma. If the unspecified asthma is documented to be in exacerbation it would be coded in addition to the COPD. Exacerbation of unspecified asthma does not describe a type of asthma, but it does provide additional specificity regarding the asthma being in acute exacerbation. *(ICD-10 Coding Guidelines, Category J44) (AHA Coding Clinic for ICD 10, 2017, 1st Quarter, Pg. 25.)*

# Quick Tips (ICD-10- CM)

The documentation in a record of COPD with exacerbation and the patient also has asthma does not automatically make the asthma exacerbated. Or, if the asthma is documented as with exacerbation, this does automatically make the COPD with exacerbation. Each condition would need to be documented as exacerbated in order to code to this specificity. (*AHA Coding Clinic for ICD 10, 2017, 1st Quarter, Pg. 25, 26)*

# THANK YOU

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