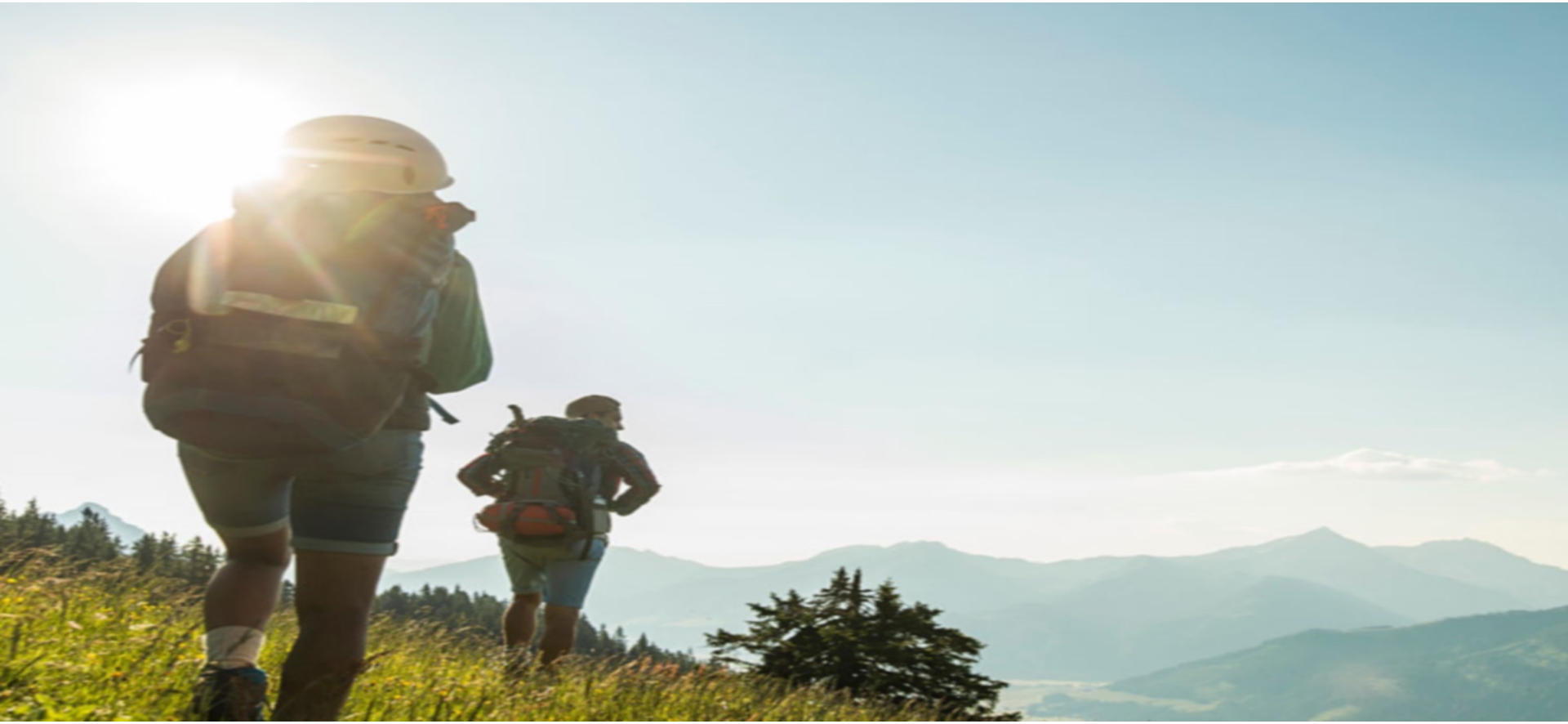
Coding Examples
Seizure Disorders



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

Follow up

History of Present Illness

Patient male 29 - year- old who accepted a virtual medical visit , he is complaining of seizure that he suffered last week, general with loss of consciousness and fecal and urine incontinence. He has history of epilepsy controlled with Keppra XR 705 mg, 2 tablets daily and Depakote ER 500 mg, 3 tablets daily, compliant with medicines, last seizure was four months ago. Today he is feeling well.

Examination

Dermatological Examination: conjunctiva clear, sclera non- icteric, no eye drainage, grossly normal.
Skin: no visible facial rash or concerning facial lesions noted. No skin redness or discoloration seen.
Neurologic: Intact recent memory. No facial or eyelid drooping. No speech impairment, answering questions appropriately.
Psych: Judgment and insight good; normal mood and affect.
N/A

Current Medications

Risperdal 2 MG Tablet 0.5 Orally three times a day

Keppra XR 750 MG Tablet Extended Release 24 Hour 2 tablets Orally twice a day

Depakote ER 500 MG Tablet Extended Release 24 Hour 3 tablet Orally twice a day, Notes: please give generic

Medication reconciliation completed with pt.

Past Medical History

Epilepsy.

Autism spectrum.

Surgical History

No Surgical History documented

Case #1- Page 2 of 2

Review of Systems

General/Constitutional:

Patient denies chills, fever, lightheadedness.

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

ENT:

Patient denies ear pain, nose bleeds, difficulty swallowing, dry mouth.

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.

Assessments

1. Not intractable epilepsy without status epilepticus, unspecified epilepsy type - G40.909

2. Autism spectrum disorder - F84.0

Treatment

1. Not intractable epilepsy without status epilepticus, unspecified epilepsy type

LAB: VALPROIC ACID (Ordered)

LAB: LEVETIRACETAM (Ordered)

IMAGING: CT HEAD W/ AND W/O CONTRAST

Referral To: Neurology

Reason: Medical evaluation and continue of care

2. Autism spectrum disorder

Clinical Notes: Continue the same medical treatment

RECAP:

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

Case #2 - Page 1 of 2

Reason for Appointment

Wellness visit

History of Present Illness

General:

Pt is a 28- year- old F with epilepsy here for annual exam. Pt has mild seizures, usually around her periods only. needing referral to neurology for f/u.

Examination

General Appearance: alert, pleasant, in no acute distress. , well developed, well nourished.
Head: normocephalic , atraumatic.
Eyes: pupils equal, round, reactive to light and accommodation, extraocular movement intact (EOMI).
Nose: nares patent.
Oral Cavity: normal , good dentition , no lesions.
THROAT: no erythema , no exudate.
Neck/Thyroid: soft, supple, full range of motion , no lymphadenopathy , no thyromegaly.
Heart: regular rate and rhythm , S1, S2 normal , no murmurs, rubs, gallops.
Lungs: clear to auscultation bilaterally , no wheezes, rales, rhonchi.
Abdomen: bowel sounds present , no organomegaly , soft, nontender, nondistended.
Musculoskeletal: No tenderness , Strength 5/5.
Extremities: full range of motion , no clubbing, cyanosis, or edema.
Psych: Normal mood and affect.

Vital Signs

Ht 62 in, Wt 112.6 lbs, BMI 20.59 Index, BP 98/62 mm Hg, HR 77 /min, RR 16 /min, Temp 98.5 F, Pain scale 0 1-10

Current Medications

Zonisamide 100 MG Capsule 1 capsule AM and 2 capsules PM Orally Twice a day
Lamictal 100 MG Tablet 1/2 tablets Orally QHS
Lamictal 200 MG Tablet 1 tablet Orally Twice a day

Past Medical History

Seizures.

Surgical History

Brain surgery 2017

Appendectomy At age 10

Case #2 - Page 2 of 2

Review of Systems

General/Constitutional:

Patient denies chills , fatigue , fever ,weight loss.

ENT:

Patient denies difficulty swallowing , hoarseness , sore throat , swollen glands.

Endocrine:

Patient denies cold intolerance, difficulty sleeping, frequent urination

Respiratory:

Patient denies cough , chest pain , shortness of breath.

Cardiovascular:

Patient denies chest pain , dizziness , palpitations.

Neurologic:

Patient denies headache , loss of strength , tingling/numbness.

Psychiatric:

Patient denies anxiety , depressed mood.

Assessments

1. Annual physical exam - Z00.00 (Primary)
2. Seizure disorder - G40.909
3. BMI 20.0-20.9, adult - Z68.20

Treatment

1. Annual physical exam
LAB: BASIC METOLIC PANEL
2. Seizure disorder
LAB: LAMOTRIGINE (Ordered)
Referral To: Neurology Reason: cont. of care
3. BMI 20.0-20.9, adult
Notes: continue diet and exercise regimen

RECAP:

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

Incorrect Coding Examples

Case #3 - Page 1 of 2 (Added missed diagnosis)

Reason for Appointment

Patient presents with request For Order

PT'S WIFE WAS SEEN YESTERDAY FOR HOSPITAL F/U FOR SYPHILLIS. PATIENT WAS RECOMMENDED TO BE TESTED AS WELL

History of Present Illness

A 62-year- old, male who is here for follow up. He last saw his primary care physician in 8/2019.

His wife was just dx with Syphilis and treated at hospital. Patient was told to get checked also. Labs ordered today and he will follow up if abnormal labs. Neuro symptoms but he has stable epilepsy. He has stable arthritis in hands.

DM 2 -- Endo follows. He had labs done in 11/2019 and per chart review, his A1C was 10.6.

Hyperlipidemia --Zocor. Endo is following now per patient. He had high TG and LDL in 11/2019.

Hypothyroid -- Thyroid labs at goal in 11/2019.

Examination

Abdominal: Soft. +BS, NTND.

Musculoskeletal: Normal range of motion. Exhibits no edema or cyanosis.

Neurological: No focal cranial nerve deficit, moves all extremities.

Skin: No rash

Psychiatric: Normal mood and affect.

Vital Signs

•BP: (P) 116/76, Pulse: (P) 73, Temp: (P) 98.1 °F (36.7 °C) Weight:(!) 118.8 kg (261 lb 12.8 oz), Height: 179.1 cm (5' 10.5") BMI: Body mass index is 37.03 kg/m².

Current Medications

Levetiracetam (KEPPRA) 500 mg tablet (Taking)
Levothyroxine (SYNTHROID, LEVOTHROID) 100 mcg tablet (Taking)
LORazepam (ATIVAN) 1 mg tablet (Taking)
Meloxicam (MOBIC) 7.5 mg tablet (Taking)
MetFORMIN (GLUCOPHAGE) 1,000 mg tablet (Taking)
NOVOLOG FLEXPEN U-100 INSULIN 100 unit/mL InPn (Taking)
Simvastatin (ZOCOR) 40 mg tablet (Taking)

Past Medical History

Diabetes mellitus

Epilepsy

Hyperlipidemia

Panic disorder

Thyroid disease

Case #3 - Page 2 of 2

Review of Systems

All other systems reviewed and are negative.

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

Assessments

1. Exposure to syphilis - Z20.2
2. Type 2 diabetes mellitus without complication – E11.9
3. Mixed hyperlipidemia – E78.2
4. Congenital hypothyroidism – E03.1
5. Mild single current episode of major depressive disorder – F32.0
5. Epilepsy, unspecified – G40.909 (*Diagnosis was added . Per coding guidelines "Code all conditions that coexist or affect patient's care")*

Treatment

Labs ordered today and he will follow up if abnormal labs.

There are no discontinued medications.

Return if symptoms worsen or fail to improve, for Follow up id positive ID test results

Plan of care was d/w patient and questions/ concerns were addressed to the patient's satisfaction

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

Reason for Appointment

Patient presented to the clinic c/o burning on urination, frequent urination.

History of Present Illness

Patient is 60- year-old female with h/o HTN, Seizure d/o on Oxcarbazepine 300 mg BID f//u with Neurologist regularly presented to the clinic for acute OV c/o burning on urination, frequent urination for the past two days, patient denies fever, chills, lower back pain. Urine dipstick done in the clinic suggestive of UTI.

Examination

General Appearance: alert, pleasant, in no acute distress.

Head: normocephalic, atraumatic.

Heart: grade 2/6 systolic murmur at left sternal border

Lungs: clear to auscultation bilaterally.

Abdomen: Positive suprapubic tenderness upon palpations, nondistended, no rebound tenderness, no guarding or rigidity.

Back: No CVA tenderness bilaterally.

Musculoskeletal: FROM Upper and Lower extremity.
Extremities: No edema, positive varicose veins.

Vital Signs

Ht 57.5 in, Wt 132.8 lbs, BMI 28.24 Index, BP sitting:125/75, HR 80 /min, RR 15 /min, Temp 98.6 F, Oxygen sat % 99 %, Pain scale 3 1-10, Ht-cm 146.05, Wt-kg 60.24.

Current Medications

Taking Losartan Potassium 100 MG Tablet 1 tablet Orally Once a day

Oxcarbazepine 300 MG Tablet 1 tablet Orally Twice a day

Aspirin 81 81 MG Tablet Chewable 1 tablet Orally Once a day

Amlodipine Besylate 10 mg Tablet 1 tablet Orally Once a day

Medication List reviewed and reconciled with the patient

Past Medical History

HTN.

Seizure d/o.

Lt carotid artery stenosis.

Anxiety d/o.

Case #4 - Page 2 of 2

Review of Systems

General/Constitutional:
Chills denies. Fever denies. Sleep disturbance denies. Weight loss Denies.

Respiratory:
Cough denies. Pain with inspiration Denies. Shortness of breath at rest Denies. Wheezing Denies.

Cardiovascular:
Chest pain at rest denies. Chest pain with exertion denies. Dizziness denies. Fluid accumulation in the legs denies. High blood pressure admits. Irregular heartbeat denies. Shortness of breath denies.

Genitourinary:
Blood in urine denies. Frequent urination Admits. Painful urination Admits.

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. Acute cystitis with hematuria - N30.01 (Primary)
2. Annual physical exam - Z00.00
3. Benign hypertensive heart disease without congestive heart failure - I11.9 4
4. Mitral regurgitation - I34.0
5. Microalbuminuria - R80.9
6. Carotid stenosis, left - I65.22
7. Epilepsy, unspecified – G40.909 (*Diagnosis was added . Per coding guidelines "Code all conditions that coexist or affect patient's care")*

Treatment

1. Acute cystitis with hematuria
Start Sulfamethoxazole-Trimethoprim Tablet, 800-160 MG, 1 tablet, Orally, Twice a day, 10 day(s), 20 Tablet, Refills
2. Annual physical exam
LAB: CBC (INCLUDES DIFF/PLT)
3. Benign hypertensive heart disease without congestive heart failure
Refill Amlodipine Besylate Tablet, 10 mg, 1 tablet, Orally, Once a day, 90 days, 90 Tablet, Refills 1
4. Mitral regurgitation
Notes: Patient asymptomatic , BP at goal.
5. Microalbuminuria -Notes: Continue ARBs.
6. Carotid stenosis, left- Continue Aspirin 81
Tablet Chewable, 81MG, 1 tablet, Orally, Once a day

Quick Tips (ICD-10- CM)

"The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved." ICD-10-CM

THANK YOU

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