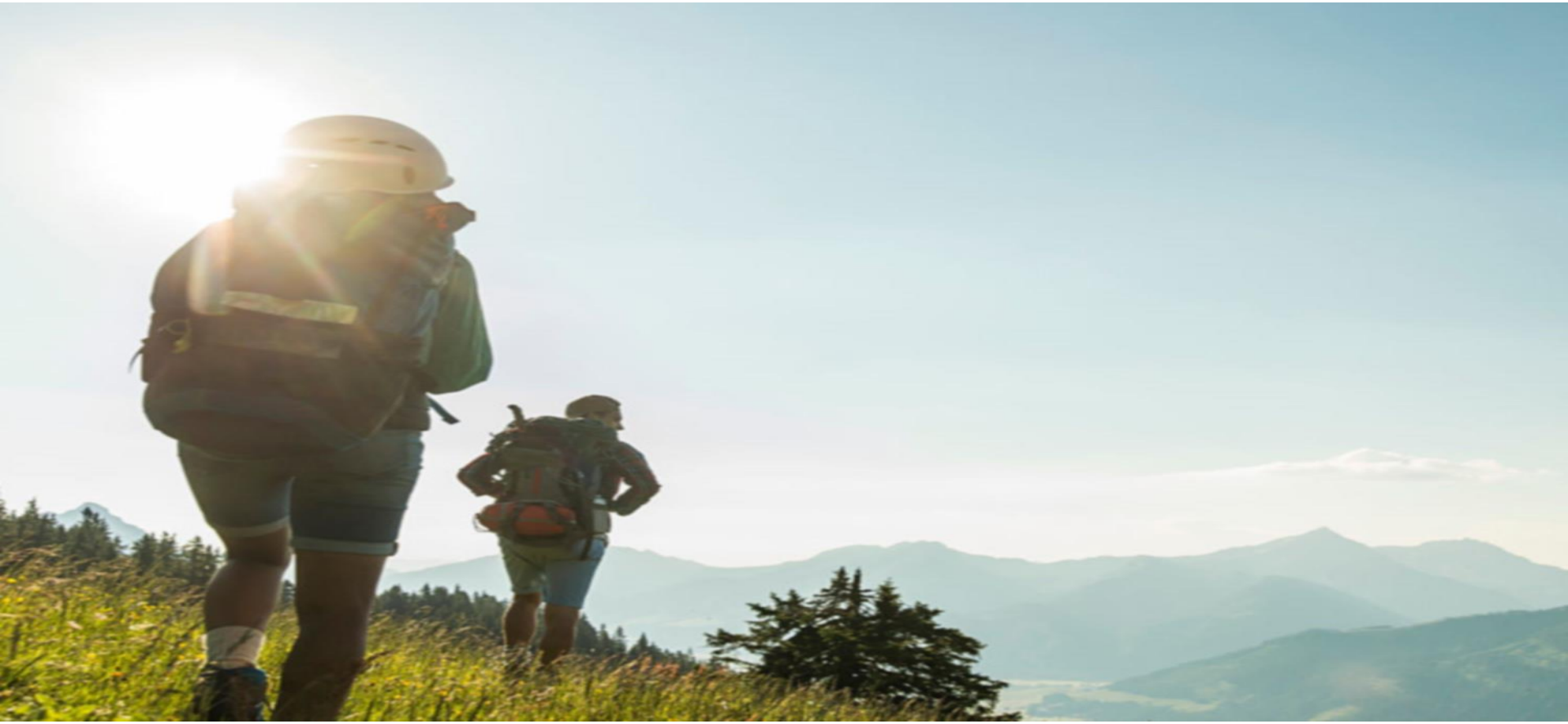
Coding Examples
NEOPLASMS (CANCER)



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. Referral
2. Bad Leg Pain
3. Back Pain
4. PSA Levels high
5. Refills

History of Present Illness

51-year- old male with prostate cancer presents for refills

Examination

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

Eyes: pupils equal, round, reactive to light and accommodation, sclera non-icteric.

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

Lungs: clear to auscultation bilaterally, good air movement, no wheezes, rales, rhonchi. 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 72 in, Wt **235.2 lbs**, BMI **31.9 Index**, BP 130/90 mm Hg**130/90 mm Hg**, HR **84 /min**, RR **16 /min**, Temp **98.0 F**, Oxygen sat % 97 %, Pain scale 6 1-10

Current Medications

Erleada 60 MG Tablet 4 tablets Orally Once a day

Temazepam 30 MG Capsule (Schedule IV Drug) TK 1 C PO QHS Oral QHS

Escitalopram Oxalate 10 MG Tablet 1 tablet Orally Once a day

Oxycodone-Acetaminophen 5-325 MG Tablet 1 tablet as needed Orally every 6 hrs

Lupron

Past Medical History

Prediabetes.

Hypercholesteremia.

Prostate CA

Surgical History

Prostate cancer surgery 04/2019

Case #1– PAGE 2 OF 2

Review of Systems

General/Constitutional: Overall health Good. Fatigue denies. Fever denies. Lightheadedness denies.

Ophthalmologic: Blurred vision denies.

Respiratory: Cough denies. Shortness of breath denies.

Gastrointestinal: Abdominal pain denies. Constipation denies.

Peripheral Vascular: Pain/cramping in legs after exertion denies

RECAP:
HPI: **Documented the condition**
Current Medications: **Documented treatment**
Surgical Hx: **Documented surgery**
Assessment: **Documented the condition is present**
Treatment: **Documented on-going treatment after surgery**

Assessments

1. Prostate cancer - C61 (Primary)
2. BMI 31.0-31.9,adult - Z68.31
3. Obesity - E66.9
4. Age-related nuclear cataract of both eyes - H25.13

Treatment

1. Prostate cancer on Lupron IM q/ 12 weeks

Referral To: Oncology Reason: prostate cancer

2. Obesity

Clinical Notes: pt is walking and dieting for weight loss.

3. Age-related nuclear cataract of both eyes

Referral To: Ophthalmology Reason: cataracts

4. Others

Refill Erleada Tablet, 60 MG, 4 tablets, Orally, Once a day, 30 day(s), 120 Tablet, Refills 4

Case #2- PAGE 1 OF 2

Reason for Appointment
NIP. Annual visit.

History of Present Illness
General:
Pt diagnosed yesterday with acute myeloid leukemia. Need a referral to Oncologist.

Examination
General Appearance: alert, pleasant, in no acute distress, well nourished.
Head: normocephalic, atraumatic, no scalp lesions.
Eyes: PERRLA, normal, extraocular movement intact (EOMI), sclera non-icteric.
Ears: BL ear canals clear; tympanic membranes clear without bulging, erythema, injection or perforation.
Nose: nares patent.
Oral Cavity: mucosa moist, no lesions, tongue in midline.
Throat: no erythema, no exudates, pharynx normal, tonsils normal, uvula midline.
Neck/Thyroid: soft, supple, full range of motion.
Heart: no clicks, no murmurs, rubs, gallops, S1, S2 normal, RRR.
Lungs: clear to auscultation bilaterally, good air movement, no wheezes, rales, rhonchi.
Abdomen: bowel sounds present, no hepatosplenomegaly, no masses, soft, nontender, nondistended.
Back: CVA tenderness bilaterally.
Neurologic: sensory exam intact, cranial nerves 2-12 grossly intact.
Psych: Normal mood and affect.

Vital Signs

Ht 66 in, Wt 203.0 lbs, BMI 32.76 Index, BP 120/69 mm Hg, HR 69 /min, RR 18 /min, Temp 98.0 F, Oxygen sat % 98 %, Pain scale 0 1-10, Ht-cm 167.64, Wt-kg 92.08.

Current Medications

Taking Lisinopril 10 MG Tablet 1 tablet Orally Once a day, Taking Aspirin EC 81 MG Tablet Delayed Release 1 tablet Orally Once a day, Taking Levothyroxine Sodium 75 MCG Tablet 1 tablet on an empty stomach in the morning Orally Once a day, Taking Amitriptyline HCl 25 MG Tablet 1 tablet at bedtime Orally Once a day, Taking Omega 3 1000 MG Capsule 1 capsule Orally Once a day

Past Medical History

Migraine, Blood pressure high, Stroke.

Hospitalization/Major Diagnostic Procedure
brain embolism 02/27/2019, carpal tunnel 2011.
Surgical History
carpal tunnel release 2011.

Case #2 - PAGE 2 OF 2

Review of Systems

All Other Systems:

Review of Systems (ROS) General/Constitutional: Patient denies fever, fatigue.

Cardiovascular: denies chest pain, SOB, palpitations, heart or extremity pain, change of skin color, other vascular problems.

Respiratory: denies asthma/COPD, cough, sputum/excess mucus, wheezing, shortness of breath.

Gastrointestinal: denies pain, nausea, vomiting, diarrhea, constipation, heartburn, GERD/Reflux.

Genitourinary: denies urinary, genital related S/S.

Endocrine: denies heat/cold intolerance, excessive sweating.

Musculoskeletal: denies neck/back/joint/muscle pain or weakness, arthritis or connective tissue disease.

Neuro: denies dizziness, headache, syncope/fainting/passing out, weakness, motor/sensory problems.

Assessments

1. Acute myeloid leukemia not having achieved remission - C92.00 (Primary)
2. BMI 32.0-32.9,adult - Z68.32
3. Obesity - E66.9

Treatment

1. Acute myeloid leukemia not having achieved remission

Referral To: Oncologist Reason: Acute Myeloid Leukemia

2. BMI 32.0-32.9,adult /Obesity – Discussed the importance of healthy diet and physical activity and the role they play in lowering BMI and its associated risks.

RECAP:

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

Case #3 - PAGE 1 OF 2

Reason for Appointment
F/U Anti-coagulation

History of Present Illness
63 y/o male patient with Hx of Pulmonary embolism in Dec/2019, currently on anticoagulation therapy with warfarin presents c/o cough, chest discomfort, and weight loss of about 18 lb. in 4 months. His symptoms have been gradually worsening over the past 4 to 5 months. He denies fever, chills, bleeding. The last INR on 5/11/2020 was 4.6, he was oriented to hold coumadin for 1 day.

Examination
General Appearance: Healthy-appearing.
Oral Cavity: Oropharynx clear, good dentition, mucosa moist, no lesions, palate normal.
Throat: No -erythema, no exudate, tonsils normal, uvula midline.
Neck/Thyroid: No lymphadenopathy or thyromegaly or JVD, neck supple, no cervical lymphadenopathy.
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 ascites, no guarding or rigidity, no organomegaly, no rebound tenderness.
Neurologic: Alert and oriented x 3, motor and sensation grossly intact, cooperative with exam, gait normal, no tremor.
Extremities: No cyanosis, clubbing, or edema.

Vital Signs
Ht 5ft6in, Wt. 153 lbs., BMI 24.69 Index, BP 138/67 mm Hg, HR 68/min, RR 17 /min, Temp 97.6 F, Oxygen sat % 95 %, Pain scale 0 1-10, Ht- cm 167.64, Wt.-kg 69.4.

Current Medications
Taking
Warfarin Sodium 6 MG Tablet 1 tablet Orally Once a day
FeroSul 325 (65 Fe) MG Tablet 1 tablet Oral daily
Vitamin B1 100 MG Tablet 1 tablet Orally Once a day
Carvedilol 6.25 MG Tablet 1 tablet with food Orally Twice a day
Furosemide 20 MG Tablet 1 tablet Orally twice a day

Past Medical History
Right ventricular dysfunction. Current use of anticoagulant therapy. Essential (primary) hypertension. Gastroesophageal reflux disease without esophagitis. Other pulmonary embolism with acute corpulmonale.

Surgical History
No Surgical History documented.

Case #3 - PAGE 2 OF 2

Review of Systems

Review of Systems: (ROS) General/Constitutional: Patient denies, fever, dizziness, Please refer to HPI.,
ENT: Pt denies sore throat, runny nose, earache.
Cardiovascular: Pt denies CXP,SOB, palpitations, leg swelling.
Respiratory: Please refer to HPI.
Gastrointestinal: Pt denies: Abdominal pain,N/V/heartburn,.
GU: Pt denies burning or pain with urination.
Neurologic: Pt denies HA, tingling or numbness sensation, memory problems, paralysis.
Psychiatry: Pt denies anxiety, depression.

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

Assessments

1. Lung tumor - D49.1 (Primary)
2. Current use of anticoagulant therapy - Z79.01
3. Chronic pulmonary embolism - I27.8
4. Metastasis to mediastinum - C78.1

Treatment

1. Lung tumor: Notes: PET scan revealed left upper lobe suprahilar nodule indicating metabolic active tumor.
2. Current use of anticoagulant therapy. Start Warfarin Sodium Tablet 5mg, 1 tablet, once a day, 10 days.
3. Chronic pulmonary embolism: Refer patient to cardiologist for additional evaluation and treatment.
4. **Metastasis to mediastinum.** Notes: PET scan revealed left upper lobe suprahilar nodule showing metabolic active tumor. Extensive mediastinal and hilar metastatic lymphadenopathy with basilar consolidation. Immediate evaluation by Pulmonologist and oncologist has been requested. Reason: Eval and tx / PET scan revealed lung tumor w/ metastasis changes in mediastinum.

Incorrect Coding Examples

Case #4 - PAGE 1 OF 2

Reason for Appointment

1. F/U , patient did not provide reason

History of Present Illness

60 y/o female established patient was contacted to perform telemedicine visit. This HPI has been obtained via video conference. Before the conversation began, the patient was asked DOB and address to verify Identity. Today patient reports feeling fine. Patient requested that we contact a DI center in order to schedule an appointment to complete a stand-up f/u MRI indicated from her Neurologist.

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.

Current Medications

Taking
Omeprazole 20 MG Capsule Delayed Release 1 capsule Orally
Once a day
Metoprolol Succinate ER 50 MG Tablet Extended Release 24
Hour 1 tablet Oral once a day

Past Medical History

Essential hypertension.
Brain tumor (benign).

Surgical History

c-section 1979/1999
cyst removal
Brain surgery 2018

Case #4 - PAGE 2 OF 2

Review of Systems

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

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

Assessments

1. Brain tumor (benign) - D33.2 (Primary)

(The correct code should be Z86.011 - Personal history of benign neoplasm of the brain. ICD-10, chapter 2, d – see TIPS)

Treatment

1. Brain tumor (benign) Notes: Surgically removed, patient is still under Neurologist's care.
2. Others Notes: The patient was advised that the diagnosis is based solely upon the symptoms provided, and the diagnosis is limited due to a limited physical exam at this time. Patient verbalized understanding and agrees with the plan and was given ample opportunity to ask questions. Patient has been educated on symptoms that require prompt in-person medical attention

RECAP: Should be history vs. present
Past Medical History: **Documented the condition**
Surgical History: **Documented prior surgery**
Assessment**: Documented the condition as present (improper coding)**
Treatment: **Documented surgically removed, with no current treatment to site.**

Case #5 - PAGE 1 OF 2 (Added missed diagnosis)

Reason for Appointment

Letter

History of Present Illness

General:

54 yr prostate cancer , dyslipidemia presents for letter to proceed with cataract surgery. He feels well.

Examination

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

Head: normocephalic, atraumatic, no scalp lesions.

Eyes: pupils equal, round, reactive to light and accommodation, sclera non-icteric.

Oral Cavity: mucosa moist, gums normal, palate normal, tongue in midline.

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

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 72 in, Wt 235.2 lbs, BMI 31.9 Index, BP 130/90 mm Hg130/90 mm Hg, HR 84 /min, RR 16 /min, Temp 98.0 F, Oxygen sat % 97 %, Pain scale 6 1-10, Ht-cm 182.88, Wt-kg 106.68.

Current Medications

Taking

Erleada 60 MG Tablet 4 tablets Orally Once a day

Temazepam 30 MG Capsule (Schedule IV Drug) TK 1 C PO QHS Oral QHS

Escitalopram Oxalate 10 MG Tablet 1 tablet Orally Once a day

Oxycodone-Acetaminophen 5-325 MG Tablet 1 tablet as needed Orally every 6 hrs

Lupron IM q/ 12 weeks (on radiation daily)

Atorvastatin Calcium 20 MG Tablet 1 tablet Orally Once a day

Past Medical History

Prediabetes. Hypercholesteremia. Prostate CA (dx 01/2019, radical prostatectomy, bone and abd CT on 02/2019 neg for mets. Kikuchi disease. Gout. Colonoscopy no hx, Cologuard ordered.

Surgical History

hernia inguinal 1992

hernia inguinal 2011

Case #5 - PAGE 2 OF 2

Review of Systems

General/Constitutional: Overall health Good. Fatigue denies. Fever denies. Lightheadedness denies.
Allergy/Immunology: Congestion denies.
Ophthalmologic: Blurred vision denies.
ENT: Ear pain denies. Nose/Throat problems denies. Sinus pain denies. Sore throat denies.
Endocrine: Cold intolerance denies. Excessive thirst denies. Weight loss denies.
Respiratory: Breathing problems 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.
Genitourinary: Difficulty urinating denies. Pain in lower back denies. Painful urination denies.
Musculoskeletal:
Peripheral Vascular: Pain/cramping in legs after exertion denies.
Skin: Eczema denies. Rash denies. Skin lesion(s) denies.
Neurologic: Difficulty speaking denies. Loss of strength denies. Seizures denies. Tingling/Numbness denies.
Psychiatric: Anxiety denies. Auditory/visual hallucinations denies. Depressed mood denies. Loss of appetite denies.

Assessments
1. Chronic silicosis - J62.8 (Primary)
3. Cataract of left eye, unspecified cataract type - H26.9
4. Moderate major depression - F32.1
5. Hypercholesteremia - E78.00
6. Malignant Neoplasm of Prostate – C61 ((*Diagnosis was added Per coding guidelines "Code all conditions that coexist or affect patient's care")*

Treatment
1. Chronic silicosis
Referral To Pulmonary Diseases Reason: silicosis ILD and hemoptysis
2. Cataract of left eye, unspecified cataract type
Clinical Notes: because patient cannot stop **Erleada due to prostate cancer**, pt must proceed with laser cataract surgery instead of traditional cataract surgery.
3. Moderate major depression
Refill Escitalopram Oxalate Tablet, 10 MG, 1 tablet, Orally, Once a day, 30 day(s), 30 Tablet, Refills 1
4. Others Refill Atorvastatin Calcium Tablet, 20 MG, 1 tablet, Orally, Once a day, 30, 90, Refills 6 Refill Erleada Tablet, 60 MG, 4 tablets, Orally, Once a day, 30 day(s), 120 Tablet, Refills

RECAP: Missed Diagnosis - Should have been captured
HPI: **Documented the condition is present**
Current Medications: **Documented treatment**
Treatment: **Documented treatment plan**

Case #6 - PAGE 1 OF 2 (Updated incorrect diagnosis)

Reason for Appointment

Chief Complaint: Hand Problem (x 1 week. L hand. Pt. feels pressure. He was given abx for this, but it came back.)

History of Present Illness

Patient is a 40-year-old Caucasian male whose had a 2-week history of intermittent inflammation in the left hand. He was seen in the emergency room on 1112022 with a diagnosis of cellulitis of the left hand and a prescription for clindamycin was given. Patient states that he had a lot of problems tolerating the clindamycin but the infection seemed to clear up although the wound did drain on its own ultimately. It was "fine" for a modest amount of time but over the last several days he has had progressively worsening redness, swelling, and pain once again. Denies any fever or chills. He was diagnosed with Non-Hodgkin lymphoma 5 yrs. ago and currently in remission and f/up with onco.

Physical Exam

Vitals and nursing note reviewed.
General: He is not in acute distress.
Appearance: Normal appearance. He is well-developed.
Musculoskeletal: Normal range of motion.
Hands: Cervical back: Normal range of motion and neck supple. Comments: Dorsum of left hand with area of erythema and a more indurated area over the first metacarpal region. No obvious fluctuance or pustule noted. Slight lymphangitis noted.
Skin: General: Skin is warm and dry. Capillary Refill:Capillary refill takes less than 2 seconds.
Neurological: General: No focal deficit present.
Mental Status: He is alert and oriented to person, place, and time. Psychiatric: Mood and Affect: Mood normal.

Vital Signs

BP 148192 I Pulse 87 I Temp 98.2 °F (36.8 °C) (Tympanic) I Resp 24 I Ht 1.626 m (5'4") I Wt. 58.5 kg (129 lb) I SpO2 97% I BMI 22.14 kg/m2 Pain Score: 7-Severe pain, Pain Loe: (L hand.)

Current Medications

Medications were reviewed with the patient during this visit

Acyclovir (ZOVIRAX) 400 MG tablet Take 400 mg by mouth every 12 hours. – Oral Patient not taking: Reported on 4/20/2022

Albuterol Sulfate albuterol hfa 90 MCG/PUFF oral inhaler (reliever)

Allopurinol (ZYLOPRIM) 300 MG tablet Take 1 tablet by mouth daily. Oral Patient not taking: Reported on 3/3/2022

Past Medical History

Lymphoma

Chronic back pain

Surgical History

Lumbar back surgery 5 years ago
Left ankle surgery post trauma
Sinus surgery

Case #6 - PAGE 2 OF 2

Assessments/Treatment

1. Cellulitis of left upper extremity (Primary)
doxycycline hyclate (VIBRAMYCIN) 100 MG capsule; Take 1 capsule by mouth 2 times daily for 1 O days.
saccharomyces boulardii (FLORASTOR) 250 MG capsule; Take 1 capsule by mouth 2 times daily for 1 O days.
- expected course of illness
- orders and follow-up as documented in EpicCare
- call back if symptoms worsen or fail to improve
Return if symptoms worsen or fail to improve.

Medical Decision Making:

Problems addressed:

Pt. was seen today for hand problem.

2. Lymphoma, unspecified – C85.90 (Diagnosis was changed to Z85.72 . Per coding guidelines "Since there is no unique code to capture lymphoma in remission, assign Personal history of non-Hodgkin lymphomas " – see TIPS regarding Lymphomas)

RECAP: Personal history of code should have been captured
HPI**: Documented the condition is in remission**
Assessment: **No mention of the condition**

Quick Tips (ICD-10-CM)

Current malignancy versus personal history of malignancy

When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site; the primary malignancy code should be used until treatment is completed.

When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy at that site, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy. Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site. The secondary site may be the principal or first-listed diagnosis with the Z85 code used as a secondary code. ICD-10-CM.2.d

Quick Tips (ICD-10- CM)

Documentation Matters

“

The categories for leukemia, and category C90, Multiple myeloma and malignant plasma cell neoplasms, have codes indicating whether or not the leukemia has achieved remission. There are also codes Z85.6, Personal history of leukemia, and Z85.79, Personal history of other malignant neoplasms of lymphoid, hematopoietic and related tissues. If the documentation is unclear as to whether the leukemia has achieved remission, the provider should be queried.” ICD-10-CM

Since there is no unique code to capture lymphoma not further specified in remission, Assign code Z85.72, Personal history of non-Hodgkin lymphomas. AHA 3Q, 2022 Title: History of Lymphoma in Remission

THANK YOU

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