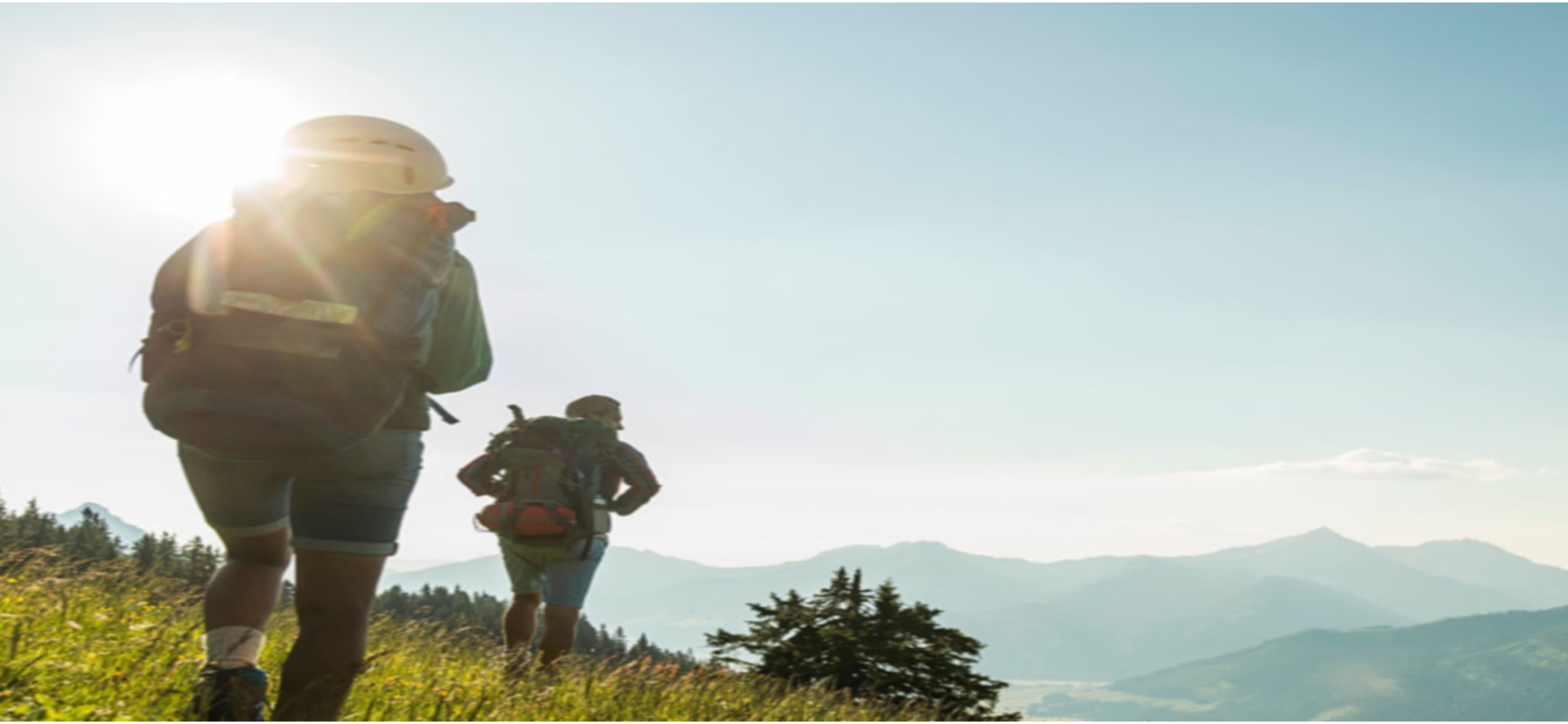
Coding Examples
Congestive Heart Failure



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

Referral for Neurology

History of Present Illness

Telemedicine:

dob and address confirmed with patient

Pt with hx of CVA 20 years. No sequela. Pt refers that it started by crossing eyes, patient having the same symptoms at this moment. that have happened 3x in the last month.

Pt taking carvedilol for heart failure, Pt went to cardiologist about 2 weeks ago and no change was made.

Examination

General Appearance: in no acute distress.
Head: normocephalic, atraumatic.
Eyes: sclera non-icteric.
Ears: hears provider well.
Oral Cavity: mucosa moist, good dentition.
Neck/Thyroid: neck supple, full range of motion.
Neurologic: answers questions appropriately.

Vital Signs

N/A

Current Medications

Taking

Carvedilol 6.25 MG Tablet 1 tablet with food Orally Twice a day

Warfarin Sodium 5 MG Tablet 1 tablet Orally Once a day

Medication List reviewed and reconciled with the patient

Past Medical History

Medical History Verified.

Case #1 – Page 2 of 2

Review of Systems

General/Constitutional:

Patient denies sob, fever, pain.

Neurologic:

Patient complaining of s/p cva, altered perception.

Assessments

1. Hypertensive heart disease with heart failure - I11.0 (Primary)
2. Chronic heart failure, unspecified heart failure type - I50.9
3. Status post CVA - Z86.73
4. Alteration in perception - R44.9

Treatment

1. Hypertensive heart disease with heart failure

Notes: continue carvedilol and f/up by cardio.

2. Chronic heart failure, unspecified heart failure type

Notes: continue carvedilol and f/up by cardio.

3. Status post CVA

Referral To: Neurology

Reason: Evaluation and treatment, thank you.

4. Alteration in perception

Referral To: Neurology

Reason: Evaluation and treatment, thank you.

RECAP:

HPI: **Documented the condition with treatment.**
Assessment: **Documented the condition is present**
Treatment: **Documented in the treatment plan and medication list.**

Case #2 – Page 1 of 2

Reason for Appointment
Annual

History of Present Illness
General:
Patient presents for annual physical; patient has history of pulmonary hypertension and is being followed by a cardiologist but requires referrals

Examination
General Appearance: alert, pleasant, in no acute distress. Patient is wearing a medicine pump and has venous port.
Head: Normocephalic, atraumatic.
Eyes: extraocular movement intact (EOMI) , pupils equal, round, reactive to light.
Heart: no murmurs, rubs, gallops.
Lungs: clear to auscultation bilaterally.
Skin: bilateral venous congestion of the legs extending up to the knees, skin is cool to the touch with multiple varicosities, skin is darker as compared to thighs and knees.

Vital Signs

Vitals: Ht 71 in, Wt 187 lbs, BMI 26.08 Index, BP 109/82 mm Hg, HR 81 /min, RR 17 /min, Temp 98.5 F, Oxygen sat % 95 %, Pain scale 0 1-10, Ht-cm 180.34, Wt-kg 84.82.

Current Medications
Taking Amoxicillin 875 MG Tablet 1 tablet Orally every 12 hrs, notes: for ten days
Taking Apixaban 5 MG Tablet 1 tablet Orally
Every 12 hours, Taking Midodrine HCl 5 MG Tablet 1 tablet Orally Three times a day,
Taking Sildenafil Citrate 20 MG Tablet 1 tablet Orally Three times a day
Taking Spironolactone 100 MG Tablet 1 tablet Orally Every 12 hours
Taking Torsemide 20 MG Tablet as directed Orally daily
Taking Veletri

Past Medical History
Pulmonary problem

Hospitalization/Major Diagnostic Procedure:

pulmonary hypertension 01/04/2020

Case #2 - Page 2 of 2

Review of Systems

General/Constitutional:
Patient complaining of skin changes to both legs. Denies Fever.
Allergy/Immunology:
Denies Wheezing.
ENT:
Denies Ear problems.
Endocrine:
Denies Thyroid problems.
Respiratory:
Patient complaining of pulmonary hypertension and edema which was drained via pleurodesis while at hospital. Denies Chest pain. Denies Cough. Denies Pain with inspiration. Denies Shortness of breath. Denies Shortness of breath at rest. Denies Wheezing

RECAP:
HPI: **Documented the condition with treatment.**
ROS: **Documented the condition as present.**
Assessment: **Documented the condition is present.**
Treatment: **Documented in the treatment plan and medication list.**

Assessments
1. Annual physical exam - Z00.00 (Primary)
2. Pulmonary hypertension - I27.20
3. Heart failure - I50.9

Treatment

1. Annual physical exam

Clinical Notes: Patient will go for labs tomorrow as he will be close to the clinic for his Cardio appt.

2. Pulmonary hypertension
Start Torsemide Tablet, 20 MG, 1 tablet, Orally, Once a day, 60 days, 60 Tablet, Refills 1 .
Clinical Notes: Patient referred to Pulmonology as well as vascular surgery due to venous congestion of the legs secondary to pulmonary HTN.
Referral To: Pulmonology

3. Heart failure
Start Sildenafil Citrate Tablet, 20 MG, 1 tablet, Orally, Three times a day, 30 day(s), 90 Tablet, Refills 1 . Clinical Notes: Patient has appointment with Cardiologist tomorrow.

Case #3 – Page 1 of 2

Reason for Appointment
Referral to Cardiology
History of Present Illness
General:
51 year old male.
-Patient with medical HX of HTN and heart condition has app today at 1:40 pm and wants the referral. Patient states feeling well .

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.

Current Medications

Taking

Entresto 24-26 MG Tablet 1 tablet Orally Twice a day

Carvedilol 6.25 MG Tablet 1 tablet with food Orally Twice a day

Furosemide 40 MG Tablet 1 tablet Orally Once a day

Not-Taking/PRN

Lisinopril 5 MG Tablet 1 tablet Orally Once a day

Past Medical History
High Blood Pressure

Surgical History

No Surgical History documented

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. Chronic diastolic heart failure - I50.32 (Primary)

2. Essential hypertension - I10 (The correct code should be I11.0 – Hypertensive heart disease with heart failure. Per coding guidelines, a diagnosis should be coded to highest level of disease specificity.)

Treatment

1. Chronic diastolic heart failure

Continue Carvedilol Tablet, 6.25 MG, 1 tablet with food, Orally, Twice a day

2. Essential hypertension

Continue Entresto Tablet, 24-26 MG, 1 tablet, Orally, Twice a day Continue Furosemide Tablet, 40 MG, 1 tablet, Orally, Once a day Notes: stable at this time

RECAP:
Assessment: **Documented the condition is present.**
Treatment: **Documented in the treatment plan and medication list.**

Incorrect Coding Examples

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

Reason for Appointment

Abnormal findings on EKG; h/o PAD; exertional chest discomfort

History of Present Illness

General:

The patient is a 77 y.o. male NP who is referred for initial cardiovascular evaluation. The patient has a history of PAD. Recent EKG showed abnormal findings (RBBB). The patient presently complains of worsening LE intermittent claudication over the last few months, new-onset exertional chest discomfort. The patient denies any recent visits to the hospital/ED/UC. Pt. is currently on Losartan 50MG for acute rt. heart failure. The patient reports compliance with medications and denies side effects or adverse events.

Examination

General Appearance: alert, in no distress, well developed, well nourished.

Head: normocephalic, atraumatic.

Eyes: sclera anicteric, conjunctiva clear, pupils equal, round.

Neck/Thyroid: no jugular venous distention.

Lungs: eupneic at rest, no conversational cough or dyspnea.

Neurologic: alert and oriented, cooperative.

Extremities: no clubbing, cyanosis, or edema; no varicose veins.

EKG Interpretation: 06/2020: SR 67 bpm, complete RBBB.

Vital Signs

Ht 66 in, Wt **187 lbs**, BMI 30.18 Index, Ht-cm 167.64, Wt-kg 84.82.

Current Medications

Taking

Losartan Potassium 50 MG Tablet 1 tablet Orally Once a day

Atorvastatin Calcium 20 MG Tablet 1 tablet Orally Once a day, Notes: undefined

Tamsulosin HCl 0.4 MG Capsule 1 capsule Orally Once a day

Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day Notes: undefined

Not-Taking/PRN

Shingrix 50 MCG/0.5ML Suspension Reconstituted as directed Intramuscular

Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension.

Acute rt. heart failure

PAD: LE intermittent claudication. Obesity.

BPH.

Case #4 – Page 2 of 2

Review of Systems

General/Constitutional:
Patient denies change in appetite, chills, fatigue, fever, night sweats, weight loss, weight gain, sleep disturbance.
Respiratory:
Patient denies cough, sputum production, hemoptysis, pain with inspiration, shortness of breath at rest, wheezing. COPD denies. Hx of pulmonary embolism denies.
Peripheral Vascular:
Patient denies absent pulses in feet, blanching of skin, cold extremities, pain/cramping in legs after exertion, painful extremities, ulceration of feet, blood clots in legs, varicose veins, skin discoloration.
Neurologic:
Patient denies balance difficulty, difficulty speaking, dizziness, gait abnormality, headache, loss of strength, memory

RECAP:
HPI: **Documented condition with treatment.**
Assessment: **Condition not added.**
Treatment: **Documented in the medication list**

Assessments
1. Anginal pain - I20.9 (Primary)
2. RBBB (right bundle branch block) - I45.10
3. PAD (peripheral artery disease) - I73.9
4. Pure hypercholesterolemia - E78.00
5. Acute Right Heart Failure - I50.811 (*Diagnosis was added . Per coding guidelines "Code all conditions that coexist or affect patient's care")*

Treatment

1. Anginal pain Start Bisoprolol Fumarate Tablet, 5 MG, 1 tablet, Orally, Once a day, 90 days, 90 Tablet, Start Isosorbide Mononitrate ER Tablet XR 24 Hour, 30 MG, 1 tablet in the morning, Orally, Once a day, 90 days, 90 Tablet

2. RBBB (right bundle branch block) Imaging: ECHO TRANSTHORACIC ; CT cardiac calcium scoring

3. PAD (peripheral artery disease) Continue Atorvastatin Calcium Tablet, 40 MG, 1 tablet, Orally, Once a day, 90 days, 90 Tablet, Continue Aspirin Tablet Delayed Release, 81 MG, 1 tablet

4. Pure hypercholesterolemia Continue Atorvastatin Calcium Tablet, 40 MG, 1 tablet, Orally, Once a day, 90 days, 90 Tablet

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

Reason for Appointment

1. Annual check up
2. "I have burning sensation when urinate and pain on right arm"

History of Present Illness

57 years old female with medical HX of HTN, type 2 diabetes mellitus on Metformin, CHF on coreg came to the office for annual physical exam and to continue care .Patient admits today burning in urination, denies fever. Also, patient admits right arm muscle pain scale 3/10. See ROS.

Examination

General Appearance: alert, in no acute distress, well nourished.
Nose: nares patent.
Throat: clear, no erythema, no exudate, pharynx normal, tonsils normal, uvula midline.
Neck/Thyroid: soft, supple, full range of motion, no cervical lymphadenopathy, neck supple, (-) cervical lymphadenopathy, (-) thyromegaly, (-) masses, (-) tenderness.
Heart: no clicks, no murmurs, rubs, gallops, S1, S2 normal, S1, S2 regular rate and rhythm.
Musculoskeletal: No paraspinal tenderness to palpation. normal appearing, normal ROM of all major joints/spine during normal exam movements, , Strength 5/5.No acute process noted
Neurologic: non focal, gait normal, motor strength of upper and lower extremities BL within normal limits, no tremor, sensory exam intact.
Extremities: full range of motion , good capillary refill in nail beds, no clubbing, cyanosis, or edema.

Vital Signs

Ht 72.83 in, Wt 271 lbs, BMI 35.92 Index, BP 118/74 mm Hg, HR 74 /min, RR 19 /min, Temp 98.7 F, Pain scale 10 1-10, Ht-cm 184.99, Wt-kg 122.92 Right arm.

Current Medications

Taking

Isosorbide Dinitrate Tablet, 30 MG

Metformin HCl 1000 MG Tablet 1 tablet with a meal Orally bid

Coreg 6.5 MG Tablet

Past Medical History

STEMI (02/17/2018).
HTN.
Diabetes II.
Hx of sciatic pain.

Surgical History

•Cholecystectomy Appendectomy
•Total Hysterectomy (ovary condition 1993 Inguinal catheterism 02/27/2018
•Cardiac cath 08/2019

Hospitalization/Major Diagnostic Procedure:

•Chest pain 02/27/2018

Case #5 – Page 2 of 2

Review of Systems

General/Constitutional: denies fever, fatigue.

Ophthalmologic: denies visual change, redness, pain.

ENT: denies ear or throat pain, nasal congestion/rhinorrhea.

Cardiovascular: denies chest pain, SOB, palpitations, vascular problems.

Respiratory: denies asthma/COPD, cough, sputum, wheezing, SOB.

Genitourinary: Pt denies pelvic Pain, Admit – Burning with urination (Dysuria), Frequent Urination (Urinary Frequency), Urgent urination (urinary urgency), Blood in urine (Hematuria, Incomplete Bladder emptying, Urinary Incontinence, and Sexually Transmitted Disease Exposure (STD exposure).

Gastrointestinal: denies N/V/D/C, heartburn, GERD.

Endocrine: denies heat/cold intolerance, hormone problems.

Musculoskeletal: denies neck/back/joint/muscle pain or weakness; admits right arm pain scale 5/10 ,no radiating.

Neuro: denies motor/sensory problems, dizziness, HA, syncope.

Psych: denies

RECAP:

HPI: **Documented condition with treatment.**

Assessment: **Condition not added.**

Treatment: **Documented in the medication list.**

Assessments

1. Annual visit for general adult medical examination with abnormal findings - Z00.01 (Primary)
2. Hypertension- I10 (The correct code should be I11.0 – Hypertensive heart disease with heart failure. Per coding guidelines, a diagnosis should be coded to highest level of disease specificity.)
3. Cystitis- N30.90
4. Muscle pain, right arm –M79.10
5. Type 2 diabetes mellitus without complications – E11.9
6. Heart failure, unspecified –I5.09 (*Diagnosis was added . Per coding guidelines "Code all conditions that coexist or affect patient's care")*

Treatment

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

LAB: CBC, BMP, LFT, LIPID panel, Hemoglobin A1C. Annual labs ordered today

2. Hypertension

Continue Isosorbide Dinitrate Tablet, 30 MG

3. Cystitis

Notes: Oriented to drink plenty fluid .urine test was order today.

4. Muscle pain

Continue Tylenol 8 Hour Arthritis Pain Tab Ext. Release, 650 MG

5. Type 2 diabetes mellitus without complications

Notes: Stable this time . Advised pt to continue to monitor BS

Case #6 – Page 1 of 2 (Added missed diagnosis)

Reason for Appointment
Hospital discharge and cardio referral

History of Present Illness

General:63 y/o male patient comes in today for follow up after hospital discharge on 02/15/2020 after being treated for CHF and is scheduled for heart valve replacement on the 02/26/2020, will request medical record . Patient with CHF, HTN and DM type 2. Patient needs Cardiologist referral for continuation of care and to scheduled heart valve replacement procedure. Patient mentioned he only has SOB and dyspnea upon exertion. No chest pain reported. No other symptoms reported.

Examination
General Appearance: alert, well hydrated, in no distress .
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.
Heart: irregularly irregular rhythm, murmurs and rubs present.
Lungs: mild diminished breath sounds throughout.
Abdomen: bowel sounds present, soft, nontender, nondistended, no masses palpable, no hepatosplenomegaly.
Neurologic: AOx3, normal strength, tone and reflexes, sensory exam intact.
Extremities: bilateral 3+ pitting edema lower extremities.

Vital Signs

Ht **66.1 in**, Wt **206 lbs**, BMI **33.15 Index**, BP **129/78 mm Hg**, HR **74 /min**, RR **17 /min**, Temp **98.0 F**, Oxygen sat % 97 %, Ht-cm 167.89, Wt-kg 93.44.

Current Medications

Furosemide 20 MG Tablet 1 tablet Orally Once a day

Aspirin 81 81 MG Tablet Chewable as directed Orally

Carvedilol 6.25 MG Tablet as directed Orally

Losartan Potassium 25 MG Tablet 1 tablet Orally Once a day

Metformin HCl 1000 MG Tablet take one tablet by mouth one time daily-Oral

Medication List reviewed and reconciled with the patient

Past Medical History

Hypertensive heart disease with CHF

Type 2 diabetes mellitus.

Surgical History

•No Surgical History documented.

Case #6 - Page 2 of 2

Review of Systems

General/Constitutional:
Change in appetite denies. Fatigue denies. Fever denies. Night sweats denies. Sleep disturbance denies. Weight gain denies.
Weight loss denies.

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

Musculoskeletal:
Joint stiffness denies. Muscle aches denies. Painful joints denies.

Neurologic:
Headache denies. Memory loss denies. Seizures denies. Tingling/Numbness denies. Tremor denies.

Psychiatric:
Anxiety denies. Depressed mood denies. Substance abuse denies.
Suicidal thoughts denies.

RECAP:

HPI: **Documented condition with treatment.**
Assessment: **Documented condition, but not coded to the highest specificity of code.**
Treatment: **Documented in the treatment plan and medication list.**

Assessments

1. . Hospital discharge follow-up - Z09 (Primary)

2. Type 2 diabetes mellitus with cardiac complication - E11.59

3. Hypertensive heart disease with heart failure - I11.0 (Per ICD-10 Coding Guidelines -Use additional code to identify type of heart failure – See below)

4. Congestive heart failure – I50.9 (*Diagnosis was added . Per coding guidelines)*

Treatment

1. Hospital discharge follow-up

Notes: request all medical records from XXXXX

2. Type 2 diabetes mellitus with cardiac complication

Refill Metformin HCl Tablet, 1000 MG, TAKE ONE TABLET BY MOUTH ONE TIME DAILY, Oral, Once a day, 90 days, 90, Refills

3. Hypertensive heart disease with heart failure

Continue Losartan Potassium Tablet, 25 MG, 1 tablet, Orally, Once a day Continue Carvedilol Tablet, 6.25 MG, as directed, Orally

Continue Aspirin 81 Tablet Chewable, 81 MG, as directed, Orally Continue Furosemide Tablet, 20 MG, 1 tablet, Orally, Once a day

Notes: Pt advised High blood pressure is a condition that puts you at risk for heart attack, stroke, and kidney disease. It does not usually cause symptoms. But it can be serious.

Quick Tips (ICD-10- CM)

In coding Hypertensive heart disease with heart failure, use ICD-10 code I11.0. The classification presumes a causal relationship between hypertension and heart involvement unless the provider documents that the conditions are unrelated. The type of heart failure from the I50 series should also be coded: AHA Coding Clinic 2017 First Quarter Number 1 Volume 4 , Page 47 titled "I10 Hypertension with Congestive Heart Failure"

Code I11.0, Hypertensive heart disease with heart failure. The classification presumes a causal relationship between hypertension and heart involvement unless the provider documents that the conditions are unrelated. The type of heart failure from the I50 series should also be coded:

I50.1, Left ventricular failure, you

I50.2, Systolic (congestive) heart failure,

I50.3, Diastolic (congestive) heart failure,

I50.4, Combined systolic and diastolic heart failure,

I50.9, Heart failure, unspecified.

THANK YOU

Commercial Risk Adjustment Team
Devon Woolcock CPC, CRC
Please send any questions to:
Commercial Risk Adjustment Provider Educator Team:
CRAProviderEducationTeam@bcbsfl.com