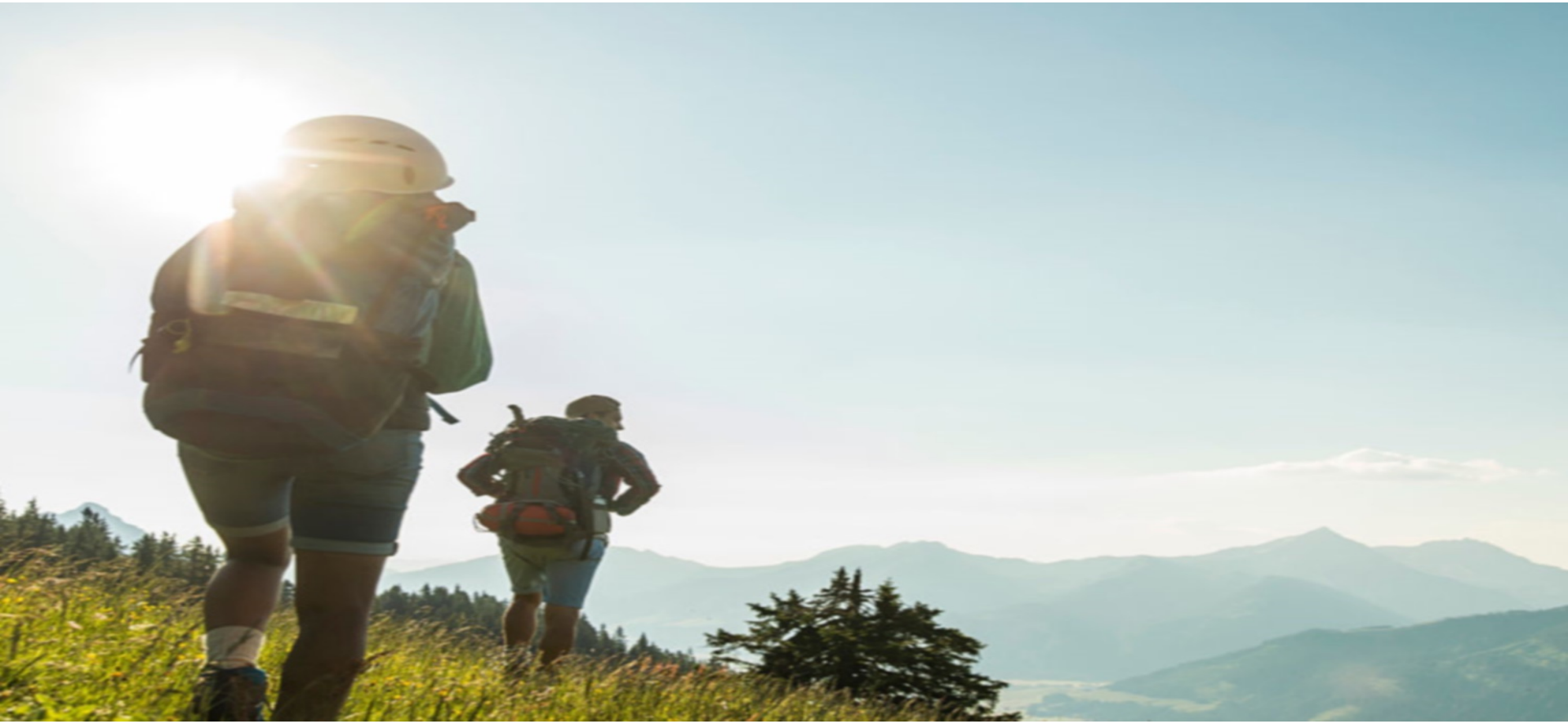
Coding Examples
Asthma



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. Initial visit

History of Present Illness

Annual Visit: 22-year female, new patient, televisit for annual preventative exam. She is from Brazil. She needs refill of her asthma medication, uses Ventolin 1- 3x/week and currently not on maintenance therapy. Feels otherwise well.

Examination

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

Oral Cavity: mucosa moist.

Psych: Normal mood and affect.

Vital Signs

Ht 67 in, Wt 145 lbs, BMI 22.71 Index, Ht-cm 170.18, Wt-kg 65.77.

Current Medications

None

Past Medical History

Asthma

Family History

Father: alive Mother: alive

Social History

Tobacco Use: Tobacco Use/Smoking Are you a current smoker

How often do you smoke cigarettes? every day

How many cigarettes a day do you smoke? 5 or less

Gyn History

Sexual activity currently sexually active. Last pap smear date none.

Date of Last Period 07/27/2020.

OB History

Total pregnancies 0.

Hospitalization/Major Diagnostic Procedure:

No Hospitalization History.

Case #1 – Page 2 of 2

Review of Systems

Ophthalmologic:

Patient denies floaters in the visual field, pain.

ENT:

Patient denies nosebleed, difficulty swallowing.

Endocrine:

Patient denies excessive sweating, heat intolerance.

Respiratory:

Patient denies hemoptysis, pain with inspiration.

Breast:

Patient denies red skin, gland swelling.

Cardiovascular:

Patient denies orthopnea, chest pain.

RECAP:

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

Assessments

1. Annual physical exam - Z00.00 (Primary)
2. Moderate asthma, unspecified whether complicated, unspecified whether persistent - J45.909
3. BMI 22.0-22.9, adult - Z68.22

Treatment

1. Annual physical exam

LAB: Lipid panel with reflex to direct LDL (Ordered for 08/03/2020)
LAB: TSH W/Reflex to FT4 (Ordered for 08/03/2020)
LAB: Hepatic function panel (Ordered for 08/03/2020)
LAB: Basic Metabolic Panel (Ordered for 08/03/2020)
LAB: Hemoglobin A1c (Ordered for 08/03/2020)

Notes:

Patient counseled on healthy lifestyle, food, exercise, sleep hygiene. Routine labs will be ordered as part of annual physical.

2. Moderate asthma, unspecified whether complicated, unspecified whether persistent

Start Ventolin HFA Aerosol Solution, 108 (90 Base) MCG/ACT, 2 puffs as needed, Inhalation, every 4 hrs, 30 days, 1, Refills 0

Start Advair HFA Aerosol, 45-21 MCG/ACT, 2 puffs, Inhalation, Twice a day, 30 days, 1, Refills 2

3. BMI 22.0-22.9, adult

Notes: Maintain healthy weight.

Case #2 – Page 1 of 2

Reason for Appointment

1. Initial visit

History of Present Illness

General:
Reached via virtual visit; reports onset of dry rough cough approx. 2 weeks ago which has now progressed to cough productive of discolored sputum; Denies SOB/DOE;
Currently on oral steroid taper prescribed by ENT for episode of acute sensorineural hearing loss; h/o ASTHMA; Symptoms of asthmatic bronchitis, and we have recommended Azithromycin. Benzonatate e-prescribed.

Examination: N/A

Vital Signs: N/A

Current Medications

Indapamide 2.5 MG Tablet TK 1 T PO QAM Oral
Irbesartan 150 MG Tablet TK 1 T PO ONCE D FOR 30 DAYS Oral
Testosterone Cypionate 100 MG/ML Solution 1 ml Intramuscular mostly
Clotrimazole-Betamethasone 1-0.05 % Cream 1 application Externally Twice a day
ClomiPHENE Citrate 50 MG Tablet 1 tablet Orally Once a day
Atorvastatin Calcium 40 MG Tablet 1 tablet Oral Once a day
PredniSONE Intensol

Past Medical History

Hypertension.

Drug-induced obesity. Sleep apnea.

Low testosterone levels. Atopic dermatitis.

Family History

No Family History documented.

Social History

No Social History documented.

Surgical History

No Surgical History documented.

Hospitalization/Major Diagnostic Procedure:

No Hospitalization History.

Case #2 – Page 2 of 2

Review of Systems

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

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.

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

Assessments

1. Mild intermittent asthmatic bronchitis with acute exacerbation - J45.21 (Primary)

Treatment

1. Mild intermittent asthmatic bronchitis with acute exacerbation

Start Azithromycin Tablet, 250 MG, 2 tablets on the first day, then 1 tablet daily for 4 days, Orally, Once a day, 5 day(s), 6, Refills 0

Start Benzonatate Capsule, 200 MG, 1 capsule, Orally, Three times a day, 5 days, 15 Capsule, Refills 1

RECAP:
Assessment: **Documented the condition**
Treatment: **Documented treatment plan**

Case #3 – Page 1 of 2

Reason for Appointment

1. Refill asthma medication - n/p

History of Present Illness

General:

58 yr old female with asthma, obesity present to annual physical. She admits mild chronic diarrhea but denies abdominal pain or rectal bleeding.

Examination

Throat: clear, no erythema, no exudate, tonsils normal, uvula midline.

Neck/Thyroid: neck supple, full range of motion, no cervical lymphadenopathy, no jugular venous distention, no thyromegaly.

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.

Extremities: full range of motion, no edema.

Vital Signs

Ht 65 in, Wt **184 lbs**, BMI **30.62 Index**, BP **128/82 mm Hg**, HR **68/min**, RR **17 /min**, Temp **98.2 F**, Pain scale 0 1-10, Ht-cm 165.1, Wt-kg 83.46.

Current Medications

None

Past Medical History

Asthma.

Social History

Tobacco Use:

Tobacco Use/Smoking Are you a *nonsmoker*

Occupational exposure

Are you exposed to Hazardous Conditions in the Workplace? *No*

Surgical History

C-Section 01/2003 Tube Ligation 02/2008

Hospitalization/Major Diagnostic Procedure:

N/A

Case #3 – Page 2 of 2

Review of Systems

General/Constitutional: Overall health Good.

Fatigue denies. Fever denies. Lightheadedness denies

ENT:

Ear pain denies. Nose/Throat problems denies. Sinus pain denies.

Sore throat denies.

Endocrine:

Cold intolerance denies. Chest pain denies. Cough denies. Shortness

of breath 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.

Assessments

1. Annual physical exam - Z00.00 (Primary)
2. Moderate persistent asthma without complication - J45.40
3. Obesity - E66.9
4. Chronic diarrhea - K52.9

Treatment

1. Annual physical exam
LABS

2. Moderate persistent asthma without complication
Refill Symbicort Aerosol, 160-4.5 MCG/ACT, 2 puffs, Inhalation, Twice a day, 30 days, 1 Inhaler, Refills 3
Refill Ventolin HFA Aerosol Solution, 108 (90 Base) MCG/ACT, 1 puff as needed, Inhalation, every 4 hrs, 30 days, 1, Refills 3

3. Obesity

Clinical Notes: we discussed diet and exercise for weight loss.

4. Chronic diarrhea
Referral To: Gastroenterology
Reason: chronic diarrhea brother has crohns|screening colonoscopy

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

INCORRECT CODING EXAMPLE

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

Reason for Appointment

1. Lower back pain right site secondary to a fall

History of Present Illness

Sick: 56 y/o male comes to the office , has miss his previous appt , well dress non acute distress well nourished and good bladder and bowel control normal gait. medical hx of htn , hyperlipidemia, gad, hypogonadism, mild intermittent asthma & copd, ed, nocturia. tolerating well his medication.

Examination

General Examination:

General Appearance: No acute distress , well developed.

Chest: No chest tenderness, normal shape and expansion, right lower rib cage, painful to touch and rom black and blue irradiation of pain to the right flank.

Heart: RRR S1S2, no gallop, no murmur.

Lungs: CTPA.

Abdomen: soft tender, +bowel sounds no palpable masses.

Back: No cva tenderness, right lower back pain with black and blue due to a fall, pain at ROM.

Neurologic: Alert, oriented, cognitive function intact, cooperative with exam, judgement and insight good.

Vital Signs

Temp 97.2 F, BP 120/80 mm Hg, Ht 68 in, HR 86 /min, RR 16 /min, Wt 186.0 lbs, Oxygen sat % 98 %, BMI 28.28 Index, Pain scale 10 1-10

Current Medications

Taking Naproxen 500 MG Tablet 1 tablet with food or milk as needed Orally every 12 hrs

Symbicort 160-4.5 MCG/ACT Aerosol 2 puffs Inhalation Twice a day – continue medication for asthma/copd.

Enalapril Maleate 20 MG Tablet 1 tablet Orally Once a day

Past Medical History

Htn

Epididymal cyst

Overweight

COPD

Asthma

Hospitalization/Major Diagnostic Procedure:

No hospitalization

Case #4 – Page 2 of 2

Review of Systems

General/Constitutional:

Denies Change in appetite. Denies Chills. Denies Fatigue. Denies Fever. Denies Headache.

Ophthalmologic:

Denies Blurred vision, denies.

Respiratory:

Admits Asthma/COPD. Admits Breathing pattern. Denies Chest pain. Admits Cough. Admits Shortness of breath. Admits Shortness of breath at rest. Admits Shortness of breath with exertion.

Musculoskeletal:

Admits Back/hip problems

Neurologic:

Denies Balance difficulty, Denies Coordination. Denies Difficulty speaking. Denies Dizziness. Denies Gait

RECAP: Missed Diagnosis - should have captured.

HPI: **Documented the condition**

Current Medications: **Documented current treatment**

Assessment: **No mention of condition**

Treatment: **No documented treatment plan**

Assessments

1. Chronic obstructive pulmonary disease, unspecified COPD type - J44.9 (Primary)
2. Benign essential HTN - I10
3. Generalized anxiety disorder - F41.1
4. Low back pain –M54.5
5. Mild intermittent asthma without complication - J45.20 (*Diagnosis was added . Per coding guidelines "Code all conditions that coexist or affect patient's care")*

Treatment

1. Chronic obstructive pulmonary disease, unspecified COPD type

continue same medication prn.

2. Benign essential HTN

Clinical Notes: stable and well control continue same rx. refill done

3. Generalized anxiety disorder

Clinical Notes: stable and better .

4. Low back pain

Clinical Notes: continue Naproxen as needed

Quick Tips (ICD-10- CM)

Correct Coding - Asthma

When ICD-10-CM was implemented, it was no longer necessary to code for the difference between extrinsic or intrinsic asthma. Found in section J45 of ICD-10-CM, **asthma now requires documentation of mild, medium, and severe asthma**. Further documentation is needed to assign the correct code between the differences of **intermittent, and persistent**. The greater specificity of ICD-10-CM requires another level of detail: uncomplicated, (acute) exacerbation, and status asthmaticus.
(ICD 10 Coding Guidelines, Section J45)

Asthma can sometimes co-exist with COPD. When a provider documents COPD with asthma, but does not specify the asthma type, the coder must assign ONLY the J44.9 for COPD. There is an instructional note in the ICD-10-CM tabular list that tells the coder to "use additional code for type of asthma, if applicable", but the provider must document the specific type for the coder to assign an additional code. There are four acceptable types: Mild intermittent asthma, Mild persistent asthma, Moderate persistent asthma, and Severe persistent asthma.
(AHA Coding Clinic for ICD-10, Vol 4, 2017, 1st Quarter, pg. 25)

Quick Tips (ICD-10- CM)

Correct Coding - Asthma

When a patient with Emphysema presents due to asthma and COPD, assign code J43.9, Emphysema, unspecified, together with a specific asthma code from category J45, to fully convey the clinical diagnosis in this case. Since Emphysema is a form of COPD, it is not appropriate to assign a code for unspecified COPD in addition to code J43.9. *(AHA Coding Clinic for ICD-10, Vol 6, 2019, 1st Quarter, pg. 36)*

This should clarify the need to be specific when documenting for asthma and the importance of describing to the highest level of specificity. Finally, a long-standing diagnosis of persistent asthma in an elderly patient should prompt a provider to consider whether the actual condition is better termed as chronic obstructive asthma or COPD, especially if treatment is consistent with COPD therapy.

THANK YOU

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