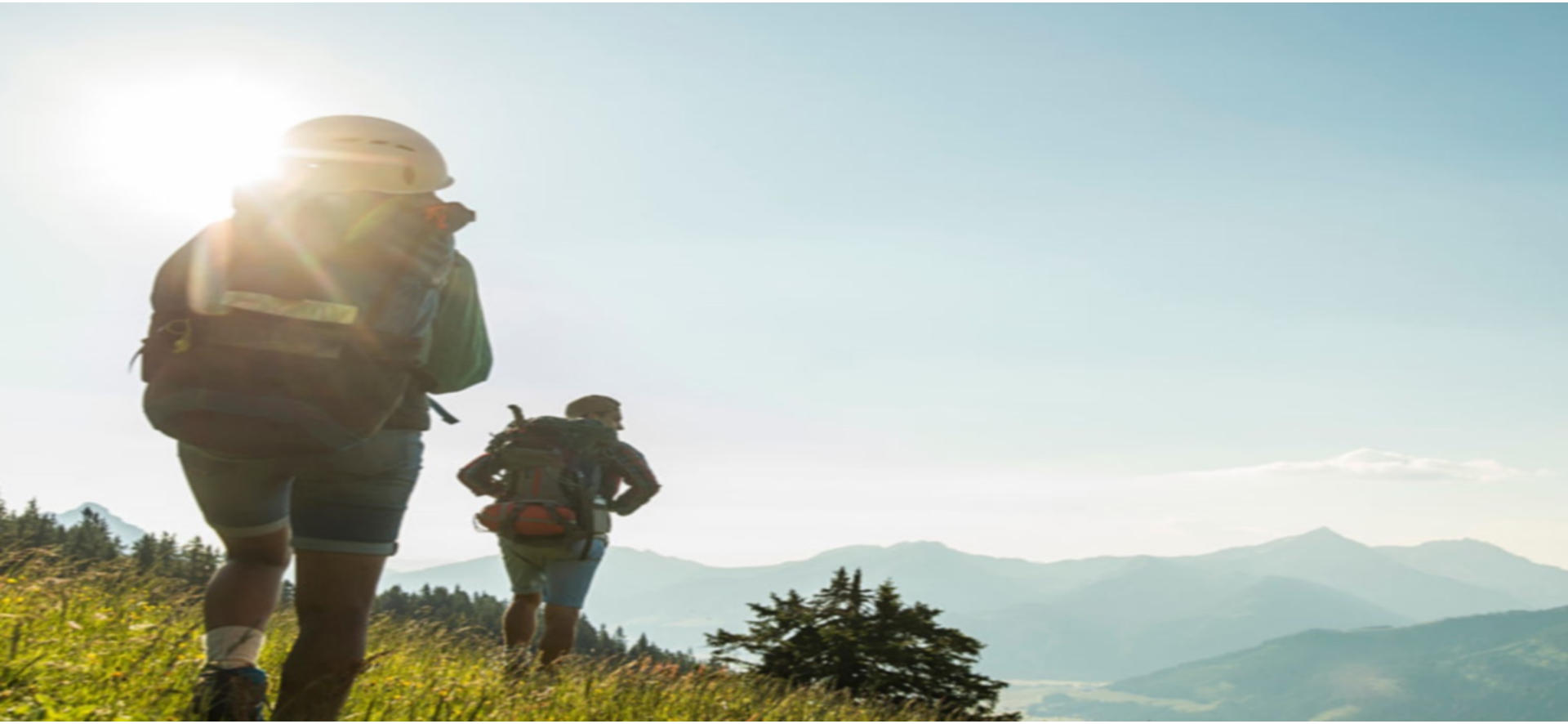
Coding Examples
Autoimmune



Six Elements of Medical Record Documentation

01 Reason for Appointment

- History of Present Illness

02 Examination

- General Appearance
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- Neurologic
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04 Review of System

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05 Assessments

- Definitive diagnosis

06 Treatment

- Notes
- Refer to
- Reason for referral

Correct Coding Examples

Case #1- Page 1 of 2

Reason for Appointment

Annual

History of Present Illness

60 yo female with Hx of Sjogren syndrome, Hashimoto's, chronic GERD and gastric polyps who presents to the office today requesting a referral to GI specialist for evaluation due to symptoms of rectal spasms/pain especially after running. Pt denies rectal bleeding, n/v/d, fever or any other acute symptomatology. No other concerns at this time.

Examination

General Appearance: alert, well hydrated, in no distress.

HEAD: normocephalic, atraumatic.

Eyes: Both eyes: PERRLA, EOMI, sclera anicteric.

Throat: clear, pharynx normal, uvula midline.

Neck/Thyroid: neck supple, full range of motion, no lymphadenopathy.

Heart: regular rate and rhythm, S1, S2 normal, no murmurs, rubs, gallops.

Lungs: clear to auscultation bilaterally, no wheezes, rales, rhonchi. no retractions or accessory muscle use.

Abdomen: bowel sounds present, soft, nontender, nondistended, no masses palpable, no hepatosplenomegaly.

Vital Signs

Ht 5 ft 1 in, Wt 126 lbs, BMI 23.8 Index, BP 118/70 mm Hg, HR 60/min, RR 17 /min, Temp 97.8 F, Oxygen sat % 98 %, Pain scale 0 1-10, Ht-cm 154.94, Wt-kg 57.15.

Current Medications

Synthroid 100 MCG Tablet 1 tablet on an empty stomach in the morning Orally Once a day

Cimetidine 400 MG Tablet 1 tablet at bedtime Orally Once a day

Estradiol 0.1 MG/24HR Patch Twice Weekly 1 patch to skin Transdermal Two times a Week, Notes: by GYN

Past Medical History

Sjogren's syndrome, with unspecified organ involvement.

Hypothyroidism. GERD.

Family History

Father: deceased, prostate cancer Mother: alive, uterine cancer, diagnosed with Unspecified heart disease.

Surgical History

Hysterectomy 01/2001

Bilateral oophorectomy 01/2016 bunionectomy 01/2016

C-section 09/1981-01/1984 Colonoscopy 12/04/2017

Hospitalization/Major Diagnostic Procedure: No Hospitalization History.

Case #1- Page 2 of 2

Review of Systems

General/Constitutional: Chills denies. Fatigue denies. Fever denies.

ENT: Blocked ear denies. Decreased hearing denies. Difficulty swallowing denies. Ear pain denies. Ringing in the ears denies.

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

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

Gastrointestinal: Abdominal pain denies. Blood in stool denies. Change in bowel habits denies. Constipation denies. Decreased appetite denies.

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

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

RECAP: Correct Coding

HPI: **Documented the condition**

Assessment: **Documented condition is present**

Treatment: **Documented treatment plan**

Assessments

1. Annual visit for general adult medical examination with abnormal findings - Z00.01 (Primary)

2. Hypothyroidism (acquired) - E03.9, Hashimoto's

3. Gastroesophageal reflux disease without esophagitis - K21.9

4. Gastric polyposis - K31.7, following with GI. Last EGD done 12/2017

5. Sjogren's syndrome with keratoconjunctivitis sicca - M35.01

6. Rectal spasm - K59.4

Treatment

1. Annual visit for general adult medical examination with abnormal findings. Notes: Annual labs ordered today.

2. Hypothyroidism (acquired). Refill Synthroid Tablet, 100 MCG

3. Gastroesophageal reflux disease without esophagitis. Continue Cimetidine Tablet, 400 MG.

4. Gastric polyposis. Referral To: Gastroenterology

5. Sjogren's syndrome with keratoconjunctivitis sicca. Notes: Diagnosed many years ago. Hx of punctual occlusion for symptomatic treatment. Pt will bring records next OV. Continue Pilocarpine for saliva production.

6. Rectal spasm. Referral To: Gastroenterology

Case #2 – Page 1 of 2

Reason for Appointment

Chest pressure, pain

History of Present Illness

52-year-old patient; states her “chest pressure" states the feeling is like pressure behind the sternum. Denies fever, SOB, COVID19 exposure. Denies chest pain on exertion, swelling of the legs. She wishes to get a continuation of care referral for her rheumatologist for her RA. She suffers from gastritis, states that sometimes the food feels "stuck" on her chest, she is taking Pantoprazole on and off.

Examination

General Appearance: alert, pleasant, in no acute distress.
Head: normocephalic, atraumatic.
Eyes: both eyes, extraocular movement full and smooth, sclera anicteric.
Lungs: Respiration appears unlabored, with no audible cough.
Chest: Able to speak in complete sentences.
Neurologic: Alert and oriented, cooperative with the exam.

Vital Signs

Ht 5 ft 4 in, Wt 233 lbs, BMI 39.99 Index, BP 110/70 mm Hg, HR 88/min, RR 17 /min, Temp 98.3 F, Ht-cm 162.56, Wt-kg 105.69.

Current Medications

Pantoprazole Sodium 20 Delayed Release Tablet 2

Tablets once a day orally 30 DAYS

Methotrexate 7.5mg Oral weekly

ProAir HFA 108 (90 Base) MCG/ACT

Aerosol Solution 1 puff as needed Inhalation every 4 hrs

Vitamin D (Ergocalciferol) 50000 UNIT Capsule TK 1 C

PO Q WK Oral weekly.

Past Medical History

Pre-diabetic.

Rheumatoid arthritis.

GERD

Surgical History

Appendectomy , Colonoscopy
Hysterectomy for benign fibroids (R. ovary removed due to cysts)

Hospitalization/Major Diagnostic Procedure:

ER visit Patient fall on 04/16/2018 and feeling pain in left knee.

Case #2 – Page 2 of 2

Review of Systems

General/Constitutional: Chills denies. Fatigue denies. Fever denies.
ENT: Blocked ear denies. Decreased hearing denies. Difficulty swallowing denies. Ear pain denies. Ringing in the ears denies. Snoring denies.
Respiratory: Cough denies. Shortness of breath denies. Wheezing denies.
Cardiovascular: Chest pain denies. Chest pain with exertion denies. Dyspnea on exertion denies. Orthopnea denies. Palpitations denies.
Gastrointestinal: Abdominal pain denies. Blood in stool denies. Change in bowel habits denies. Constipation denies. Decreased appetite denies. Diarrhea denies. Heartburn denies. Vomiting denies.
Musculoskeletal: Joint stiffness denies. Muscle aches denies. Painful joints denies.

RECAP:

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

Assessments

1. Chest pain, unspecified type - R07.9 (Primary)
2. Mild intermittent asthma- J45.20
3. Rheumatoid Arthritis- M06.9
4. BMI 39.0-39.9,adult - Z68.39
5. Obesity, unspecified - E66.9

Treatment

1. Chest pain, unspecified type: Clinical Notes: The discomfort could be related to her RA, her gastritis, or asthma.

2. Mild intermittent asthma without complication: Clinical Notes: Controlled, denies cough or wheezing, see above.

3. Rheumatoid arthritis, involving unspecified site, unspecified rheumatoid factor presence: Referral To: Rheumatology Reason: RA| Chest discomfort| Chronic lower back pain. Continue Methotrexate.

4.BMI 39.0-39.9,adult - Z68.39

5.Obesity, unspecified - E66.9

Case #3 – Page 1 of 2

Reason for Appointment
"I was recently in the ER because of an abscess in my right breast"

History of Present Illness

62- Year- old female came in today SAME DAY s/p hospital discharge; removed drainage in 2 days per patient (NO MR); requested. Per patient her drainage was removed 2 days after by the hospital. She is currently taking Bactrim denies any complaints at this time.

Examination
General Appearance: alert, pleasant, in no acute distress., pleasant, in no acute distress, well nourished.
Breasts: right breast, incision healing well, no oozing, no redness, no warmth.
Eyes: Both eyes, PERRLA, EOMI, sclera anicteric.
Throat: clear, pharynx normal, uvula midline.
Neck/Thyroid: neck supple, full range of motion, no lymphadenopathy.
Heart: regular rate and rhythm, S1, S2 normal, no murmurs, rubs, gallops.
Lungs: clear to auscultation bilaterally, no wheezes, rales, rhonchi. no retractions or accessory muscle use.
Abdomen: bowel sounds present, soft, nontender, nondistended, no masses palpable, no hepatosplenomegaly.
Neurologic: AOx3, normal strength, tone and reflexes, sensory exam intact.
Extremities: edema.

Vital Signs
Ht 62 in, Wt 178 lbs, BMI 32.55 Index, BP 138/70 mm Hg, HR 72 /min, RR 17 /min, Temp 98.5 F, Pain scale 0 1-10, Ht-cm 157.48, Wt-kg 80.74.

Current Medications
BusPIRone HCl 5 MG Tablet 1 tablet Orally once a day
Clonazepam 0.5 MG Tablet 1 tablet Orally daily Sertraline HCl 100 MG Tablet 1 tablet Orally Once a day
Trazodone HCl 50 MG Tablet 1 tablet at bedtime as needed Orally Once a day
Albuterol Sulfate (2.5 MG/3ML) 0.083% Nebulization Solution 3 ml as needed Inhalation Three times a day
ProAir HFA 108 (90 Base) MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 6 hrs Ergocalciferol 50000 UNIT Capsule 1 capsule Orally q weekly
Azathioprine 50 MG Tablet as directed Orally

Past Medical History
Hypertension. Pulmonary fibrosis.
Left breast cancer last quimio on 2010.
Systemic lupus erythematous.
Malignant neoplasm of central portion of left female breast.

Surgical History
cholecystectomy
3 C-section
left mastectomy (breast cancer)

Hospitalization/Major Diagnostic Procedure:
Sinusitis and Bronchitis
Pneumonia
ER visit / Breast abscess

Case #3 – Page 2 of 2

Review of Systems

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

Respiratory: Denies Asthma, denies. Denies Breathing pattern. Denies Tuberculosis, denies. Denies Wheezing.

Cardiovascular: Denies Chest pain. Denies Chest pain at rest. Denies Chest pain with exertion. Denies Claudication. Denies Cyanosis. Denies Difficulty laying flat. Denies Dizziness. Denies Dyspnea on exertion. Denies Fluid accumulation in the legs. Denies Heart murmur, denies. Denies Heart problems, denies. Denies High blood pressure, denies. Denies Irregular heartbeat, denies. Denies Orthopnea. Denies Palpitations, denies. Denies Rheumatic fever, denies. Denies Shortness of breath. Denies Weakness. Denies Weight gain.

Gastrointestinal: Denies Abdominal pain. Denies Blood in stool. Denies Change in bowel habits. Denies Weight loss.

Musculoskeletal: Admits joint pain & stiffness.

RECAP: Correct Coding

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

Assessments

1. Hospital discharge follow-up - Z09 (Primary)
2. BMI 32.0-32.9,adult - Z68.32
3. Obesity (BMI 30-39.9) - E66.9
4. Breast abscess - N61.1
5. Systemic lupus erythematosus, unspecified – M32.9

Treatment

1. BMI 32.0-32.9,adult: Notes: lifestyle mod low fat diet and exercise.

2. Obesity (BMI 30-39.9) Notes: lifestyle mod low fat diet and exercise.

3. Breast abscess: Start Mupirocin Calcium Cream, 2 %, 1 application, Externally, Three times a day, 10 day(s), 1, Refills . Continue Bactrim DS Tablet, 800-160 MG, 1 tablet, Orally, Twice a day.

4. SLE- Azathioprine 50 MG Tablet as directed Orally

Incorrect Coding Examples

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

Reason for Appointment

Reason for visit includes: follow up labs, headaches, insomnia, meds.

History of Present Illness

56 yo F presents for follow up. Patient would like to review her recent lab results. She complains of insomnia described as trouble falling asleep every night for the past few years. She was previously on Zolpidem which stopped working so switched to Temazepam 15mg qhs which is also not working well now. She has fibromyalgia and Sjogren's, recently restarted on Methotrexate by rheumatology. She has fatigue and frequent headaches. Headaches started in her 20s but worsened over the past few months. Headaches are sharp, usually right occipital region, with associated nausea but no vomiting or photosensitivity. There is no associated fever and headaches do not awaken patient at night. No known triggers other than stress. Fioricet provides partial relief.

Examination

Constitutional: No acute distress.
Eyes: Pupils equal, round and reactive to light and accommodation. Extraocular movement intact. Conjunctiva clear and nonicteric.
Ears, Nose, Mouth and Throat: Nose is clear. Tympanic membranes normal. No erythema. Throat is clear. No mucosal lesion. Mouth is without inflammation or lesion. Nasal mucosa normal, no discharge.
Neck: Neck is supple. Thyroid normal. Carotids are palpable without bruit.
Pulmonary: Respirations unlabored. Lungs clear to auscultation bilaterally, with no rubs, rhonchi or wheezing.

Vital Signs

Height 5 ft 3 in Weight 107 lb 4 oz BMI Calculated 19 BSA Calculated 1.48 Systolic 98, LUE, Sitting Diastolic 65, LUE, Sitting Temperature 97.3 F, Oral Heart Rate 78 Respiration 18 O2 Saturation 98

Current Medications

Taking

Butalbital-APAP-Caffeine 50-325-40 MG Oral Capsule
Folic Acid 1 MG Oral Tablet
Gabapentin 400 MG Oral Capsule
Methotrexate 2.5 MG Oral Tablet
Pravastatin Sodium 10 MG Oral Tablet
Metformin HCl - 500 MG Oral Tablet
Temazepam 15 MG Oral Capsule
Tramadol HCl - 50 MG Oral Tablet prn for pain.

Active Problems

Ankle pain, left (719.47) (M25.572)

Fibromyalgia (729.1) (M79.7)

Frequent headaches (784.0) (R51)

Mixed hyperlipidemia (272.2) (E78.2)

Multiple joint pain (719.49) (M25.50)

Sjogren's syndrome (710.2) (M35.00)

Sleep apnea (780.57) (G47.30)

Case #4 – Page 2 of 2

Review of Systems

Constitutional: eye, otolaryngeal, cardiovascular, pulmonary, gastrointestinal, genitourinary, musculoskeletal, skin, endocrine and hematologic review of systems are normal except as noted in the HPI or as below.
Neurological: headache.
Psychiatric: sleep disturbances.
Cardiovascular: Regular heart rate and rhythm. No murmurs, rubs or gallops; S1, S2 normal.
Musculoskeletal: Normal gait. No clubbing or cyanosis. Full range of motion of all extremities. Normal motor strength and tone.
Skin: No gangrenous changes. No loss of skin integrity. No rash or significant lesion. Neurologic: Alert and oriented. Limited exam shows no focal deficits. normal finger to nose, normal rapid alternating hand movements, negative Romberg's, normal heel to toe walking. Cranial nerves grossly intact. DTR's normal. Sensation normal.
Psychiatric: Pleasant and cooperative.

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

Assessments

1. Hyperglycemia (R73.9)
2. Refused influenza vaccine (Z28.21)
3. Chronic insomnia (F51.04)
4. Immunization due (Z23)
5. Frequent headaches (R51)
6. Mixed hyperlipidemia (E78.2)
7. Sjogren's syndrome (M35.00) (Diagnosis was added. Per coding guidelines "Code all conditions that coexist or affect patient's care")

Treatment

1. Hyperglycemia (790.29) (R73.9) continue Metformin 500mg qd.

2. Refused influenza vaccine (V64.06) (Z28.21) Gets sick from shot

3. Chronic insomnia (780.52) (F51.04) Start rx Amitriptyline 25mg

4. Immunization due (V05.9) (Z23) Tdap administered today. Declines flu vaccine. Will add to Shingrix waiting list.

5. Frequent headaches (784.0) (R51) On Fioricet PRN.

6. Mixed hyperlipidemia (272.2) (E78.2) start statin

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

Reason for Appointment
Lab results & back pain

History of Present Illness

30 years old male patient comes to the office to discuss lab results. He has prediabetes and ankylosing spondylitis. He states he always has back pain. He denies any other signs or symptoms at this moment.

Examination

General Appearance: Healthy-appearing.
Neck/Thyroid: No lymphadenopathy or thyromegaly or JVD, neck supple, no cervical lymphadenopathy.
Heart: no murmurs, rubs, gallops.
Lungs: normal , no wheezes, rales, rhonchi.
Chest: Able to speak in complete sentences , no retractions or accessory muscle use.
Abdomen: normal , no ascites , no organomegaly , no hernias present.
Musculoskeletal: normal appearing, normal ROM of all major joints/spine during normal exam movements.

Vital Signs
Ht 5 ft 9 in, Wt 237 lbs, BMI 34.99 Index, BP 120/78 mm Hg, HR 82 /min, RR 16 /min, Temp 98.1 F, Pain scale 0 1-10, Ht-cm 175.26, Wt-kg 107.5

Current Medications
Meloxicam 15 MG Tablet 1 tablet Orally Once a day
Metformin HCl 500 MG Tablet 1 tablet with a meal Orally Once a day
Enalapril Maleate 5 MG Tablet 1 tablet

Past Medical History

Prediabetes.

Ankylosing spondylitis.

Surgical History
Cyst removal 01/01/2005
Tonsillectomy 01/01/2016

Hospitalization/Major Diagnostic Procedure:

Bradycardia 01/01/2018

Case #5 – Page 2 of 2

Review of Systems

Constitutional: No weight loss, fever, chills, weakness or fatigue.
HEENT: Eyes: No visual loss, blurred vision, double vision or yellow sclerae. Ears, Nose, Throat: No hearing loss, sneezing, congestion, runny nose or sore throat.
Skin: No rash or itching.
Cardiovascular: No chest pain, chest pressure or chest discomfort. No palpitations or edema.
Respiratory: No shortness of breath, cough or sputum.
Gastrointestinal: No anorexia, nausea, vomiting or diarrhea. No abdominal pain or blood in stools.
Genitourinary: Denies Burning on urination, urgency or dribbling

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

Assessments

1. Hypertension - I10
2. Elevated liver enzymes - R74.8
3. Elevated hemoglobin A1c - R73.09
4. BMI 34.0-34.9,adult - Z68.34
5. Obesity - E66.9
6. Ankylosing spondylitis lumbar region - M45.6 (Diagnosis was added. Per coding guidelines "Code all conditions that coexist or affect patient's care")

Treatment

1. Hypertension -Pt was instructed about medication compliance, low diet and regular exercise for blood pressure control

2. Elevated liver enzymes LAB: HEPATIC FUNCTION PANEL (Ordered) IMAGING: US ABDOMEN LIMITED (Ordered)

3. Elevated hemoglobin A1c LAB: COMPREHENSIVE METABOLIC PANEL (Ordered) HEMOGLOBIN A1c (Ordered)

4. BMI 34.0-34.9,adult/Obesity - Patient counseled on the importance of a balanced diet and was advised to exercise at least 150 minutes/week divided in 3-5 daily sessions. Diet/exercise reviewed with patient. Eat vegetables, fruits, whole grains, complex carbohydrate, lean meats (poultry/turkey), seafood, nuts and fiber rich foods.

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

Reason for Appointment

Follow up with blood work results /Mammogram

History of Present Illness

Hypercholesterolemia:

Diet- no specific diet. Statin therapy Patient is currently taking Simvastatin and has been tolerating it well . Exercising, no regular exercise

Examination

Head: symmetric, NC/AT, no temporal tenderness.
Eyes: normal eyelids, anicteric scleras, normal conjunctiva.
Nose: normal mucosa.
Mouth: no lesions, no exudates, no erythematous, mucosa pink. Neck: no lymphadenopathy.
Chest: symmetric, normal shape and expansion.
Heart: RRR, normal S1S2, no murmur.
Lungs: clear to auscultation.
Abdomen: soft, NT/ND, BS present.
Extremities: psoriatic arthritis hands.
Skin: psoriatic lesions in both hands.
Neurological: AAO X 3.

Vital Signs

Oxygen Sat % 97 %, Temp 98.4 F, BP 132/82 mm Hg, Ht 61 in, Wt 173 lbs, BMI 32.68 Index, PL 74, Pain Scale 0, RR 18.

Current Medications

Zyrtec 10 mg tablet 1 tab(s) orally once a day
Ibuprofen 600 mg tablet 1 tab(s) orally bid prn, Notes: PRN
Omeprazole 20 mg delayed release tablet 1 tab(s) orally once a day, Notes: PRN
Simvastatin 40 mg tablet TAKE 1 TABLET BY MOUTH ONCE A DAY AT BEDTIME
Folic acid 1 mg Tablet 1 tab(s) once a day orally 90 days orally 1 time a day
Methotrexate 2.5 mg Tablet 6 TAB(S) ONCE A WEEK ORALLY 90 DAYS orally once a week
Triamcinolone Acetonide Topical 0.1% Cream 1 app applied topically 3 times a day

Past Medical History

Hyperlipidemia. Gastritis. Esophageal reflux. Constipation.

Kidney stones. Migraine headache. Psoriatic arthritis

Surgical History

ruptured appendix- appendectomy 2005
c section 1999
c section 1991
tonsillitis 1989

CASE #6 – Page 2 of 2

Review of Systems

Review of all other systems **is otherwise as above or negative**.

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

Assessments

1. Mixed hyperlipidemia - E78.2

2.Encounter for screening mammogram for malignant neoplasm of breast - Z12.31

3. Arthropathic psoriasis, unspecified - L40.50 (Diagnosis was added. Per coding guidelines "Code all conditions that coexist or affect patient's care")

Treatment

1. Mixed hyperlipidemia

Stop simvastatin tablet, 40 mg, 1 tab(s), orally, once a day (at bedtime) Start Atorvastatin Calcium tablet, 40 mg, 1 tab(s), orally, once a day, 90 days, 90 Tablet, Refills 1

Notes: LDL: 135 mg/dl, worsening, not at goal, target LDL < 100, dietary avoidance discussed, high fiber recommended, will change to Atorvastatin.

2. Encounter for screening mammogram for malignant neoplasm of breast

Notes: f/u mammogram, Pt advised

THANK YOU

Commercial Risk Adjustment Team
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