Coding Examples
Heart Arrhythmia

Six Elements of Medical Coding Documentation

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- History of Present Illness

02 Examination

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03 Vital Signs

- Current Medication
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04 Review of System

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- Peripheral Vascular

05 Assessments

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06 Treatment

- Notes:
- Refer to:
- Reason for referral:

Correct Coding Examples

Case #1 - Page 1 of 2

Reason for Appointment

Patient requested Tele visit to discuss blood work result.

History of Present Illness

General: This HPI has been obtained via telephone. Patient is 64 year old female with h/o DM Type 2 on Pioglitazone HCl, A fib on Eliquis 5 mg BID, HLD on Atorvastatin 10 mg. QHS schedule for Virtual visit to discuss blood work result , overall patient doing well, no acute complaints at present, patient denies chest pain , SOB , dizziness, HA, GI or Gu symptoms.

Blood work done on 5/6/2020 showed FBG 104, Albumin/Cr ratio random 84, HbA1C 6.2%, TG 216, HDL 45, LDL 118, RBC 10-20 HPF, d/w patient blood work result in details all questions answered, recommendations provided.

Examination

General Examination: N/A.

Current Medications:

Taking

Pioglitazone HCl 15 MG Tablet TAKE 1 TABLET BY MOUTH EVERY DAY
Eliquis 5 mg Tablet TAKE 1 TABLET BY MOUTH TWICE DAILY
Ergocalciferol 1.25 MG (50000 UT) Capsule 1 capsule

Atorvastatin Calcium 10 mg Tablet 1 tablet Orally QHS

Past Medical History:

DM Type 2
Hepatic steatosis
Anxiety
HLD
Mild Depression.
OSA on CPAP
A fib on Eliquis

Surgical History

A fib ablation 2014

Case #1 – Page 2 of 2

Review of Systems

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

Ophthalmologic: Patient denies visual loss

Respiratory: Patient denies shortness of breath, wheezing

Cardiovascular: Patient denies Chest pain, chest pressure or chest discomfort, difficulty laying flat, dyspnea on exertion. Comments See HPI for details, h/o A fib.

Gastrointestinal: Patient denies abdominal pain, nausea

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

Psychiatric: Patient denies Depressed mood, anxiety

RECAP:

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

Assessments

1. OSA (obstructive sleep apnea) - G47.33
2. Vitamin D deficiency - E55.9
3. Chronic atrial fibrillation - I48.20
4. Controlled type 2 diabetes mellitus without complication, without long-term current use of insulin - E11.9
5. Hyperlipidemia – E78.5

Treatment

1. **OSA (obstructive sleep apnea)**Notes: Advise patient use CPAP regularly.

2. **Vitamin D deficiency** Continue Ergocalciferol Capsule, 1.25 MG (50000 UT), 1 capsule, Orally, weekly, 90 days, 12, Refills 0

3. **Chronic atrial fibrillation** Continue Eliquis Tablet, 5 mg, 1 tablet, Orally, Every 12 hours, 90 days, 180 Tablet,

4. **Controlled type 2 diabetes mellitus without complication, without long-term current use of insulin** Continue Pioglitazone HCl Tablet, 15 MG, 1 tablet, Orally, Once a day, 30 days, 30 Tablet

5. **Hyperlipidemia** Continue Atorvastatin Calcium Tablet, 10 mg, 1 tablet, Orally, QHS

Case #2 – Page 1 of 2

Reason for Appointment
1. New Patient
2. Referral
3. Stomach Pain

History of Present Illness

General:

38 year old female with SVT, hepatitis B, anemia presents for annual physical. She admits recurrent palpitations with some dyspnea, no dizziness, no syncope, no chest pain.

Examination
General Appearance: alert, well hydrated, in no acute distress.
Heart: regular rate and rhythm, S1, S2 normal, no murmurs, rubs, gallops.
Lungs: clear to auscultation bilaterally, good air movement, no wheezes, rales, rhonchi.
Abdomen: soft, nontender, nondistended, bowel sounds present, no hepatosplenomegaly, no masses palpable.
Neurologic: nonfocal, motor strength normal upper and lower extremities, sensory exam intact, cranial nerves 2-12 grossly intact, deep tendon reflexes 2+ symmetrical.
Extremities: full range of motion, no edema.

Vital Signs
Ht 60 In, Wt 216.2 lbs, BMI 42.22 Index, BP 120/80 mm Hg, HR
76 /min, RR 14 /min, Temp 97.7 F, Oxygen sat % 99 %, Pain scale
5 1-10, Ht- cm 152.4, Wt-kg 98.07.

Current Medications

Metoprolol Tartrate 50 MG Tablet 1 tablet with food Orally Twice a day

Aspirin 81

Amlodipine Besylate 5 MG Tablet as directed Orally Once a day

Ferrous Sulfate 325 (65 Fe) MG Tablet as directed Orally Once a day

Nitrofurantoin Monohyd Macro 100 MG Capsule 1 capsule at bedtime with food Orally Once a day

Medication List reviewed and reconciled with the patient

Past Medical History
HTN
HEP B
Anemia

Surgical History

Kidney Laser 01/2016

Case #2 – Page 2 of 2

Review of Systems

General/Constitutional: Overall health Good. Fatigue denies. Fever
denies. Lightheadedness denies.
Endocrine: Cold intolerance denies. Excessive thirst denies. Weight loss denies.
Cardiovascular: Chest pain denies. Difficulty laying flat denies.
Dizziness denies. Fluid accumulation in the legs denies. Palpitations denies.
Gastrointestinal: Abdominal pain denies. Constipation denies. Difficulty swallowing denies. Heartburn denies. Nausea denies.
Neurologic: Difficulty speaking denies. Loss of strength denies.
Seizures denies

RECAP:

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

Assessments

1. Annual physical exam - Z00.00 (Primary)
2. SVT (supraventricular tachycardia) - I47.1
3. Essential hypertension - I10
4. Chronic viral hepatitis B without delta agent and without coma - B18.1
5. Iron deficiency anemia due to chronic blood loss - D50.0

Treatment

1. Annual physical exam
LAB: MICROALBUMIN, RANDOM URINE (W/CREATININE)
LAB: LIPID PANEL WITH REFLEX TO DIRECT LDL LAB: URINALYSIS, COMPLETE W/REFLEX TO CULTURE

2. SVT (supraventricular tachycardia) Referral To Cardiology Reason: SVT for ablation

3. Essential hypertension Clinical Notes: continue metoprolol

4. Chronic viral hepatitis B without delta agent and without coma
LAB: HEPATITIS PANEL, ACUTE W/REFLEX TO CONFIRMATION

5. Iron deficiency anemia due to chronic blood loss
Clinical Notes: due to menorrhagia.

Case #3 – Page 1 of 2

Reason for Appointment

1. Referral for Endocrinology and Cardiology
2. Left shoulder pain

History of Present Illness

General: Patient with hypertension, AICD in place, hyperthyroidism, paroxysmal atrial fibrillation and cholecystectomy presents for follow up. She is requesting a referral to cardiologist and endocrinologist for continuation of care. Pacemaker checked in April 2020; she has not seen endocrinologists for 6 months.

C/o left shoulder pain, hx of frozen shoulder. She had PT in the past.

Examination

General Appearance: alert, well developed, in no acute distress, overweight female.
Head: normocephalic.
Eyes: pupils equal, round, reactive to light and accommodation. Throat: no erythema, no exudate.
Heart: regular rate and rhythm, S1, S2 normal.
Lungs: clear anteriorly and posteriorly, no wheezes, rales, rhonchi.
Abdomen: bowel sounds present, soft, nontender, nondistended.
Musculoskeletal: strength 5/5, stable gait.
Neurologic: alert and oriented, cooperative with exam, normal

Vital Signs

Ht 63 in, Wt 190.6 lbs, BMI 33.76 Index, BP 138/88 mm Hg,126/84 mm Hg, HR 76 /min, RR 16 /min, Temp 98.1 F, Pain scale 5 1-10, Ht-cm 160.02, Wt-kg 86.45

Current Medications

Sotalol HCl 80 MG Tablet 1 tablet Orally every 12 hrs

Amlodipine Besylate 10 MG Tablet 1 tablet Orally Once a day

Methimazole 5 MG Tablet 1 tablet with food Orally Once a day

Past Medical History

HTN
GERD
Hyperthyroidism
Tachycardia s/p pacemaker

Surgical History

TONSILECTOMY 01/1963
PACEMAKER 08/2017

Case #3 – Page 2 of 2

Review of Systems

General/Constitutional:
Patient denies chills, fatigue, fever, weight loss.

Respiratory:
Patient denies shortness of breath, cough.

Cardiovascular:
Patient denies chest pain, palpitations, swelling in hands/feet, racing heart.

Musculoskeletal:
Patient denies weakness, painful joints, muscle aches. Patient complaining of left shoulder pain.

Neurologic:
Patient denies balance difficulty, gait abnormality, headache, seizures.

RECAP:

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

Assessments

1. Hyperthyroidism - E05.90 (Primary)
2. Paroxysmal atrial fibrillation - I48.0
3. Essential hypertension – I10
4. Pacemaker – Z95.0
5. Pain in left shoulder – M25.512

Treatment

1. Hyperthyroidism -Continue Methimazole Tablet, 5 MG, 1 tablet with food, Orally, Once a day

2. Paroxysmal atrial fibrillation
Continue Sotalol HCl Tablet, 80 MG, 1 tablet, Orally, every 12 hrs Clinical Notes: one episode; not on anticoagulation per cardiologist

3. Essential hypertension - Continue Amlodipine Besylate Tablet, 10 MG, 1 tablet, Orally, Once a day
Continue Hydrochlorothiazide Tablet, 25 MG, 1 tablet, Orally, Once a day

4. Pacemaker - Clinical Notes: checked in April, 2020.

5. Pain in left shoulder - Clinical Notes: hx of left frozen shoulder; treated with PT; patient states she will continue shoulder exercises at home.

Incorrect Coding Examples

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

Reason for Appointment

Skin Problem

History of Present Illness

The patient reports the following problems: Patient is here today for skin issues. He has chronic post shaving erythematous rash to the nasolabial region. He has been using antifungal and steroid with minimal relief. He states he used to have similar issue when he had a mustache.

He has not seen any specialist since his last visit he continues on Eliquis for atrial fibrillation, which is controlled. He takes Klonopin to sleep. He is due to have labs. He did not complete his Cologuard ordered in May of last year.

Vital

Signs BP: 134/81, Pulse: 71 ,Resp: 13

Temp:	97.8 °F (36.6 °C)
Weight:	66.2 kg (146 lb)
Height:	170.2 cm (5' 7")

Current Medications

clonazepam (KLONOPIN) 0.5 mg tablet

metoprolol succinate (TOPROL- XL) 25 mg

Eliquis 5 MG Tablet 1 tablet Orally twice a day

Examination

General: Well appearing male
Well developed, well nourished, no acute distress
Cardiovascular: Heart RRR without murmur.
Skin: patient is neatly shaven, he does have some erythema to the nasolabial region. No dandruff or scaling of the hair lines.
Lungs: No acute distress. No dyspnea. Normal effort.
Psych: Good insight and judgement. Mood is normal

Case #4 – Page 2 of 2

Review of Systems

See HPI

RECAP: Missed Diagnosis - should have captured.
HPI: **Documented the condition is present**
Current Medications: **Documented treatment**
Assessment: **No mention of condition**
Treatment: **No documented treatment plan.**

Assessments

1. Seborrheic dermatitis - L21.9

2. Routine general medical examination - Z00.00

3. Unspecified Atrial fibrillation I48.91 - (*Diagnosis was added . Per coding guidelines "Code all conditions that coexist or affect patient's care")*

Treatment

Orders Placed This Encounter

CBC AND AUTOMATED DIFFERENTIAL RFLX MANUAL DIFF

COMPREHENSIVE METABOLIC PANEL (CMP), SERUM

LIPID PANEL WITH TOTAL CHOLESTEROL:HDL RATIO, SERUM/PLASMA

PROSTATE SPECIFIC ANTIGEN (PSA)

HEPATITIS C VIRUS (HCV) ANTIBODY, SERUM/PLASMA

COLOGUARD

ketoconazole (NIZORAL) 2 % cream

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

Reason for Appointment

1. Referral: Cardiologist
2. Consultation

History of Present Illness

General:

Needs referral to follow-up with cardiology for a-fib. States that he also needs referral for screening colonoscopy. Reports that for the past 2 months he has noted a soft tissue mass to right lower arm. States that this started after he fell 2 months ago.

Examination

General Appearance: alert, in no acute distress, well developed, well nourished.
Heart: regular rate and rhythm, S1, S2 normal, no murmurs.
Lungs: no wheezes, rales, rhonchi, clear to auscultation bilaterally.
Abdomen: soft, nontender, nondistended.
Musculoskeletal: Full active range of motion to upper and lower extremities. Soft Freely mobile 1inch x 1inch soft tissue mass to right lower arm.
Neurologic: cranial nerves 2-12 grossly intact.
Extremities: full range of motion, no edema.
Psych: Normal mood and affect.

Vital Signs

- Ht 71 in, Wt 239 lbs, BMI 33.33 Index, BP 130/70 mm Hg, HR 69 /min, RR 16 /min, Temp 98 F, Oxygen sat % 99 %, Pain scale 0 1-10, Ht-cm 180.34, Wt-kg 108.41

Current Medications

Taking
Eliquis 5 MG Tablet 1 tablet Orally twice a day
Losartan Potassium 50 MG Tablet 1 tablet Orally Once a day
Medication List reviewed and reconciled with the patient

Past Medical History

Essential hypertension
Low vitamin D level
Chronic atrial fibrillation

Surgical History

Cardiac ablation 03/14/17
Colonoscopy 1999

Case #5 – Page 2 of 2

Review of Systems

General/Constitutional:
Denies Change in appetite. Denies Chills. Denies Fatigue.
ENT:
Denies Difficulty swallowing. Denies Ear pain. Denies Sinus pain.
Endocrine:
Denies Cold intolerance. Denies Dizziness. Denies Excessive thirst. Denies Heat intolerance.
Respiratory:
Denies Chest pain. Denies Cough. Denies Hemoptysis. Denies Shortness of breath.
Cardiovascular:
Denies Chest pain. Denies Dyspnea on exertion.
Palpitations.
Denies Shortness of breath.
Musculoskeletal:
Patient complaining of right lower arm 1 inch x 1 inch freely mobile soft tissue mass.
Neurologic:
Denies Headache. Denies Loss of strength. Denies Memory loss.

RECAP: Missed Diagnosis - should have captured.
HPI: **Documented the condition is present**
Current Medications: **Documented treatment**
Assessment: **No mention of condition**
Treatment: **Documented treatment plan**

Assessments

1. History of cardiac radiofrequency ablation - Z98.890 (Primary)

2. Colon cancer screening - Z12.11

3. Soft tissue mass - M79.9

4. Chronic atrial fibrillation , unspecified– I48.20- (*Diagnosis was added . Per coding guidelines "Code all conditions that coexist or affect patient's care")*

Treatment

1. History of cardiac radiofrequency ablation

Referral To: Cardiovascular Disease

Reason: Follow-up on cardiac ablation.

2. Colon cancer screening

Referral To: Gastroenterology Reason: Colon cancer screening

3. Soft tissue mass

Referral To: General Surgery Reason: soft tissue mass right lower arm

Quick Tips (ICD-10- CM)

Codes in category I48, Atrial fibrillation and flutter, were expanded and the following new codes created to provide unique codes to describe the different types of atrial fibrillation (AF).

- I48.11 Longstanding persistent atrial fibrillation
- I48.19 Other persistent atrial fibrillation
- I48.20 Chronic atrial fibrillation, unspecified
- I48.21 Permanent atrial fibrillation

AHA Coding Clinic History of A Fib on Anticoagulant Therapy, p 101
Body: VOLUME 30 FOURTH QUARTER
NUMBER 4 2013, Page 101

Quick Tips (ICD-10- CM)

Unfortunately, “history” as used in physician documentation can be a vague term that can have different meanings. Therefore, query the provider for clarification of whether the patient has a past history of atrial fibrillation which has resolved, or whether the atrial fibrillation is a current chronic condition. Assign code I48.20, and code Z79.01, Long-term (current) use of anticoagulants, if the provider clarifies current chronic atrial fibrillation on long-term anticoagulation with Coumadin. Assign code Z86.79 , Personal history of certain other diseases, Disease of circulatory system, and code Z79.01, if the provider clarifies past medical history of atrial fibrillation on long –term anticoagulation with Coumadin .

1. Be specific when documenting and coding (Testing, physical findings, diagnosis, medication, diet, etc.)
2. Clarify : active vs history of (no longer present)

THANK YOU

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