Coding Examples
HIV

Six Elements of Medical 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. Referral

History of Present Illness
General:
54 years old female with DM on Janumet last a1c on 6/27/2020 is 6.5 with asymptomatic HIV on Dovato , with HLD on atorvastatin

Examination
General Appearance: alert, pleasant, well-hydrated, in no distress.
Eyes: both eyes, normal, extraocular movement intact (EOMI), sclera non-icteric.
Lungs: no wheezing heard, no coughing.
Musculoskeletal: normal appearing, normal ROM of all major joints during normal exam movements.
Neurologic: Cooperative with the interview, patient is speaking full sentences, no tremor noted.
Psych: Normal mood and affect, no anxious or depressive appearance

Vital Signs

Telemedicine:

Current Medications

Taking

Dovato 50-300 MG Tablet 1 tablet Orally Once a day

FreeStyle Libre 14 Day Reader - Device as directed daily

FreeStyle Libre 14 Day Sensor - Miscellaneous as directed daily

Janumet 50-1000 MG Tablet 1 tablet with meals Orally Twice a day

Atorvastatin Calcium 20 MG Tablet 1 tablet Orally Once a day

Case #1 – Page 2 of 2

Review of Systems

General/Constitutional: Denies Chills. Denies Fatigue. Denies Cough. Denies Hemoptysis

Cardiovascular: Denies Chest pain. Denies Dyspnea on exertion.
Denies Fluid accumulation in the legs. Denies Palpitations.

Genitourinary: Denies Blood in urine. Denies Difficulty urinating. Denies Frequent urination

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

Assessments

1. Type 2 diabetes mellitus without complication, without long-term current use of insulin - E11.9 (Primary)
2. Mixed hyperlipidemia - E78.2
3. Asymptomatic HIV infection - Z21

Treatment

1. Type 2 diabetes mellitus without complication, without long- term current use of insulin

Refill Janumet Tablet, 50-1000 MG, 1 tablet with meals, Orally, Twice a day, 90 days, 180 Tablet, Refills 2

Referral To: Ophthalmology Reason:eval and management

2. Mixed hyperlipidemia

Continue Atorvastatin Calcium Tablet, 20 MG, 1 tablet, Orally, Once a day Notes: Patient advised on lifestyle changes including low sodium, low fat, low carb diet, frequent physical activity, attempt to lose weight.

3. Asymptomatic HIV infection

Refill Dovato Tablet, 50-300 MG, 1 tablet, Orally, Once a day, 90 days, 90 Tablet, Refills 1

RECAP:

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

Case #2 – Page 1 of 2

Reason for Appointment
1. New Patient
2. Annual Check, and refill medication

History of Present Illness
General:
52yr old male, new pt., to establish care.
His medical hx. includes HTN, HIV, asthma, depression. He continues with his meds, no adverse side effects. He has no acute complaints at this time.

Examination
General Appearance: alert, pleasant, in no acute distress.
Ears: bilateral ear canals clear: tympanic membranes clear without bulging.
Oral Cavity: normal , good dentition.
Neck/Thyroid: thyroid normal , no carotid bruit.
Heart: Regular rate and rhythm, normal S1 and S2, no murmurs/gallops/rubs..
Lungs: Clear to auscultation bilaterally. Well ventilated. No rhonchi, wheezes or rales.
Abdomen: bowel sounds present , no hepatosplenomegaly.
Musculoskeletal: Strength 5/5
Extremities: no clubbing, cyanosis, or edema.

Vital Signs
Ht 5 ft 8 inch, Wt 157 lbs, BMI 23.87 Index, BP sitting:132/80, HR 88/min, RR 16 /min, Temp 98.3 F, Oxygen sat % 98 %, Ht-cm 172.72, Wt- kg 71.21.

Current Medications
Taking
Biktarvy 50-200-25 MG Tablet 1 tablet Orally Once a day
Irbesartan 75 MG Tablet 1 tablet Orally Once a day
Albuterol Sulfate HFA 108 (90 Base) MCG/ACT Aerosol Solution 2 puff as needed Inhalation every 6 hrs
Descovy 200-25 MG Tablet as directed Orally

Past Medical History
Hypertension
Asthma
HIV

Social History
Have you had any sexually transmitted diseases? Yes
HIV

Surgical History
Colonoscopy 01/2019 Denies Past Surgical History

Hospitalization/Major Diagnostic Procedure:
Syncope- 05/2020
Pneumonia-03/2020

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:

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

Assessments

1. Annual physical exam - Z00.00 (Primary)
2. HIV infection, unspecified symptom status - B20
3. Essential hypertension - I10
4. Moderate persistent asthma without complication - J45.40
5. Major depressive disorder with current active episode, unspecified depression episode severity, unspecified whether recurrent - F32.9

Treatment

1. Annual physical exam
LAB: LIPID PANEL WITH REFLEX TO DIRECT LDL,
2. HIV infection, unspecified symptom status
Refill Biktarvy Tablet, 50-200-25 MG, 1 tablet, Orally, Once a day, 30 days, 30 Tablet, Refills 5 Notes: continue with current meds, Will refer to new ID doctor. Referral To: Infectious Disease Reason: 52yr old male with HIV since 2004, on meds
3. Essential hypertension
Refill Irbesartan Tablet, 75 MG, 1 tablet, Orally, Once a day, 30 days
4. Moderate persistent asthma without complication
Refill Albuterol Sulfate HFA Aerosol Solution, 108 (90 Base) MCG/ACT, 2 puff as needed
5. Major depressive disorder with current active episode, unspecified depression episode severity, unspecified whether recurrent
Start Fluoxetine HCl Capsule, 20 MG, 1 capsule, Orally, Once a day, 30 day(s), 30 Capsule, Refills 5

Case #3 - Page 1 of 2

Reason for Appointment
Follow up- refill on medication
C/o sprained left little toe

History of Present Illness
General:
53 YO M comes in for meds. Sprained left little toe.
Also needs refill Atripla for his HIV.

Examination
Constitutional: Patient is oriented to time, person and place, pleasant, no acute distress, normal, mood is appropriate.
HEENT: Head: normocephalic, Head: atraumatic, Sclera: normal, PERRLA, EOMI. Turbinates: pink, Ears: Canal clear, TM intact, light reflex present. Throat: Non erythematous, tongue unremarkable.
Pulmonary: The respiratory pattern is nonlabored, No rales are detected by auscultation, no rhonchi, no wheezes, Breath sounds: clear all lobes.
Cardiac: normal S1S2, regular rhythm, no murmurs.
Abdomen: soft, non distended, BS normal, no abdominal tenderness to palpation, no abdominal masses present on palpation, no hepatomegaly, no splenomegaly.
Neurology: normal coordination, normal motor strength bilaterally, normal reflexes, normal sensation and strength.

Vital Signs
Ht 70 in, Wt 173 lbs, BMI 24.82 Index, Temp 98.1, BP 118/68 mm Hg, HR 68 /min, RR 17 /min, O2 SAT 98 %.

Current Medications
Taking

Atorvastatin 40 mg tablet 1 tab(s) orally once a day
Atripla 600 mg-200 mg-300 mg tablet 1 tab(s) orally once a day (at bedtime)
Ambien 10 mg tablet 1 tab(s) orally once a day (at bedtime)
Alavert 10 mg tablet 1 tab(s) orally once a day

Medication List reviewed and reconciled with the patient

Past Medical History
Bell's palsy.
Human immunodeficiency virus [HIV] disease.
Hyperlipemia. Insomnia, unspecified.

Social History
no Exercise . no Alcohol . no Smoking: Caffeine: yes, Drinks 1-2
cups of coffee a day.

Hospitalization/Major Diagnostic Procedure:

Denies Past Hospitalization

Case #3 - Page 2 of 2

Review of Systems

Constitutional:
fatigue denies. fever denies. headache denies. loss of appetite denies. weakness denies. weight gain denies. weight loss denies.
ENT:
Patient Denies: hoarseness, cough, sore throat, sinus pain, ear pain, lymphadenopathy.
Cardiovascular:
Shortness of Breath – SOB (Dyspnea) denies. Swelling (Edema) denies. chest pain denies.
palpitations denies.
Respiratory:
chest pain denies. cough denies.
Genitourinary:
Patient Denies: dysuria, difficulty urinating.
Musculoskeletal:
joint pain denies. joint stiffness denies. joint swelling denies.
Psychology:
Patient Denies: anxiety, depression.
Hematology:
easy bruising denies.
Allergy/Immunology:
Patient Denies: itchy eyes, runny nose, scratchy throat.

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

Assessments

1. Human immunodeficiency virus [HIV] disease - B20
2. Insomnia, unspecified - G47.00
3. Hyperlipidemia - E78.5
4. Sprained of left lesser toe – S93.505D

Treatment

1. Human immunodeficiency virus [HIV] disease

Refill Atripla tablet, 600 mg-200 mg-300 mg, 1 tab(s), orally, once a day (at bedtime), 30 days, 30, Refills 5

2. Insomnia, unspecified

Refill Ambien tablet, 10 mg, 1 tab(s), orally, once a day (at bedtime), 30 days, 30, Refills 5

3. Hyperlipemia

Refill atorvastatin tablet, 40 mg, 1 tab(s), orally, once a day, 30 days, 30, Refills 5 STABLE ON STATIN.

4. Sprained of left lesser toe

Follow-up as needed.

Incorrect Coding Examples

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

Reason for Appointment

1. Physical

History of Present Illness

General: 52yo AAF presents for CPE, fasting, denies acute complaints, recently switched by Dr. XXXX to new ID drug for his positive HIV test, unsure of name, has yet to start. States she wanted to research prior to starting. Aware overdue for mammo, completed PAP at planned parenthood due to insurance coverage. States was normal 02/2020.

Examination

Pulmonary: The respiratory pattern is nonlabored, No rales are detected by auscultation, no rhonchi, no wheezes, Breath sounds: clear all lobes.
Cardiac: normal S1S2, RRR, no murmurs.
Abdomen: obese but soft, non distended, BS normal, no abdominal tenderness to palpation, no abdominal masses present on palpation, body habitus limits exam.
Neurology: normal coordination, normal motor strength bilaterally, normal reflexes, normal sensation and strength.
Vascular: No evidence of clubbing, cyanosis, or edema.
Back: no costovertebral angle (CVA) tenderness, normal spine. Psychology: mood is appropriate, affect is appropriate.
Musculoskeletal: Normal Bulk and tone for age.

Vital Signs

Ht 67 in, Wt 224.0 lbs, BMI 35.08 Index, Temp 98.0, BP 122/80 mm Hg, HR 74 /min, RR 16 /min, O2 SAT 99 %.

Current Medications

Taking
Atripla 600-200-300 MG Tablet 1 tablet on an empty stomach Orally Once a day
Ferrous sulfate 220 mg/5 mL elixir 10 mL orally once a day
Bactrim DS 800 mg-160 mg tablet 1 tab(s) orally EOD
Not-Taking/PRN
Diclofenac Sodium Topical 1% gel 2 g applied topically Q8hr PRN pain to affected area
Ferralet 90 Vitamin B Complex with C, Folic Acid, Iron and Docusate tablet 1 tab(s) orally once a day

Medication List reviewed and reconciled with the patient

Past Medical History

HIV Dr. XXXX ID.
Hpv -12/16. Lupus.
Iron def Anemia.

Hospitalization/Major Diagnostic Procedure:

pneumonia 07/16

Case #4 – Page 2 of 2

Review of Systems

Constitutional: fatigue denies. fever denies. headache denies. loss of appetite denies.

weakness denies. weight gain denies. weight loss denies.

ENT: Patient Denies: hoarseness, cough, sore throat, sinus pain, ear pain, lymphadenopathy.

Cardiovascular: denies chest pain denies cough denies

Swelling (Edema)

Gastroenterology: abdominal pain denies. constipation denies. diarrhea denies. nausea denies.

Musculoskeletal: Joint pain denies. Joint stiffness denies. Joint swelling denies.
Integumentary: skin sores denies.
Psychology: Patient Denies: anxiety, depression.
Endocrinology: Patient Denies: cold intolerance, diabetes, fatigue, heat intolerance, polydipsia, polyuria, weight loss, goiter.

Hematology: easy bruising denies.

RECAP:
HPI: **Documented condition and Treating MD.**
Assessment: **Not Documented the condition.**
Treatment: **Documented in the medication list.**

Assessments
1. Adult general medical exam - Z00.00 (Primary)
2. Obesity (BMI 30-39.9) - E66.9
3. Iron deficiency - E61.1
4. Screening for breast cancer - Z12.31
5. Systemic lupus erythematosus, unspecified SLE type, unspecified organ involvement status - M32.9
6. Asymptomatic human immunodeficiency virus [HIV] infection status – Z21 (*Diagnosis was added . Per coding guidelines "Code all conditions that coexist or affect patient's care")*

Treatment
1. Adult general medical exam
LAB: CBC (INCLUDES DIFF/PLT,H/H, RBC, INDICES, WBC, PLT) LAB: URINALYSIS, COMPLETE W/REFLEX TO CULTURE
LAB: COMPREHENSIVE METABOLIC PANEL
IMAGING: EKG -Electrocardiogram (IH) NSR, Normal EKG
2. Obesity (BMI 30-39.9)
LAB: TSH W/REFLEX TO FT4
LAB: HEMOGLOBIN A1c
3. Iron deficiency
LAB: IRON, TIBC AND FERRITIN PANEL- quest 5616
4. Screening for breast cancer
IMAGING:MAMMOGRAM, SCREENING
5. Systemic lupus erythematosus, unspecified SLE type, unspecified organ involvement status
LAB: ANA IFA SCREEN W/REFL TO TITER AND PATTERN, IFA 249

Case #5 – Page 1 of 2

Reason for Appointment
Gynecologic consultation Routine GYN Exam.

History of Present Illness
Essential Hypertension on Benazepril
HIV positive on Complera

Examination

General Appearance:
Vagina: Normal. Mucosa was not erythematous. Mucosa was not dry. Mucosa was not atrophied. No vaginal discharge was observed. No cystocele was observed. No rectocele was observed. ° No uterine prolapse.
Cervix: Normal Pap done. Showed no lesion. Not tender. Did not demonstrate pain elicited by motion.
Uterus: Normal. Not enlarged. Not tender.
Uterine Adnexa: Normal. Uterine adnexa was not tender.
Perineum: Normal, no lesions.
Rectal:
Anus Examination: Anal sphincter tone was tight. No hemorrhoids were seen.

Current Medications

Benazepril-hydroCHLOROthiazide 20-12.5 MG TABS, TAKE 1 TABLET BY MOUTH EVERY DAY, 90 days, 0 refills

Complera 200-25-300 MG Tablet 1 by mouth once a day 30 days, 1 refills

Past Medical History

Reported:

LMP: 6/9/2019, Last pap smear date 6/25/2018, result: normal, Last mammogram date: 8/17/2018, and result: normal.

Pregnancy: Gravida 3, para 3, and aborta 0.

Diagnoses:

Hypertension

Social History
Behavioral: No tobacco use. Never smoked. Smoking status: Never smoker. Alcohol: Not using alcohol. Never drank alcohol.
Drug Use: Not using drugs. Never used drugs. Habits: Poor exercise habits.
Education: Has high school diploma. Work: Student. Marital: Currently married. Sexual: Sexually active.

Surgical History

- Breast surgery left breast

Case #5 – Page 2 of 2

Review of Systems

Systemic: No systemic symptoms and no symptoms.

Neck: No neck symptoms.

Eyes: No eye symptoms.

Otolaryngology: Tinnitus.

Breasts: No breast symptoms.

Cardiovascular: No cardiovascular symptoms.

Pulmonary: No pulmonary symptoms.

Gastrointestinal: No gastrointestinal symptoms.

Genitourinary: No genitourinary symptoms.

Endocrine: No endocrine symptoms.

Musculoskeletal: No musculoskeletal symptoms.

Psychological: No psychological symptoms.

Skin: No skin symptoms.

Assessments

1. Routine gynecological exam – Z01.419

2. HIV Positive – B20 (The correct code should be Z21. Per coding guidelines, Asymptomatic human immunodeficiency virus [HIV] infection status, is to be applied when the patient without any documentation of symptoms is listed as being *"HIV positive,"* "known HIV," "HIV test positive," or similar terminology).

Treatment

1. Encounter for gyn exam (general) (routine) w/o abnormal findings

Lab: THINPREP PAP RFLX HPV*

Other

Gynecology Sched Annual/prn : Weight loss diet, Lose weight

2. Continue Complera 200-25-300 MG

RECAP:

HPI: **Documented condition and positive status.**
Assessment: **Documented condition but not coded to highest specificity of code per coding guidelines.**
Treatment: **Documented in the treatment plan.**

Case #6 – Page 1 of 2

Reason for Appointment
1. Hearing loss

History of Present Illness

Patient is a 65 years old male who presents today with a new problem of: hearing loss. The patient presents to the clinic today with a chief complaint of difficulty hearing and requesting referral to another infectious dse. Dr. closer to his home for his AIDS dx. Pt denies chest pain, shortness of breath, palpitations, ankle edema, and changes in bowel movements. All medications, labs, and imaging pertinent to today's visit were reviewed. All questions addressed.

Examination
Constitutional: well developed, well nourished, in no acute distress.
Ears: L canal impacted w/cerumen, R canal impacted w/cerumen.
Mouth/Throat: 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.
Musculoskeletal: no joint abnormalities.
Pulses: 2+ dorsalis pedis and posterior tibial pulses bilaterally.
Extremities: no clubbing, no cyanosis, no edema.

Vital Signs

Height: 66 inches

Weight: 150 lbs

BMI: 24.30

Counseled on appropriate diet O2 sat: 98% on room air

Respirations: 16/min

Current Medications

Taking

GENVOYA 150-150-200-10 MG ORAL TABLET (ELVITEG-

COBIC-EMTRICIT-TENOFAF) Take 1 tablet daily; Route: ORAL

Past Medical History

HIV since 2013 , follows Dr. XXXX

neg stress test 2015

Colonoscopy 2018

Surgical History

left groin hernia repair

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

Review of Systems

ENT: Complains of HEARING LOSS.

Cardiovascular: Denies chest pain or shortness of breath, swelling hands/feet.

Respiratory: Denies difficulty breathing, chronic cough, wheezing,
coughing blood.

Gastrointestinal: Denies nausea, constipation, bloody stool, indigestion, vomiting, diarrhea, hemorrhoids, change in bowel habits, abdominal pain, excessive gas.

Musculoskeletal: Denies joint pain, muscle pain, muscle weakness.

Assessments

1. CERUMEN IMPACTION; BILATERAL (ICD10-H61.23)

The patient has cerumen impaction bilaterally. Patient underwent ear flush in the office today. Will continue to monitor. Alter treatment plan if condition worsens or fails to improve.

2. B20 Human immunodeficiency virus [HIV] disease *(Diagnosis was added . Per coding guidelines "Code all conditions that coexist or affect patient's care")*

RECAP:

HPI: **Documented condition requesting referral.**
Assessment: **Condition not documented.**
Treatment: **Documented in medication list.**

Quick Tips (ICD-10- CM)

Asymptomatic human immunodeficiency virus Z21 Asymptomatic human immunodeficiency virus [HIV] infection status, is to be applied when the patient without any documentation of symptoms is listed as being “HIV positive,” “known HIV,” “HIV test positive,” or similar terminology. Do not use this code if the term “AIDS” is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from his/her HIV positive status; use B20 in these cases.

Previously diagnosed HIV-related illness

Patients with any known prior diagnosis of an HIV-related illness should be coded to B20. Once a patient has developed an HIV-related illness, the patient should always be assigned code B20 on every subsequent admission/encounter. Patients previously diagnosed with any HIV illness (B20) should never be assigned to R75 or Z21, Asymptomatic human immunodeficiency virus [HIV] infection status

HIV Infection in Pregnancy, Childbirth and the Puerperium

During pregnancy, childbirth or the puerperium, a patient admitted (or presenting for a health care encounter) because of an HIV-related illness should receive a principal diagnosis code of **O98.7**-, Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium, **followed by B20** and the code(s) for the HIV-related illness(es). Codes from Chapter 15 always take sequencing priority.

Patients with asymptomatic HIV infection status admitted (or presenting for a health care encounter) during pregnancy, childbirth, or the puerperium should receive codes of **O98.7- and Z21**.

THANK YOU

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