Coding Examples
Major Depression and Bipolar Disorders

Six Elements of Medical Record Documentation

01 Reason for Appointment

- History of Present Illness

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- Heart
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- Extremities

03 Vital Signs

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- Surgical History

04 Review of System

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- 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

Test results

Medication refills

History of Present Illness

General:

Patient is a 51 y/o female who presents today for test results and medication refill for her htn, HLD & bipolar.

Examination

General Appearance: alert, well hydrated, in no distress.
Head: normocephalic, atraumatic.
Eyes: extraocular movement intact (EOMI) , pupils equal, round, reactive to light and accommodation, sclera non-icteric.
Neurologic: nonfocal, alert and oriented

Vital Signs

Ht 61 in, Wt **134 lbs**, BMI **25.32 Index**, BP **sitting:100/70**, HR **85 /min**, RR **14 /min**, Temp **98.2 F**, Oxygen sat % **98 %**, Pain scale 0 1-10, Ht-cm154.94, Wt-kg 60.78.

Current Medications

Taking

Losartan Potassium 50 MG Tablet 1 tablet Orally Once a day

Amlodipine Besylate 5 MG Tablet 1 tablet Orally Once a day

Escitalopram Oxalate 20 MG Tablet 1 tablet Orally Once a day

Aripiprazole 2 MG Tablet 1 tablet Orally Once a day

Past Medical History

Hypertension

Bipolar disorder

Case #1 – Page 2 of 2

Review of Systems

General/Constitutional: Denies Change in appetite. Denies Fatigue. Denies Fever. Denies Sleep disturbance. Denies Weight gain. Denies Weight loss.

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

RECAP:

HPI: **Documented the condition**
Current Medications: **Documented treatment**
Assessment: **Documented the condition is present**
Treatment: **Documented treatment plan**

Assessments

1. Hypertension - I10 (Primary)
2. Dyslipidemia - E78.5
3. Bipolar affective disorder, remission status unspecified - F31.9
4. Person consulting for explanation of examination or test findings - Z71.2

Treatment

1. Hypertension

Refill Losartan Potassium Tablet, 50 MG, 1 tablet, Orally, Once a day, 90 days, 90 Tablet, Refills 2 Refill Amlodipine Besylate Tablet, 5 MG, 1 tablet, Orally, Once a day, 90 days, 90 Tablet, Refills 2

2. Dyslipidemia

Notes: Patient counseled on the importance of a balanced low-fat diet and was advised to exercise at least 150 minutes/week divided in 3-5 daily sessions., High Cholesterol: Care Instructions material was published.

3. Bipolar affective disorder, remission status unspecified Refill Aripiprazole Tablet, 2 MG, 1 tablet, Orally, Once a day, 90 days, 90 Tablet, Refills 0

Notes: As per patient-reported, following Psychiatrist . Well-controlled with current treatment.

Requested medication refills. , Bipolar Disorder: Care Instructions material was published.

4. Person consulting for explanation of examination or test findings

Notes: Test results discussed with patient

Case #2 – Page 1 of 2

Reason for Appointment

Anxiety attack

Medication refill

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: anxious appearance.

Current Medications

Taking

Valtrex 500 MG Tablet 1 tablet Orally Once a day, stop date 09/11/2020

Medication List reviewed and reconciled with the patient

Past Medical History

Heart attack (2011).

Hospitalization/Major Diagnostic Procedure:

Denies Past Hospitalization

Case #2 – Page 2 of 2

Review of Systems

General/Constitutional:
Patient denies fever , chills , weakness.
ENT:
Patient denies decreased hearing , hoarseness.
Endocrine:
Patient denies cold intolerance , Heat Intolerance.
Respiratory:
Patient denies cough , wheezing.
Cardiovascular:
Patient denies chest pain , palpitations.
Gastrointestinal:
Patient denies abdominal pain , change in bowel habits.
Men Only:
Patient denies hernia , scrotal pain.
Genitourinary:
Patient denies difficulty urinating , frequent urination.
Musculoskeletal:
Patient denies joint stiffness , muscle aches.
Psychiatric:
Patient denies feelings of anxiety ,feelings of depression

RECAP:

Reason for appointment: **Documented the condition**
Examination and ROS: **Documented the condition**
Assessment: **Documented the condition is present**
Treatment: **Documented treatment plan**

Assessments

1. Severe episode of recurrent major depressive disorder, without psychotic features - F33.2 (Primary)
2. GAD (generalized anxiety disorder) - F41.1
3. Herpes - B00.9

Treatment

1. Severe episode of recurrent major depressive disorder, without psychotic features

Start Sertraline HCL Tablet, 50 MG, 1 tablet, Orally, Once a day, 30 day(s), 30 Tablet, Refills 2

Clinical Notes: Patient previously treated with Zoloft; admits good tolerance Referral : Reason: please evaluate patient with anxiety/depression and anxiety attacks for treatment

2. GAD (generalized anxiety disorder)

Start Diazepam Tablet, 5 MG, 1 tablet as needed, Orally, Once a day, 30 days, 30 Tablet, Refills 0, Notes: for panic attacks

3. Herpes

Start Ibuprofen Tablet, 800 MG, 1 tablet with food or milk as needed, Orally, Three times a day, 20 days, 60 Tablet, Refills 1

Clinical Notes: Suffering herpes outbreak; tx with acyclovir but pain is significant.

Case #3 – Page 1 of 2

Reason for Appointment

3 month f/u, Bipolar 1 disorder

History of Present Illness

General:
Patient is a 45 y/o female who presents today for follow-up.
Current tobacco use. 1 pack per day.

Examination

General Appearance: female, in no acute distress, well developed, well nourished.
Mental Status: alert and oriented.
Heart: no murmurs, no S3, S4, regular rate and rhythm, S1, S2 normal. LUNGS: clear to auscultation bilaterally.

Vital Signs

Temp **98.2 F**, BP **107/68 mm Hg**, Ht 65.5 in, HR **89 /min**, RR **17 /min**, Wt **129.8 lbs**, Oxygen sat % 98 %, BMI **21.27 Index**, Ht-cm 166.37, Wt-kg 58.88.

Current Medications

Taking
Lamictal 100 MG Tablet 1 tablet Orally Once a day
Gabapentin 300 MG Capsule 1 capsule Orally Once a day
Ropinirole HCl 0.5 MG Tablet 1 tablet Orally nightly
Diflucan 150 MG Tablet 1 tablet Orally Once

Case #3 – Page 2 of 2

Review of Systems

General/Constitutional:
Change in appetite denies. Chills denies. Fever denies.
ENT:
Decreased hearing denies. Sore throat denies. Swollen glands denies.
Endocrine:
Cold intolerance denies. Excessive thirst denies. Heat intolerance
denies. Weight loss denies.
Respiratory:
Cough denies. Shortness of breath at rest denies. Shortness of breath with exertion denies. Wheezing denies.
Cardiovascular:
Chest pain at rest denies. Chest pain with exertion denies. Irregular
heartbeat denies. Shortness of breath denies.
Gastrointestinal:
Abdominal pain denies. Diarrhea denies. Nausea denies. Vomiting
denies.
Genitourinary:
Blood in urine denies. Difficulty urinating denies. Frequent urination denies.
Musculoskeletal:
Painful joints denies. Weakness denies.
Neurologic:
Dizziness denies. Fainting denies. Headache denies.

RECAP:

Reason for appointment: **Documented condition**
Current Medications: **Documented current treatment**
Assessment: **Documented the condition is present**
Treatment: **Documented treatment plan**

Assessments

1. Bipolar 1 disorder - F31.9 (Primary)
2. Nicotine abuse/ dependence - F17.200
3. Schizophrenia, unspecified - F20.9

Treatment

1. Bipolar 1 disorder, depressed Refill Lexapro Tablet, 20 MG, 1 tablet, Orally, Once a day, 90 days, 90 Refill Lamictal Tablet, 100 MG, 1 tablet, Orally, Once a day, 90 days, 90 Refill Gabapentin Capsule, 300 MG, 1 capsule, Orally, Once a day

Clinical Notes: Patient currently stable with medication

2. Nicotine abuse/ dependence
Clinical Notes:
Counseled on risks associated with smoking
Continue to monitor
Reassess with next clinic visit

3. Schizophrenia, unspecified
Clinical Notes:
Continue to monitor
Discussed need for patient to maintain adherence to medication
Recommended continued mental health counseling
Reassess with next clinic visit

Case #4 – Page 1 of 1

Reason for Appointment
f/u with psych, Major depression and bipolar d/o, bpd

History of Present Illness
Mr. Singer's PHQ 9 today is a 5. He has issues with anhedonia, depression (depends on the day 2-10 with 10 being the worst), sleep, fatigue and trouble concentrating on some days. Currently his bipolar d/o is in remission. Denies issues with appetite, feeling bad about self, and has not thoughts of harming self in any way. Anxiety has been running high (a 10 lately). States a lot has happened since last seen. Oldest son had an outburst a couple months ago, he told him to get out, and to son's surprise, his wife backed him up. He has since come back home and is acting better. Son is not open to seeking treatment or with considering meds, which he feels he needs. Had court hearing for social security, is waiting to hear results-increased money could make it so his wife can work less. Had to go in front of a judge and was a nervous wreck. Mr. Singer and his wife have decided to wait to move up north until younger son graduates from high school which has turned out to be a good thing because it gives him and his wife more time to get things in order to move. The patient has been spending more time with his wife which is good for both as well. Sometimes he feels a fear of abandonment or being left alone due to his mental issues but since being on Lamotrigine, he feels his moods are evening out a bit. Mr. Singer will continue to utilize supportive and cognitive therapies in managing self and relationships with others.

Assessments

1. Major depression, recurrent, with bipolar d/o currently in full remission, most recent episode depressed –F31.76
2. Borderline personality disorder , F60.3

Plan

1. Diagnostic steps: none apply.
2. Psychotherapy: Continue psychotherapy to include cognitive behavior therapy, supportive therapy and solution-focused therapy
- Frequency: every other week
- Today's therapy homework: apply the approaches discussed today and return with feedback
3. Medication/Somatic Treatment: Continue Lamotrigine 200 mg daily
4. Routine Monitoring: obtain PHQ-9
5. Psychoeducation: Psychoeducation was done today with the patient and relevant others. It included review of diagnosis and treatment plan, recommendations for follow up care, answering questions, providing educational materials related to the patient's condition, providing clinic contact information and providing information for emergencies and crises.
6. Disposition: continue outpatient care

RECAP:
Reason for appointment: **Documented condition**
Current Medications: **Documented current treatment**
Assessment: **Documented the condition is present**
Treatment: **Documented treatment plan**

Case #5 – Page 1 of 2

Reason for Appointment

Patient presented to the clinic for f/u chronic headaches and **major depression**

History of Present Illness

Mrs. Warby presents today for a re-check of headaches. Pain scale is 3/10. The onset of the headache has been gradual and occurring in an intermittent pattern for 6 months. The course has been recurrent. The headache is characterized as pounding and throbbing. The headache is experienced any time of the day and is described as located in the entire head. The symptoms are aggravated by noise and bright light. The symptoms have been associated with blurred vision, eye pain, nausea, and vertigo. No associated vomiting. Mrs. Warby's headaches have improved in frequency and severity with Fioricet. Mrs. Warby also has a history of recurrent **MDD** with hallucinations during her depressive episodes.

Examination

General Appearance: Disheveled. Well-developed and well nourished. Normal posture.
Integumentary: Normal coloration of skin. Normal warmth is noted.
Head: Head forward, normocephalic, atraumatic with no lesions or palpable masses.
Extremities: No edema.
Neurologic: Cranial nerves 2-12 grossly intact. There are no gross field deficits. Patient has full range of extraocular muscles, facial sensation intact. There is no facial asymmetry. Weber is midline, gag reflex is present. Tongue is midline and sternocleidomastoid muscles are 5/5. Mental status examination reveals that the patient is alert and oriented x 3. Speech is fluent and coherent, responds to questions and commands appropriately.
Musculoskeletal: No evidence of atrophy or spasm.

Vital Signs

BP-110/80, HR-88, R-18, Height-5'8, Wt-185lbs, BMI-28.1

Current Medications

Fioricet 325mg-50mg-40mg, po q4hr
Seroquel 100mg daily

Medication List reviewed and reconciled with the patient

Past Medical History

Major Depression (recurrent, mild)

Contusion of left chest wall

Endometriosis

Chiari I malformation

Case #5 – Page 2 of 2

Review of Systems

General: No alcohol use, chills, fatigue or fever
Skin: No bruising, hives, itching, lesions, or rash
HEENT: No double vision, ear pain, eye pain, hearing loss, sinus pain, visual loss or voice changes
Neck: No neck stiffness
Respiratory: No cough or difficulty breathing
Cardiovascular: No calf cramps, chest pain, leg pain, swelling or SOB
Gastrointestinal: No abdominal pain, nausea or vomiting
Musculoskeletal: No back pain, joint pain, joint stiffness, leg cramps, muscle atrophy, muscle cramps, muscle weakness and swelling of extremities.
Neurological: Positive for **headaches**. No auras, decreased memory, difficulty speaking, fainting, LOC, seizures, or weakness.
Psychiatric: Positive for **depression**. No anxiety, hallucinations, mood changes, or panic attacks.

RECAP:
Reason for appointment: **Documented condition**
Current Medications: **Documented current treatment**
Assessment: **Documented the condition is present**
Treatment: **Documented treatment plan**

Assessments

1. Major depression, recurrent, current episode severe with psychotic symptoms- F33.3

2. Chronic headaches- R51.9

3. Chiari I malformation-asymptomatic, no syrinx noted-G93.5

4. h/o endometriosis s/p TAH, Z90.710

Treatment

1. Major depression, recurrent, current episode severe with psychotic symptoms- Refill Seroquel Tablet, 100 MG, 1 tablet, Orally, Once a day, 30-day refill

2. Chronic headaches, continue Fioricet 325mg-50mg-40mg. Good candidate for chemodenervation.

3. Chiari I malformation-asymptomatic, no syrinx noted, f/u with neuro

4) h/o endometriosis s/p TAH, f/u with gyno

Incorrect Coding Examples

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

Reason for Appointment

Patient presented to the clinic for f/u blood work result

History of Present Illness

Patient is 45 yo female with Hashimoto disease, Bipolar d/o, s/p Thyroidectomy ,OD Congenital cataract/Legally blind presented to the clinic for f/u blood work result. Patient c/o bilateral knee pain. d/w patient blood work result in details all questions answered, recommendations provided.

Examination

General Appearance: alert, pleasant, in no acute distress.
Head: normocephalic , atraumatic.
Eyes: extraocular movement intact (EOMI) ,H/o congenital cataract.
Nose: nares patent.
Throat: no erythema , no exudate.
Neck/Thyroid: no carotid bruit , soft, supple, full range of motion , no cervical lymphadenopathy.
Heart: S1, S2 normal , regular rate and rhythm.
Lungs: clear anteriorly and posteriorly.
Abdomen: bowel sounds present , no guarding or rigidity , soft, nontender, nondistended , no rebound tenderness.
Neurologic: cranial nerves 2-12 grossly intact , deep tendon reflexes 2+ symmetrical.
Extremities: no clubbing, cyanosis, or edema.

Vital Signs

Ht 63 in, Wt 165 lbs, BMI 29.23 Index, BP 120/80 mm Hg, HR 78 /min, RR 19 /min, Temp 98.7 F, Oxygen sat % 99 %, Ht-cm 160.02, Wt-kg 74.84.

Current Medications

Taking

Vistaril 50 MG Capsule 1 capsule as needed Orally three time a
day
Prozac 20 MG Capsule 1 capsule Orally Once a day
Levothyroxine Sodium 150 MCG Tablet 1 tablet on an empty
stomach in the morning Orally Once a day
Lithium Carbonate 300 MG Capsule 1 capsule TID Orally three time a day

Medication List reviewed and reconciled with the patient

Past Medical History

Bipolar disorder.

Hashimoto's thyroiditis.

H/o congenital cataract

OD/Legally blind.

Case #6 – Page 2 of 2

Review of Systems

General/Constitutional:

Fever denies. Sleep disturbance denies. Weight gain denies.

Ophthalmologic:

Comments

See HPI for details. Admits Diminished visual acuity.

ENT:

Decreased hearing denies. Sore throat denies.

Endocrine:

Excessive thirst denies. Frequent urination denies. Admits Thyroid problems.

Respiratory:

Cough denies.

Cardiovascular:

Chest pain at rest denies. Chest pain with exertion denies. Dizziness denies. Fluid accumulation in the legs denies. Irregular heartbeat denies. Shortness of breath denies.

Gastrointestinal:

Abdominal pain denies. Blood in stool denies. Constipation denies. Diarrhea denies. Heartburn denies. Nausea denies. Vomiting denies.

Neurologic:

Headache denies. Seizures denies. Tingling/Numbness denies.

Psychiatric:

Anxiety denies. Admits Depressed mood. Difficulty sleeping denies. Loss of appetite denies. Psychiatric condition admits. Suicidal thoughts denies.

Assessments

1. Hashimoto's thyroiditis - E06.3 (Primary)
2. S/P thyroidectomy – E89.0
3. Polyarthralgia - M25.50
4. Legally blind - H54.8
5. Bipolar disorder – F31.9 (*Diagnosis was added . Per coding guidelines "Code all conditions that coexist or affect patient's care")*

Treatment

1. Hashimoto's thyroiditis
LAB: THYROID PANEL WITH TSH
Please inform patient decrease Levothyroxine
2. S/P thyroidectomy
Please inform patient Endocrinology referral placed based on lab results
3. Polyarthralgia
ANA SCREEN, IFA NEGATIVE
4. Legally blind
Notes: OD.

RECAP:

HPI: **Documented the condition is present**
Current Medications: **Documented treatment**
Assessment: **No mention of condition**
Treatment: **No documented treatment plan**

Case #7 – Page 1 of 2 (Added missed diagnosis)

Reason for Appointment

New patient.

History of Present Illness

A 59 years old female who presents today as a new patient complaining of : Hypercholesterolemia- follows a low fat and low chol diet. Compliant with statin/Crestor and; has had increase in calf tightness and cramps. Tries to hydrate. Mental health disturbances-to include bipolar disorder-patient does sees a psychiatrist, managing her medications. She does have a follow-up next month and there has been no acute decompensation. Wellness- utd with physical, needs Tdap, had flu vax last wk thru Walgreens mammogram, well woman care utd.

Examination

Constitutional: well developed, well nourished, in no acute distress. obese
Eyes: EOM intact, conjunctiva and sclera clear with out nystagmus.
Mouth/Throat: no deformity, no lesions.
Pulmonary: clear bilaterally to auscultation and percussion.
Cardiac: regular rate and rhythm, normal S1/S2, no murmurs.
Abdomen: normal bowel sounds, soft non tender, no hepatosplenomegaly, no masses noted. obese
Musculoskeletal: no joint abnormalities, normal ROM all joints. neg homan's bl, tender calves to touch BL Extremities: no clubbing, no cyanosis, no edema.
Neurological: no focal deficits, cranial nerves II-XII grossly intact, normal coordination, normal muscle strength and tone.
Psych: alert and oriented x 3, normal mood and affect, EASILY

Vital Signs

Height: 64 inches

Weight: 225 lbs

Weight change since last visit: +3 lbs.

BMI: 38.76

O2 sat: 96% on room air **Respirations:** 14/min

Current Medications

Taking
LAMICTAL 150 MG ORAL TABLET (LAMOTRIGINE) TAKE 1 TABLET daily; Route: ORAL
ABILIFY 15 MG ORAL TABLET (ARIPIPRAZOLE) Take 1 tablet by mouth at bedtime; Route: ORAL
ZOFRAN 4 MG ORAL TABLET (ONDANSETRON HCL) take 1 tablet po every 8 hours prn nausea/vomiting; Route: ORAL
CALCIUM PLUS VITAMIN D3 600-500 MG-UNIT ORAL CAPSULE (CALCIUM CARB-CHOLECALCIFEROL) ;
CO 0 10 10 MG ORAL CAPSULE (COENZYME 010) ;
Route: ORAL

Past Medical History

IBS

Bipolar Disorder

Anxiety

ADD

Case #7 – Page 2 of 2

Review of Systems

Constitutional: Complains of FEVER, WEIGHT GAIN. Denies fatigue.

Respiratory: Denies difficulty breathing, chronic cough, wheezing.

Gastrointestinal: Complains of NAUSEA, INDIGESTION. Denies constipation, vomiting, diarrhea, change in bowel habits, abdominal pain.

Musculoskeletal: Complains of MUSCLE PAIN. Denies joint pain, muscle weakness.

Dermatological: Denies rash, new sore/lesion.

Neurological: Denies fainting, numbness, headaches.

Psychiatric: Complains of ANXIETY. Denies change in sleep pattern, depression.

Heme/Lymphatic: Denies gland problems.

Functional: Denies problems with ambulation, problems with falling.

Assessment and Treatment Plan:

1. HYPERLIPIDEMIA - E78.5
Assessment: New
Continue with statin therapy- rx given ; pt aware of possible adverse/side effects continue with CoEnzyme 010 daily but increase to 400mg po qd.

2. WELLNESS EXAM -Z00.00
wellness exam is up to date Tdap given today
flu vaccine is already utd f/u in 2 wks - review labs

3. Bipolar disorder – F31.9 (*Diagnosis was added . Per coding guidelines "Code all conditions that coexist or affect patient's care")*

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

Case #8 – Page 1 of 2 (Added missed diagnosis)

Reason for Appointment

1. Low back pain

History of Present Illness

62 yo female. Patient was called upon patient's request in order to refill all medications for chronic illnesses via Virtual Visit. Patient suffers treated Spinal stenosis of lumbar region with neurogenic claudication & Radiculopathy lumbar region. Patient is requesting referral to Pain Medicine & Neuro Surgery. States that she has chronic low back pain. No pain at this moment. Patient is requesting medication refills. Pt is currently under psychiatric care for single episode of severe depression

Examination

General Examination:

Patient does not sound in distress

Seems to be Alert and Oriented

Does not sound dyspneic, is able to speak in full sentences there are no audible wheezes

No speech impediment noted, patient is answering questions appropriately

Normal judgement and insight as well as mood and affect.

Current Medications

Seroquel 200 MG Tablet 1 tablet at bedtime Orally Once a day

Syringe (Disposable) 1 ML Miscellaneous Use IM Monthly.

Dispense syringe of choice per insurance.

Lamictal 200 MG Tablet 1 tablet Orally Once a day

Past Medical History

Fibromyalgia.

Chronic Cervical & Lumbar Pain Radicular Pain. DEXA, 1/2019:

L-Spine Osteoporosis T score -2.6.

B12 deficiency.

Surgical History

Appendectomy 1975

Hospitalization/Major Diagnostic Procedure

for Surgeries

Abdominal pain 03/03/2019 Rt groin pain 3/29/2019

Lumbar Radiculopathy 08/31/2019

Case #8 – Page 2 of 2

Review of Systems

General/Constitutional:

Patient denies chills, fever, lightheadedness.

Endocrine: Patient denies cold intolerance, excessive thirst, frequent urination, heat intolerance, excessive sweating

Respiratory: Patient denies shortness of breath, wheezing, hemoptysis, cough, sputum production.

Cardiovascular: Patient denies chest pain, chest pressure or chest discomfort, palpitations, irregular heartbeat, difficulty laying flat, dyspnea on exertion.

Gastrointestinal: Patient denies abdominal pain, nausea, vomiting change in bowel habits, anorexia, blood in stool, diarrhea

Hematology: Patient denies bleed easily, easy bruising.

Genitourinary: Patient denies painful urination, difficulty urinating, frequent urination, blood in the urine.

Peripheral Vascular: Patient denies blood clots in legs, new ulceration of feet.

Skin: Patient denies blistering of skin, changing moles, hair changes, itching, nail changes, rash, skin lesion(s), hives, discoloration.

Neurologic: Patient denies paralysis, seizures, tingling/numbness, dizziness, weakness, new onset headache.

Psychiatric: Patient denies depressed mood, anxiety, suicidal/homicidal thoughts, difficulty sleeping, delusions.

Assessments

1. Spinal stenosis of lumbar region with neurogenic claudication - M48.062 (Primary)
2. Radiculopathy, lumbar region - M54.16
3. Chronic low back pain - M54.5
4. Other chronic pain - G89.29
5. Major depressive disorder, single episode, severe without psychotic features –F32.2 (*Diagnosis was added. Per coding guidelines "Code all conditions that coexist or affect patient's care")*

Treatment

1. Spinal stenosis of lumbar region with neurogenic claudication- Follow-up with Neuro Surgery. Referral To: neurosurgery Reason: failure treatment

2. Radiculopathy, lumbar region - Start Ibuprofen Tablet, 800 MG, 1 tablet with food or milk as needed. Referral To: Pain Medicine

3. Chronic low back pain - Prescribed Flexeril as a reasonable first-choice drug for muscle relaxant

4. Other chronic pain - Notes: On treatment.

RECAP: Missed Diagnosis

HPI: **Documented condition**

Current Medications: **Documented treatment**

Assessment: **No mention of condition**

Treatment: **No documented treatment plan**

Case #9 – Page 1 of 2 (Added missed diagnosis)

Reason for Appointment

ADHD and Bipolar d/o

History of Present Illness

15 year-old male here to follow up for his ADHD and bipolar d/o. He states that he has been out of medication due to not having insurance. Mom states that he has had more anger issues and that his ADHD is not controlled at this time due to him not having medications. His symptoms include short attention span, impulsive behavior, easy distractibility, poor listening skills, racing thoughts, and a feeling of worthlessness.

Examination

Constitutional-General appearance: No acute distress, well appearing and well nourished.
Neck: Supple, symmetric, no masses
Pulmonary: Normal respiratory rate and rhythm, no increased work of breathing. Auscultation of lungs-clear bilaterally.
Cardiovascular: Auscultation of heart-RRR, normal S1 and S2, no murmur. Examination of extremities for edema and/or viscosities-normal.
Abdomen: Normal bowel sounds, soft, non-tender, no masses. Liver and spleen-no hepatomegaly or splenomegaly.
Lymphatic: Palpitation of lymph nodes in neck-no anterior or posterior lymphadenopathy.
Musculoskeletal: Digits and nails-**abnormal.**
Skin: Skin and subcutaneous tissue-normal.
Neurologic: Cranial nerves-normal.
Psychiatric: Mood and affect-depressed mood.

Current Medications

Symbicort 160-4.5mcg inhalation aerosol-inhale 2 puffs twice daily and rinse mouth after use
Ventolin HFA 108 (90 Base), mcg inhalation aerosol solution-inhale 1-2 puffs every 4-6 hours prn
Abilify 10mg daily

Past Medical History

ADHD
Bipolar d/o
Pneumonia
Asthma

Surgical History

ORIF of humerus

Vitals

Temp: 97.7°F
HR 76
R 18
BP 120/72
Height 5'11
Weight 185
O2 sat 96
BMI: 85th percentile

Case #9 – Page 2 of 2

Review of Systems

Constitutional: Feeling tired, but no fever, no recent weight gain, and no chills,
Cardiovascular: Negative.
Respiratory: Negative.
Gastrointestinal: Negative.
Neurological: Negative.

Assessments

1. ADHD, renew Vyvanse 70mg, take one capsule daily in the morning- F90.9
2. Asthma, continue Symbicort and Ventolin- J45.909, Z79.51
3. Non-compliance with ADHD medication, Vyvanse d/u not having medical insurance- Z91.148
4. Bipolar d/o, most recent episode mixed, moderate- F31.62 (*Diagnosis was added. Per coding guidelines "Code all conditions that coexist or affect patient's care")*

Plan

The patient does have a history of behavioral problems. Unfortunately, he has been very abusive towards his mother and wound up in court over the summertime. I am restarting him on Vyvanse for his ADHD again and I am questioning whether this is really going to stop the patient's behavioral issues, but they do appear to worsen when he was off of the medication. Due to the patient's bipolar d/o (most recent episode mixed, moderate), I will consider increasing his dosage for Abilify to see if that helps with his symptoms as well. Refilled Symbicort 160-4.5mcg and Ventolin HFA 108 (90 Base), mcg inhalation for asthma

RECAP: Missed Diagnosis

HPI: **Documented condition**
Current Medications: **Documented treatment**
Assessment: **No mention of condition**
Treatment: **No documented treatment plan**

Case #10 – Page 1 of 2 (Added missed diagnosis)

History of Present Illness

Patient presents today for a follow-up for her recent hospitalization for a diagnosis of bipolar II disorder and altered mental status. The patient has also been newly diagnosed about 3 months ago with diabetes and is on insulin. She is unable to lose weight. She stated she has been having difficulty doing so. She is a medical assistant at a busy doctor's office.

Examination

HEENT: Head is normal. Eyes: Pupils are equal, round, and reactive to light EOMs intact. Conjunctivae pink. Sclerae are not icteric. Oral mucosa is pink and moist.
Lymphatic: The patient has no peripheral lymphadenopathy.
Respiratory: Chest is clear.
Cardiovascular: Regular rate and rhythm. S1 and S2 are normal.
Gastrointestinal: Abdomen is soft and non-tender with no hepatosplenomegaly. Insulin pump present.
Extremity: There is no edema. R pinky toe amputation.
Neurological: The patient is alert and oriented with no focal deficits.

Current Medications

Risperidone 3mg at bedtime
Lantus 100 Units vial, 25 units subcutaneous twice daily
Zoloft 200mg
Ambien 10mg at bedtime

Past Medical History

IDDM
Bipolar II
Leukocytosis

Vitals

BP-100/80
HR 70
R 18
Height 5'9
Weight 200lbs
BMI 29.5

Case #10 – Page 2 of 2

Assessments

1. r/o Delirium (no code-uncertain diagnoses are not coded in the outpatient setting)
2. IDDM, continue Lantus E11.9, Z79.4
3. BMI 29.5- Z68.29
4. Bipolar II d/o, most recent episode mixed, moderate- F31.81 (*Diagnosis was added. Per coding guidelines "Code all conditions that coexist or affect patient's care")*

Plan

The patient is mentally stable. No evidence of psychosis at the moment. I am referring the patient to a psychiatrist for her diagnosis of bipolar II disorder. We discussed the possible need for her to be on Adderall since she stated that she needed it in order to help her with her attention and concentration. She can discuss this matter with the psychiatrist. She can continue with Risperidone 3 mg at bedtime, Zoloft 200 mg daily, and Ambien 10 mg at bedtime prn.

RECAP: Missed Diagnosis

HPI: **Documented condition**
Current Medications: **Documented treatment**
Assessment: **No mention of condition**
Treatment: **No documented treatment plan**

Quick Tips (ICD-10- CM)

Bipolar disorder includes both depression and mania, and it is more important to capture the bipolar disorder. Therefore, a code for depression would not be reported separately. AHA Coding Clinic Volume 7, 1st Quarter 2020, Page 23

Three things need to be documented to appropriately code the severity of illness of patients who suffer from depression:

Episode
- Single
- Recurrent

Activity
- Not in remission
- Partial remission
- Full remission

If not in remission, document the severity
- Mild
- Moderate
- Severe
  - If severe, document any complications
    - With psychotic features
    - Without psychotic feature

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THANK YOU

Commercial Risk Adjustment Team

Please send any questions to:

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