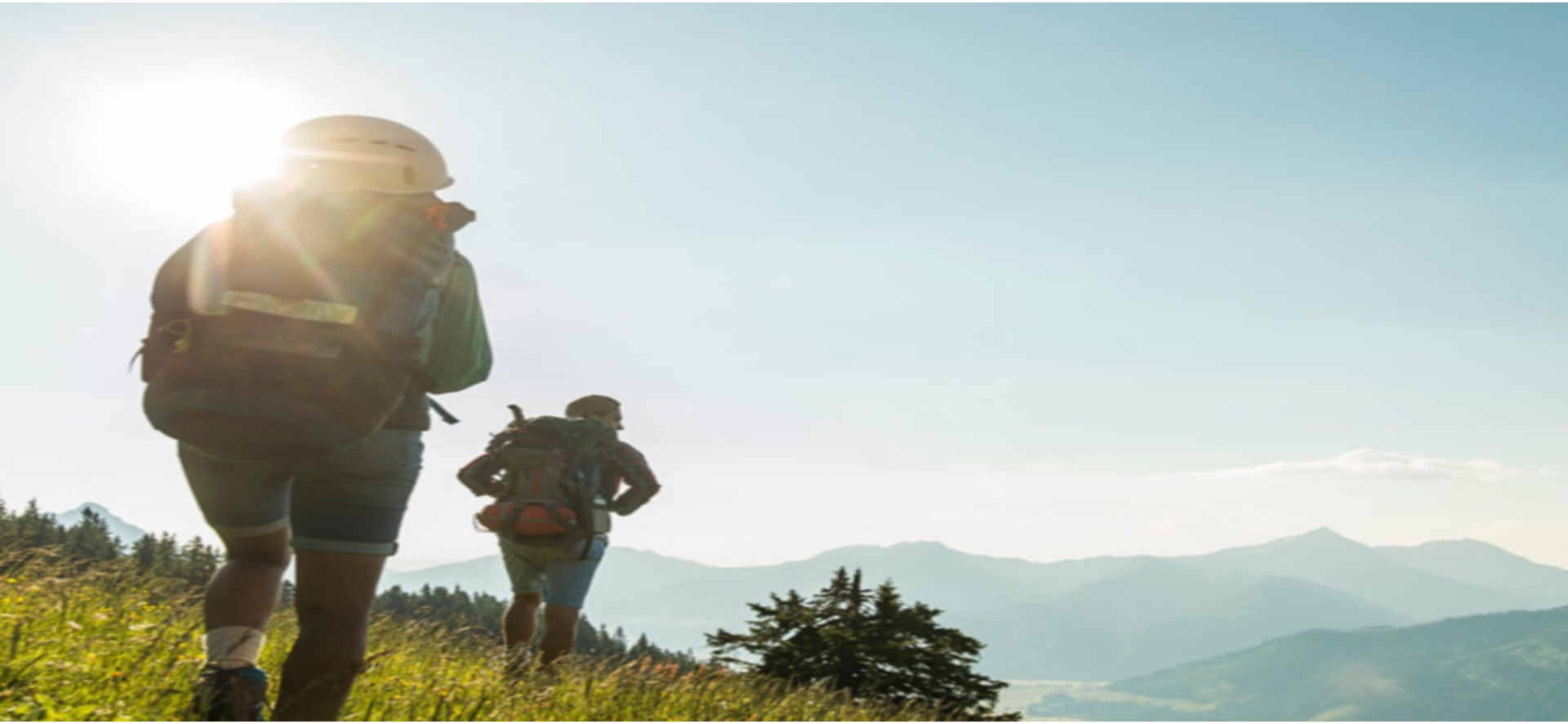
Coding Examples
Diabetes



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

1. F/U abnormal labs

History of Present Illness

This is a 50- year- old patient who is here today for labs results and discuss dm.

Examination

General Appearance: alert, pleasant, in no acute distress, well hydrated , obese.
Heart: regular rate and rhythm, S1, S2 normal, no murmurs.
Lungs: clear to auscultation bilaterally.

Vital Signs

Ht 5 ft 4 in, Wt **269 lbs**, BMI **46.17 Index**, BP **140/80 mm Hg**, HR **77 /min**, RR **17 /min**, Temp **98.3 F**, Oxygen sat % 95 %, Pain scale 0 1-10

Current Medications

Taking

Ipratropium-Albuterol 0.5-2.5 (3) MG/3ML Solution 3 ml Inhalation every 6 hrs as need it for SOB

Prednisone 20 MG Tablet 1 tablet Orally Once a day

Past Medical History

Medical History Verified

Surgical History

Rupture appendix, peritonitis

Case #1 – Page 2 of 2

Review of Systems

General/Constitutional: Patient denies change in appetite chills, fatigue, fever, headache, lightheadedness.
Respiratory:
Patient denies cough, hemoptysis, shortness of breath, sputum production, wheezing.
Cardiovascular:
Patient denies chest pain, palpitations, shortness of breath.

RECAP:
Assessment: **Documented the condition is present, uncontrolled, specified as hyperglycemia**
Treatment: **Documented treatment plan**

Assessments

1. Uncontrolled Type 2 diabetes mellitus with hyperglycemia, without long-term current use of insulin - E11.65 (Primary)

2. BMI 45.0-49.9, adult - Z68.42

3. Morbid obesity - E66.01

Treatment

1. Uncontrolled Type 2 diabetes mellitus with hyperglycemia, without long-term current use of insulin
Start Metformin HCl Tablet, 500 MG, tablet with a meal, Orally, every 12hours, 30 day(s), 60 Tablet, Refills 3
Notes: continue to monitor glucose keep logs, diet, and exercise, last A1c over than 9. 1

2. BMI 45.0-49.9, adult

Notes: Treatment of obesity starts with comprehensive lifestyle management (ie, diet, physical activity, behavior modification)

3. Morbid obesity

Notes: Self-monitoring of caloric intake and physical activity, Goal setting, Stimulus control

Case #2 – Page 1 of 2

Reason for Appointment
Pt request referral
Annual visit

History of Present Illness

36 y/o Male with Hx of T1DM was contacted today upon patient's request for referral to Endocrinologist for continuity of care.

Review of system
General Appearance: Stable appearing, in no distress. Alert and oriented.
Dermatological Examination: conjunctiva clear, sclera non-icteric, no eye drainage, grossly normal.
Oral Cavity: no visible perioral lesions, no perioral cyanosis, no lip swelling.
Lungs: Does not appear dyspneic. No audible wheezes or rales. No nasal flaring.
Musculoskeletal: Grossly normal active ROM in upper extremities.
Skin: no visible facial rash or concerning facial lesions noted. No skin redness or discoloration seen.
Neurologic: Intact recent memory. No facial or eyelid drooping. No speech impairment, answering questions appropriately.
Psych: Judgment and insight good; normal mood and affect..
N/A

Current Medications
Insulin Glargine 100 UNIT/ML Solution 25u Subcutaneous twice a day
Insulin Lispro 100 UNIT/ML Solution Subcutaneous
Metoclopramide HCl 5 MG Tablet 1 Orally three times daily

Past Medical History

Diabetes type 1

Social History
Social:
Health Literacy
Do you have a preferred method of learning? If Yes, please select an option *No*
Do you have any communication needs or impairments? If Yes, please select an option *No*
Community involvements
Occupational exposure
Are you exposed to Hazardous Conditions in the Workplace? *No*
Highest Level Of Education *patient refused*

Surgical History
Denies Past Surgical History

Case #2 – Page 2 of 2

Review of Systems

General/Constitutional:
Patient denies chills, fever, lightheadedness.

Ophthalmologic:
Patient denies visual loss, floaters or flashings of light in the visual field, discharge, double vision, eye pain, itching and redness, yellowing of sclerae, itching and redness of the eyelid.

ENT:
Patient denies ear pain, nose bleeds, difficulty swallowing, dry mouth.

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.

Assessments

1. Type 1 diabetes mellitus with hyperglycemia - E10.65 (Primary)
2. Encounter for general adult medical examination without abnormal findings Z00.00

Treatment

1. Type 1 diabetes mellitus with hyperglycemia

Continue Insulin Glargine Solution, 100 UNIT/ML, 25u, Subcutaneous, twice a day

Continue Insulin Lispro Solution, 100 UNIT/ML, Subcutaneous L AB: HEMOGLOBIN A1c (Ordered for 05/19/2020)

Referral To: Ophthalmology

Reason:T1DM, diabetic retinopathy check

2. Annual Visit: Routine Labs for CMP, BMP.

RECAP:
Assessment: **Documented the condition is present for Type 1 DM with hyperglycemia.**
Treatment: **Documented in the treatment plan**

Case #3 – Page 1 of 2

Reason for Appointment
1. Follow up visit

History of Present Illness
General: 59 year old male who presents to clinic for follow up and lab result discussion. Also requesting Ortho referral for continuity of care. Patient has no acute medical complaints.

Examination
Abdomen: The abdomen is soft, non-tender, non-distended, normoactive bowel sounds present, no guarding, rebound tenderness or rigidity, no organomegaly.
Neurologic: Cooperative with the exam, gait normal, no tremor.
Extremities: No cyanosis, clubbing or pitting edema of lower extremities.
Foot exam: Date of Last Diabetic Foot Exam: 02/11/2020
Sensory Testing Performed: Sensations Normal Bilaterally
Motor Testing Performed: Strength Normal Pedal Pulse Taking Performed: 1+Dorsalis Pedis and Posterior Tibialis
Visual Exam of Foot Performed: Yes, Hydrated, no ulcer, no blisters or cuts. Onychomycosis
Psych: Normal mood and affect, no anxious or depressive appearance.

Vital Signs

Ht 69.88 in, Wt 216.6 lbs, BMI 31.18 Index, BP 110/70 mm Hg, HR 70 /min, RR 17 /min, Temp 97.5 F, Pain scale 0 1-10, Ht-cm 177.5, Wt-kg 98.25.

Current Medications

Taking
Ozempic 0.25 or 0.5 MG/DOSE Solution
Glimepiride 4 MG Tablet
Omeprazole 40 mg Capsule Delayed
Atenolol 100 MG Tablet
Jardiance 10 MG Tablet
Atorvastatin Calcium 20 mg Tablet
Insulin Glargine 100 UNIT/ML Solution Pen-injector 35 iu Subcutaneous Every 12 hours

Past Medical History
DM
HTN
Sinus bradycardia

Surgical History

TS sx 1982

Case #3 – Page 2 of 2

Review of Systems

General/Constitutional: Denies Chills. Denies Fatigue. Denies Fever. Night sweats denies.
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.
Skin: Denies Itching. Denies Rash. Denies Skin lesion(s).

RECAP: Condition was properly linked to manifestation
Current Medications: **Documented treatment**
Assessment: **Documented the condition is present**
Treatment: **Documented the treatment plan**

Assessments

1. Type 2 diabetes mellitus with other specified complication- E11.69 Associated with HLD
2. Essential hypertension - I10
3. Hyperlipidemia - E78.5
4. Long term (current) use of insulin - Z79.4
5. Encounter for administration of vaccine - Z23

Treatment

1. Type 2 diabetes mellitus with other specified complication- E11.69 Associated with HLD ; Cont. insulin & oral medication as directed. Advised on lifestyle modifications. Will cont. to monitor
2. Essential hypertension: Controlled –Refilled medications.
3. Hyperlipidemia due to DM: Advised on lifestyle modifications such as diet and exercise routine-Continue current medication.
4. Long term (current) use of insulin: Refer above.
5. Pneumococcal polysaccharide PPV23 : 0.5 mL (Route: Intramuscular) given on Left Deltoid (Encounter for administration of vaccine)

Incorrect Coding Examples

Case #4 – page 1 of 2

Reason for Appointment.

1. Follow up

History of Present Illness

The patient is a 55-year-old male who presents to the clinic today for follow-up. He has a history of mixed hyperlipidemia, hypertension, and diabetes. Since December, he has been following a good diet, so he thinks his blood sugar is under good control. He comes in to get repeat labs to see where we are. He denies any other complaint today.

Examination

Constitutional: Patient is overweight. He is oriented to time, person and place, no acute distress.

Pulmonary: The respiratory pattern is nonlabored, No rales are detected by auscultation, no rhonchi, no wheezes, Breath sounds: clear all lobes, no stridor.

Cardiac: normal S1S2, no murmurs, normal rate, regular rhythm.

Vascular: bilaterally symmetrical, No evidence of clubbing, cyanosis, or edema.

Back: no spine tenderness, normal range of motion of spine, sacroiliac joints non-tender, straight leg raising normal

Vital Signs

Ht 68 in, Wt 246 lbs, BMI 37.4 Index, Temp 98.6, BP 150/90 mm Hg150/90 mm Hg, HR 80 /min, RR 16 /min, O2 SAT 97 %.

Current Medications

Taking
ezetimibe 10 mg tablet 1 tablet orally every day (qd)
losartan 100 mg tablet 1 tablet orally every day (qd)
atorvastatin 80 mg tablet 1 tablet orally every day (qd)
Janumet XR 1000 mg-50 mg tablet, extended release 1 tablet orally once a day (in the evening)

Past Medical History

Skin cancer
Type 2 diabetes
Hypertension
Hyperlipidemia

Surgical History

Skin cancer
Gallbladder removed

Case #4 – Page 2 of 2

Review of Systems

Constitutional: Patient Denies: fever, chills, body aches

Respiratory: Patient Denies: shortness of breath, dyspnea

Gastroenterology: Patient Denies: abdominal pain, constipation, diarrhea, nausea, vomiting

Musculoskeletal: Patient Denies: joint pain, joint stiffness, muscle aches

Neurology: Patient Denies: dizziness, headache, tingling/numbness

Endocrinology: Patient Denies: cold intolerance, heat intolerance, polydipsia, polyuria, goiter.

RECAP:
HPI: **Documented the condition**
Medication: **Documented treatment**
Assessment: **Documented the condition is present with complications but no documentation specifying or linking a complication with the condition**
Treatment: **Documented treatment plan**

Assessments

1. Essential hypertension - I10 (Primary)

2. Mixed hyperlipidemia - E78.2

3. Type 2 diabetes mellitus with other specified complication- NEC E11.69

(The correct code should be E11.8- Type 2 diabetes with unspecified complications. see TIPS for NEC guidelines)

Treatment

1. Essential hypertension

LAB: CBC (IF/PLT,H/H, RBC, INDICES, WBC, PLT) LAB: COMPREHENSIVE METABOLIC PANEL

2. Mixed hyperlipidemia

LAB: LIPID PANEL

3. Type 2 diabetes mellitus with other specified complications

LAB: CBC (INCLUDES DIFF/PLT,H/H, RBC, INDICES, WBC, PLT) LAB: COMPREHENSIVE METABOLIC PANEL

Case #5 – Page 1 of 2

Reason for Appointment

3 MO F/U Lab Review

States just took pill 1 hour ago and was rushing to appoint

States she hasn't had Januvia for several months

History of Present Illness

No Hospitalization History.

Examination

Physical Examination:
Constitutional: Patient is oriented to time, person and place, pleasant, no acute distress, mood is appropriate .
HEENT: Head: atraumatic, Head: normocephalic.
Pulmonary: The respiratory pattern is nonlabored, No rales are detected by auscultation, no rhonchi, no wheezes, Breath sounds: clear all lobes .
Cardiac: normal S1S2,11-IV murmurs LSB 2nd ICS, normal rate, regular rhythm .
Neurology: Cognitive exam normal .
Vascular: bilaterally symmetrical, No evidence of clubbing, cyanosis, or edema.
Psychology: mood is appropriate, cooperative with exam, good eye contact.

Vital Signs

Ht 68 in, Wt 226 lbs, BMI 34.36 Index, Temp 98, BP 160/90 mm Hg, Repeat BP 148/88, HR 76 /min, RR 16 /min, O2 SAT 98 %.

Current Medications

True Metrix Test Strips Test BS 2-3 times daily

multivitamin Vitamin B Complex capsule 1 tablet orally once a day

Fish Oil 500 mg capsule 1 tablet orally once a day

magnesium aspartate

Aspir-81 81 MG Tablet Delayed Release 1 tablet Orally Once a day

cabergoline 0.5 mg tablet 1 tab(s) orally 2 times a week

glipizide 10 mg tablet 1 tab(s) orally every 12 hours

Januvia 100 mg tablet 1 tab(s) orally once a day

Amlodipine Besylate-Benazepril Hydrochloride 5 mg-20 mg capsule 1 cap(s) orally once a day

atorvastatin 40 mg tablet 1 tab(s) orally QPM Diclofenac Sodium Topical 1% gel 2 g applied

topically 4 times a day

Metformin 1000 mg tablet 1 tab(s) orally 2 times a day

Past Medical History

Diabetes Type 2

Hypertension.

Hyperlipidemia

Surgical History

Hysterectomy(Jamaica) 2/2004

Case #5 – Page 2 of 2

Review of Systems
Constitutional:
Patient Denies: fever, chills, body aches. fatigue denies. weight gain denies. weight loss denies.
ENT:
Patient Denies: hoarseness, cough, epistaxis, sore throat, sinus pain, ear pain.
Respiratory:
Patient Denies: shortness of breath.
Cardiovascular:
Patient Denies: chest pain, palpitations, diaphoresis, syncope.
Gastroenterology:
Patient Denies: abdominal pain, constipation, diarrhea, nausea, vomiting.
Musculoskeletal:
Patient Denies: joint pain, muscle aches.
Neurology:
Patient Denies: gait abnormality, headache.

RECAP: Condition not coded to highest specificity.
Assessment: **Documented the condition is present**
Treatment: **Documented in the treatment plan**

Assessments

1. DM w/o complication type II, uncontrolled - E11.65 (Correct code should have been E11.9 DM without complications, See coding TIPS for "uncontrolled" guidelines.)
2. Essential (primary) hypertension - I10
3. Hyperlipidemia, unspecified hyperlipidemia type - E78.5

Treatment

1. Follow-up exam: LAB: COMPREHENSIVE METABOLIC PANEL
2. DM w/o complication type II, uncontrolled: Continue Glipizide tablet, 10 mg, 1 tab(s), orally, every 12 hours, 30 day(s), 60 Tablet, Refills 5, Refill Januvia tablet, 100 mg, 1 tab(s), orally, once a day, 30 days, 30 Tablet, Refills 5, Refill metformin tablet, 1000 mg, 1 tab(s), orally, 2 times a day, 30
3. Essential (primary) hypertension: Continue Aspir-81 Tablet Delayed Release, 81 MG, 1 tablet, Orally, Once a day.
4. Hyperlipidemia, unspecified hyperlipidemia type: Continue Fish Oil capsule, 500 mg, 1 tablet, orally, once a day

Case #6 – Page 1 of 2

Reason for Appointment

1 month f/u

History of Present Illness

Constitutional:

Doing better reviewed the blood sugar log. Patient had an appt with cardiologist was told her cardiac status is stable

Examination

General Appearance: in no acute distress, well developed, well nourished.
Head: normocephalic, atraumatic.
Eyes: pupils equal, round, reactive to light and accommodation.
Ears: normal.
Oral Cavity: mucosa moist.
Throat: clear.
Neck/Thyroid: neck supple, no cervical lymphadenopathy.
Skin: no suspicious lesions, warm and dry.
Heart: no murmurs, regular rate and rhythm, S1, S2 normal.
Lungs: clear to auscultation bilaterally.
Abdomen: normal, bowel sounds present, soft, nontender, nondistended.
Neurologic: nonfocal.
Psych: alert, oriented, cooperative with exam.

Vital Signs

Temp 96.9 F, BP 186/110 mm Hg186/110 mm Hg, Ht 5 ft 4 in, HR 86 /min, RR 16 /min, Wt 254 lbs, Oxygen sat % 98 %, BMI 43.59 Index b/p rechecked 170/100

Current Medications

Lisinopril 40 MG Tablet

Viibryd 40 MG Tablet

Metformin HCl 500 MG Tablet

Glipizide ER 2.5 MG Tablet Extended Release 24 Hour, Notes: need refill

Past Medical History

H/o psychiatric disorder.

S/p pacemaker.

Hypertension.

Hypothyroid.

Lipid disorder.

Surgical History

knee surgery 2014
pacemaker 2008

Hospitalization/Major Diagnostic Procedure

No Hospitalization History.

CASE #6 – Page 2 of 2

Review of Systems

General/Constitutional: Denies Change in appetite. Denies Chills. Denies Fatigue. Denies Fever.
Ophthalmologic: Denies Blurred vision. Denies Discharge.
Endocrine: Denies Cold intolerance. Denies Dizziness. Denies Weakness.
Respiratory: Denies Cough. Denies Sputum production. Denies Wheezing.
Cardiovascular: Denies Chest pain. Denies Palpitations. Denies Shortness of breath.
Gastrointestinal: Denies Abdominal pain. Denies Change in bowel habits.
Hematology: Denies Bleeding problems. Denies Easy bruising.
Genitourinary: Denies Blood in urine. Denies Difficulty urinating. Denies Frequent urination.
Musculoskeletal: Denies Joint stiffness. Denies Leg cramps.
Skin: Denies Dry skin. Denies Eczema.
Neurologic: Denies Pain.
Psychiatric: Denies Difficulty sleeping. Denies Loss of appetite.

Assessments

1.Essential hypertension - I10
2.Type 2 diabetes mellitus without complication, without long-term current use of insulin - E11.9 (The correct code should be E11.22 -Type 2 diabetes mellitus with diabetic chronic kidney disease. See coding TIPS for "With" guidelines).
3.BODY MASS INDEX (BMI) 45.0-49.9, ADULT - Z68.42 (Primary)
4.Morbid obesity, unspecified obesity type - E66.01
5.Psychiatric diagnosis - F99
6.Chronic kidney disease stage 3 - N18.3

Treatment

1. Hypertension-Refill Lisinopril Tablet, 40 MG
2. Type 2 diabetes mellitus - Start Glipizide ER Tablet Extended Release 24 Hour, 5 MG, 1 tablet with breakfast, Orally, Once a day, 90 days, 90 Tablet, Refills 1

Notes: pt to cut down diet soda.

3. Morbid obesity/BMI – Advised patient to start 45-minute exercise and provided dietary counselling
4. Psychiatric diagnosis – Continue medications as prescribed
5. Chronic kidney disease stage 3 Notes: monitor.

RECAP: Condition not linked with manifestation
Current Medications: **Documented treatment**
Assessment: **Documented the condition is present**
Treatment: **Documented the treatment plan**

Quick Tips (ICD-10- CM)

"The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system. As many codes within a particular category, as are necessary to describe all of the complications of the disease may be used. Assign as many codes from categories E08 – E13 as needed to identify all of the associated conditions that the patient has." ICD-10-CM

"An additional code should be assigned from category Z79 to identify the long-term (current) use of insulin or oral hypoglycemic drugs. If the patient is treated with both oral hypoglycemic drugs and insulin, both code Z79.4, Long term (current) use of insulin, and code Z79.84, Long term (current) use of oral hypoglycemic drugs, should be assigned. " ICD-10-CM

Quick Tips (ICD-10- CM)

The word “with” or “in” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index (either under a main term or subterm), or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. ICD-10-CM

The “with” guideline does not apply to “not elsewhere classified (NEC)” index entries that cover broad categories of conditions. The complication should be clearly documented. Coding professionals should not assume a casual relationship when the diabetic complication is “NEC.” AHA Coding Clinic, 4th quarter, 2017

Applies to index :DM with arthropathy NEC (E11.618), Circulatory complication NEC (E11.59), Complication specified NEC (E11.69), Kidney complication NEC (E11.29), Neurologic complication NEC (E11.49), Ophthalmic complication NEC (E11.39), Oral complication NEC (E11.638), Renal complication NEC (E11.29), Skin complication NEC (E11.628), Skin ulcer NEC (E11.622)

It would be appropriate to assign code E11.8, Type 2 diabetes mellitus with unspecified complications, when the provider documents that the patient has a diabetic complication but the medical record does not provide sufficient information to identify the complication that will allow the assignment of a more specific code. AHA July 29, 2020

Quick Tips (ICD-10- CM)

There is no default code for “uncontrolled diabetes.” Effective October 1, 2016, uncontrolled diabetes is classified by type and whether it is hyperglycemia or hypoglycemia. If the documentation is not clear, query the provider for clarification whether the patient has hyperglycemia or hypoglycemia so that the appropriate code may be reported; uncontrolled diabetes indicates that the patient’s blood sugar is not at an acceptable level, because it is either too high or too low. In the ICD-10-CM Index to Diseases, uncontrolled diabetes can be referenced as follows:

Diabetes, diabetic (mellitus) (sugar)
Uncontrolled
Meaning
hyperglycemia – see Diabetes, by type,
with hyperglycemia
hypoglycemia – see Diabetes, by type,
with hypoglycemia
Coding Clinic, 1st quarter, 2017

It would be inappropriate for coding professionals to interpret the clinical findings for a diagnosis. Example A1C - AHA October 2018

THANK YOU

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