Coding Chronic Conditions
Presented by Brenda Edwards, CPC, CPB, CPMA, CPC-I, CEMC, CRC

Fair Warning!
**Objectives**

- To learn and have fun
- To share your knowledge
- To communicate effectively with your provider
- To enjoy HEALTHCON!

**Definition of a Chronic Condition**

- Lasting 3 months or more
- Marked by long duration
- Do not resolve spontaneously
- Frequent recurrence over a long time
- May have slow progressive course of indefinite duration
- Treatment can alleviate but not cure the condition

http://www.cdc.gov/chronicdisease/
Chronic diseases are responsible for 7 of 10 deaths each year, and treating people with chronic diseases accounts for 86% of our nation’s health care costs

http://www.cdc.gov/chronicdisease/

Did You Know?

- 1 in 5 Americans suffer from one or more mental disorders
- More than 2/3 of adults with a mental disorder have one or more chronic general medical disorders

AND

- Nearly 1/3 of adults with a chronic general medical disorder also suffer from a comorbid mental disorder

- Comorbidity is the rule rather than the exception
Facts for the U.S.

- Chronic diseases and conditions are among the most common, costly, and preventable of all health problems.
- As of 2012, about ½ of all adults had one or more chronic conditions
  - 1 in 4 had two or more
  - 7 of top 10 causes of death in 2010 were chronic diseases
    - Cancer and heart disease (together) accounted for 48% of all deaths
  - Obesity present in more than 1/3 of adults
    - 1 in 5 youth (2-19) are obese
  - Arthritis is most common cause of disability
  - Diabetes is leading cause of kidney failure and lower limb amputations other than those due to injury

The Cost...

- Chronic conditions account for most health care costs in the U.S.
  - In 2010, costs for heart disease and stroke were over $315.4 billion
  - In 2012 the cost of diagnosed diabetes was $245 billion
  - Decreased productivity
    - Absence from work
    - Less productive while at work
    - Inability to work due to complications
  - 10% of Americans 47 and older develop a chronic disease each year
  - 80% of nation’s 2.5 trillion health spending goes to chronic disease management
The Cost…cont.

Diabetes
• $174 billion

Lung disease
• $154 billion

Heart disease and stroke
• $432 billion

Alzheimer’s disease
• $148 billion

Chronic Diseases

In 2014 chronic diseases accounted for 93% of all Medicare spending


Health Risk Behaviors Causing Chronic Diseases

• Lack of exercise
• Major risk factors for heart disease or stroke
• Poor diet-lack of fruits and vegetables
• Cigarette smoking
• Excessive drinking (alcohol)

http://www.cdc.gov/chronicdisease/overview/
Review of the

IMPORTANCE OF

DOCUMENTATION

Documentation

• “Documentation is only good if the next physician who treats the patient can pick up your record and know exactly what happened”
• The medical record should be:
  • Complete
  • Precise
  • Reliable
  • Consistent
  • Legible
  • Timely
Medical Necessity

**CMS definition:**
- Reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code. It would not be medically necessary or appropriate to bill a higher level of E&M service when a lower level of service is warranted. *The volume of documentation should not be the primary influence upon which a specific level of service is billed.*

**AMA definition:**
- Health care services a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms

Medical Necessity

**Medically necessary services must be:**
- In accordance with generally accepted standards of medical practice
- Clinically appropriate in terms of type, frequency, extent, site and duration
- Not for the convenience of the patient, physician or other health care provider
- Performed or prescribed by the provider
**Purpose of Good Documentation**

- The medical record should be complete and legible
- The documentation of each patient encounter should include
  - The reason for the encounter and relevant history
  - Physical examination, findings, and prior diagnostic test results
  - Assessment, clinical impression, or diagnosis
  - Medical plan of care
  - The date and legible identity of the observer

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**Accuracy is of THE Utmost Importance!**

- Documentation should clearly indicate what was done
- Something that might seem trivial for the provider to document may be the reason a higher level of service could be supported
- Details, details, details!
Best Practices for Documentation

- Be graphic
- What are the thought processes that made your provider arrive at a final diagnosis?
- The more specificity, the better
- Make a case for your provider’s work
- Use key terms
- What were the results of the treatment?
- Document total time spent with patient
  - Document time for counseling/coordinating care

Best Practices for Documentation

- Avoid words which are vague or have more than one meaning
- Every entry should be signed and dated
- All contact, including telephone calls and correspondence with the patient should be documented in the record
- All instructions given to the patient and/or caregiver should be adequately recorded
- Avoid recording conflicting information
  - The reason should also be documented
<table>
<thead>
<tr>
<th>Clinical Concepts</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td>History of</td>
</tr>
<tr>
<td>Temporal factors</td>
<td>Morphology</td>
</tr>
<tr>
<td>Caused by/Contributing factors</td>
<td>Complicated by</td>
</tr>
<tr>
<td>Symptoms/Findings/</td>
<td>External Cause</td>
</tr>
<tr>
<td>Manifestations</td>
<td>Activity</td>
</tr>
<tr>
<td>Localization/Laterality</td>
<td>Place of Occurrence</td>
</tr>
<tr>
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<td>Loss of Consciousness</td>
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<tr>
<td>Associated with</td>
<td>Substance</td>
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<td>Severity</td>
<td>Number of Gestations</td>
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<td>Episode</td>
<td>Outcome of Delivery</td>
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<td>Remission status</td>
<td>BMI</td>
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Documentation Concepts

- The concept of type describes a condition that is typically considered a type of a condition, like type 1 diabetes or pathological fracture.
- Temporal factors relate a condition to a particular time parameter, such as acute, chronic, paroxysmal, or recurrent.
- Causation or contributing factors are just what they sound like. This concept relates that the patient’s condition is a result of another condition. You see this a lot in conditions caused by the patient’s use of drugs or alcohol, or by a physical disease.

 Documentation Concepts

- The codes should not be the primary focus of the education
- Turn attention to clinical concepts
- Must have an in-depth understanding of clinical conditions
  - Clinicians document based on the clinical condition
  - They do not document based on code descriptors
Chronic Conditions

- Diabetes
- Arthritis
- Cancer
- Heart Failure
- Hypertensive diseases
- Kidney disease
- Alzheimer Disease
- Osteoporosis
- Asthma
- Obesity
- Atrial Fibrillation
- Depression

A CLOSER LOOK

Diabetes
Heart Failure
Hypertensive Diseases
Kidney Disease
Sepsis
Multiple chronic diseases
Diabetes E08-E13

- **Type**
  - Type 1
  - Type 2

- **Cause**
  - Drug or chemical induced
  - Due to underlying condition
  - Gestational

- **Complication/Manifestation**
  - Kidney
  - Ophthalmic
  - Neurological
  - Skin
  - Oral

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E11 Type 2 diabetes mellitus
Includes: diabetes (mellitus) due to insulin secretory defect
diabetes NOS
Insulin resistant diabetes (mellitus)
Use additional code to identify any insulin use (Z79.4)

E10.62 Type 1 diabetes mellitus with skin complications
E10.620 Type 1 diabetes mellitus with diabetic dermatis
Type 1 diabetes mellitus with diabetic neprolihiasis
E10.621 Type 1 diabetes mellitus with foot ulcer
Use additional code to identify site of ulcer (L07.4- L07.5-)
E10.622 Type 1 diabetes mellitus with other skin ulcer
Use additional code to identify site of ulcer (L07.1-L07 6, L98.41-L98.49)
E10.628 Type 1 diabetes mellitus with other skin complications

E10.63 Type 1 diabetes mellitus with oral complications
E10.630 Type 1 diabetes mellitus with periodontal disease
E10.638 Type 1 diabetes mellitus with other oral complications

E10.64 Type 1 diabetes mellitus with hypoglycemia
E10.641 Type 1 diabetes mellitus with hypoglycemia with coma
E10.649 Type 1 diabetes mellitus with hypoglycemia without coma

E10.65 Type 1 diabetes mellitus with hyperglycemia
E10.69 Type 1 diabetes mellitus with other specified complication
The patient is a 67 year old female who presents with a subcutaneous abscess. Last visit was 1 week ago. Symptoms include pain, swelling, tenderness, and drainage. Abscess location is the left buttock. The patient describes the pain as sharp. Patient had previous abscess that was treated by antibiotics. Will try antibiotics again however; if this does not improve will need to I&D. Patient has a history of Diabetes. Patient checks BP regularly and this is controlled on Toprol. Blood sugars are stable and controlled with Metformin. No episodes of hypoglycemia. No side effects of meds and compliant with treatment.

Buttock abscess. DM – well controlled. HTN – well controlled. Will try antibiotics again however; if this does not improve will need to I&D.

### Heart Failure I50

- **Type/severity**
  - Left sided: Fluid may back up in lungs causing shortness of breath
  - Right sided: Fluid may back up in abdomen, feet and legs, causing swelling
  - Systolic: Left ventricle doesn’t pump blood out to body as well as normal
  - Diastolic: Left ventricle cannot relax fully which limits ability to fill properly with blood
  - Congestive: Fluid that builds in lungs, liver, GI tract, arms and legs

- **Temporal factors**
  - Acute
  - Chronic
  - Acute on chronic
  - Combined systolic and diastolic
Heart Failure I50

- Associated conditions
- Cause/Contributing Factors/Complicated by
  - Code First in Tabular Index prior to codes
    - Complicating abortion or ectopic pregnancy
    - Due to hypertension
    - Due to hypertension with chronic kidney disease
    - Following surgery
    - Obstetric surgery and procedures
    - Rheumatic heart failure

150 Heart failure

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<th>ICD-10-CM Code</th>
<th>Description</th>
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<tr>
<td>I50.0</td>
<td>Heart failure complicating abortion or ectopic pregnancy (065.0-077, 069.9)</td>
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<tr>
<td>I50.1</td>
<td>Heart failure due to chronic hypertension (I15.9)</td>
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<tr>
<td>I50.2</td>
<td>Heart failure due to chronic hypertension with obstructive sleep apnea (I15.3)</td>
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<td>I50.3</td>
<td>Heart failure following surgery (I47.9)</td>
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<td>I50.4</td>
<td>Rheumatic heart failure (150.1-)</td>
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<td>I50.5</td>
<td>Cardiac failure due to chronic kidney disease (585.9)</td>
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<tr>
<td>I50.6</td>
<td>Cardiac failure following surgery (516.9)</td>
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<td>I50.7</td>
<td>Cardiac failure with complications (516.9)</td>
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<td>I50.9</td>
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150.1 Left ventricular failure

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150.2 Syndromic (progressive) heart failure

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<td>Acute systolic (progressive) heart failure (I50.22)</td>
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<td>Acute on chronic systolic (progressive) heart failure (I50.23)</td>
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<td>I50.30</td>
<td>Chronic systolic (progressive) heart failure (I50.34)</td>
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150.3 Isolated (progressive) heart failure

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<td>I50.36</td>
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150.4 Combined systolic (progressive) and diastolic (progressive) heart failure

150.9 Other specified syndromic/progressive heart failure
CHIEF COMPLAINT: COPD
HISTORY OF PRESENT ILLNESS: The patient is an 85-year-old female with advanced COPD, who presents to the emergency room complaining of 2-day history shortness of breath after she ran out of her inhalers. She is having increased sinus congestion, postnasal drip, but not having purulent sputum production. No fevers, chills, night sweats, or hemoptysis. No orthopnea or chest pain.
PAST MEDICAL HISTORY: Significant for advanced COPD with asthma diathesis, congestive heart failure with cardiomyopathy, baseline ejection fraction 30% to 35%, 2+ mitral regurgitation, nocturnal hypoxia, former history of tobacco abuse, diet-controlled diabetes, and paroxysmal atrial fibrillation.
SOCIAL HISTORY: She has a significant history of smoking, quitting over 5 years ago. She has worked at the hospital as a nurse in 1960s and 1970s. Does not abuse alcohol. Has a daughter who lives nearby.
IMPRESSION AND PLAN: Chronic obstructive pulmonary disease exacerbation, triggered by allergies and running out of her medications. So, we will admit her and start her on steroids and nebulizers. I will give her Flonase nasal spray and Ocean spray nasal spray to help with her allergies. I will also start her on Singulair 10 mg a day, which will not only help with her allergies, but also with the asthmatic component of her bronchospasm.

Hypertensive Diseases (I10-I15)

- Type
  - Essential (primary)
    - Hypertensive heart disease
    - Hypertensive chronic kidney disease
    - Hypertensive heart and chronic kidney disease
  - Secondary
    - Renovascular
    - Renal disorders
    - Endocrine disorders
- Caused by/Contributing factors
  - Chronic kidney disease
  - Heart failure
- Associated complications
- Severity
- Symptoms/Findings/Manifestations
- Temporal factors

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<tr>
<th>Clinical Concept</th>
<th>COPD</th>
<th>HTN</th>
<th>HF</th>
<th>DM</th>
<th>AF</th>
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CHIEF COMPLAINT: The patient is here today for follow-up of diabetes and high blood pressure.

HISTORY OF PRESENT ILLNESS: - is a very pleasant 52-year-old lady with history of diabetes and high blood pressure. The patient is here today really volunteers no new complaints. The patient will like me to go over her results with her.

I did review the patient’s lab and also did review the imaging studies. Echocardiogram is normal. CT of the brain was also unremarkable. Lab result was reviewed. Her Chem panel is essentially normal with sodium of 138, potassium of 4.5, and blood sugar of 96. Hemoglobin A1c of 6.2. Lipid profile shows total cholesterol of 198 with triglyceride of 93 and LDL of 136.

PHYSICAL EXAMINATION: Vital signs: Blood pressure today is 108/76 with a pulse of 76.

ASSESSMENT/PLAN:
1. Diabetes without nephropathy or neuropathy. The patient will continue on current regimen.
2. Hypertension. Blood pressure is optimal. I have given her a refill of her Micards.
3. COPD. I spent considerable amount of time encouraging the patient and educating her on importance of tobacco cessation. The patient demonstrated understating. The patient tells me she is working on it. The patient will return to see me in three to four months.
Kidney Disease

- **Type**
  - Stage 1-6
  - End stage
- **Temporal factors**
  - Acute
  - Chronic
- **Associated with/Caused by/Contributing factor**
  - Underlying condition
  - Diabetic chronic kidney disease
  - Hypertensive chronic kidney disease
- **History of**
  - Transplant
CHIEF COMPLAINT: Swelling, Foot.

HISTORY OF PRESENT ILLNESS: The patient presents with bilateral acute swelling in his feet. He knows that his kidneys are failing and is under the care of Dr. X. He had a kidney biopsy last week and is currently undergoing workup for impending need for dialysis. He noticed over the last few days that his lower extremities are swelling. He denies SOB or other related symptoms. He thinks his last creatinine was 7. Patient states that he was getting most of his care with his primary care physician, but was sent to Dr. X for the biopsy. The onset of the swelling was 4 days ago. The severity of symptoms is worsening. Type of injury: none. Location: Bilateral ankles. The character of symptoms is swelling. The degree at present is moderate, 5/10. The relieving factor is elevation. Risk factors consist of chronic renal insufficiency and type 2 DM on insulin. Prior episodes: chronic. Therapy today: none. Associated symptoms: none. Additional history: none.

PAST MEDICAL HISTORY: MEDICAL HISTORY:

IMPRESSION AND PLAN: Acute on chronic renal failure volume overload.

Sepsis

- Type
  - Sepsis
  - SIRS
  - Severe Sepsis
- Caused by/Contributing factors
  - Underlying infection
- Associated with/complicated by
  - Specific organ failure
  - Severity
    - With acute organ dysfunction
    - With acute organ failure
Sepsis Progression

- Bacteremia (R78.81)
- Septicemia (A41.9)
- Sepsis, with SIRS due to infection
- Severe Sepsis: mortality rate: 40-50% (R65.21)
- With septic shock (life threatening low blood pressure) and acute organ dysfunction
- Multiple organ dysfunction
- Death

Sepsis Progression

- Organism in blood (blood contains bacteria)
- More specific and systemic infection (replicating bacteria that causes an infection)
- Indicates progression into sepsis but no acute organ dysfunction (SIRS=Systemic Inflammatory Response Syndrome)
- With septic shock (life threatening low blood pressure) and acute organ dysfunction

R65.2 Severe sepsis
Infections with associated septic organ dysfunction
Croup with multiorgan dysfunction
Systemic inflammatory response syndrome due to infectious process with acute organ dysfunction

Code First: underlying medical/other causes:
infection following instrumentation (R11.1)
sepsis following influenza, vaccination, and therapeutic injection (R86.2)
sepsis following complicated unspecified spontaneous abortion (R30.82)
sepsis following complete or incomplete spontaneous abortion (R30.82)
sepsis following ectopic and in vitro pregnancy (C66.02)
sepsis following incomplete spontaneous abortion (C63.02)
sepsis following induced termination of pregnancy (O22.0)
sepsis NOS (A41.9)

Use additional codes to identify specific acute organ dysfunction, such as:
- acute kidney failure (R07.0)
- acute respiratory failure (R17.0)
- critical illness myopathy (G71.20)
- critical illness polyneuropathy (G55.87)
- disseminated intravascular coagulopathy (E87.0)
- encephalopathy (nephrotic) (E10.41)
- hepatic failure (E21.0)

R65.20 Severe sepsis without septic shock
Severe sepsis NOS

R65.21 Severe sepsis with septic shock
FINDINGS:
This is a critically ill 81-year-old gentleman whom I was asked to evaluate for antibiotic management. This patient is currently intubated and sedated. As a result, the history of present illness was obtained from review of the medical record and discussion with staff. The patient has been dealing with bronchitis at home and working with physical therapy and became increasingly weak and more dyspneic. The patient was hospitalized on February 7, 2016; antibiotic regimen was changed to ceftriaxone and doxycycline the following day. The patient began to complain of right upper quadrant pain that radiated to the lower quadrant. CT scan demonstrated right-sided hydronephrosis with a ureteral calculus and fluid in the pelvic gutter. The patient was transferred for surgical evaluation; after the CT scan was obtained, nephrolithiasis was documented. The patient was clearly going to need cystoscopy given the dimensions and configuration of the stone which was not going to pass; however he was on Plaxiv and Coumadin, this required a delay. Unfortunately, while waiting for the patient to become medically stable to proceed with treatment, he developed encephalopathy and had to be emergently intubated. He developed findings consistent with aspiration pneumonia. He was placed on Zosyn. Blood cultures were obtained on February 15, 2016 in response to his clinical decline, these were negative until today. Indeed 106 hours after the blood was drawn, the sample from the patient’s Port-A-Cath has yielded yeast.

IMPRESSION:
- Sepsis from a pulmonary source
- Healthcare-associated pneumonia due to aspiration.
- Hydronephrosis due to nephrolithiasis.
- Acute-on-chronic renal failure.
- Fungemia, not yet further identified.
- Acute hypoxic respiratory failure.
- Chronic immunosuppression, on exogenous glucocorticoids.
- Diabetes mellitus, type 2, noninsulin requiring.

<table>
<thead>
<tr>
<th>Clinical Concept</th>
<th>Sepsis</th>
<th>Pneumonia</th>
<th>Renal Failure</th>
<th>Respiratory Failure</th>
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<td>Temporal Factors</td>
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Multiple Chronic Conditions

- Sequencing
- When to code, which to code
- Effects on each other
CHIEF COMPLAINT: The patient is an 83-year-old white female who presents with a chief complaint of nausea, vomiting, and belly cramping, with no significant bowel movement over the last 7 to 10 days.

HISTORY OF PRESENT ILLNESS: The last time she had a good bowel movement was when she drank GoLYTELY. She has tried MiraLax, enemas, and Dulcolax suppositories, and was unsuccessful. She has no complaints of hematemesis, melanotic stools, or bright red blood per rectum.

PAST MEDICAL HISTORY: Significant for atrial fibrillation, CHF, hypertension, diabetes, arthritis, uterine cancer, and pneumonia.

ED COURSE: The patient had an IV, CBC, CMP, coags which are pending, and a CRP and lipase. Her labs otherwise are normal. She also had an x-ray of her abdomen, which did reveal nonspecific, nonobstructive bowel gas pattern with moderate feces within the colon. I went over the results with the patient. She has failed outpatient management for the constipation, so she will be placed into observation for relief of the constipation. Dr. D was consulted. Dr. M was on call; I discussed it with him. He asked us to do 1 dose of MiraLax and soapsuds enemas until clear. EKG and coags are pending, and I will update if there are significant abnormalities.

DIAGNOSES:
Constipation.
Atrial fibrillation.
Diabetes.
Hypertension.

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<td>Temporal Factors</td>
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K60.8 Constipation
Excludes: fecal impaction (K54.1)
Incomplete defecation (R15.2)
K58.80 Constipation, unspecified
K58.01 Slow transit constipation
K58.02 Obstetric dysfunction constipation
K58.09 Other constipation

E11 Type 2 diabetes mellitus
Includes: diabetes (mellitus) due to insulin secretory defect
insulin resistant diabetes (mellitus)
Use additional code to identify any insulin use (Z79.4)

I10 Essential (primary) hypertension
Includes: high blood pressure
hypertension (arterial) (benign) (essential) (malignant) (primary) (cystic)
Excludes: hypertensive disease complicating pregnancy, childbirth and the puerperium (O10-D11, O13-D10)
Excludes2: essential (primary) hypertension involving vessels of brain (I68.008)
essential (primary) hypertension involving vessels of eye (I135.0)

I48.0 Paroxysmal atrial fibrillation
I48.1 Persistent atrial fibrillation
I48.2 Chronic atrial fibrillation
I48.3 Typical atrial flutter
I48.4 Atrial fibrillation and flutter
I48.5 Atrial fibrillation
I48.9 Unspecified atrial fibrillation and flutter
I48.91 Unspecified atrial fibrillation
I48.92 Unspecified atrial flutter
Reason for Visit: Here on consultation from Dr. Bruman for Diabetes.

HPI: She has had diabetes mellitus for the last 40 years. She has been on an insulin pump for the last 7 years. Diabetic complications-polyneuropathy. She has been getting her diabetes care from her nurse practitioner in Nashville, but she is getting tired of making this trip 4 times a year. Hemoglobin A1C is said to be 7.1% 2 months ago. Fasting blood sugar is near 146, but this can be as low as 55, by noontime her blood sugar is 158, going down to 49 at times. At supper time, her blood sugar is 210 on average. By bedtime, her blood sugar is near 72. She boluses NovoLog 1 unit for every 6 g of carbohydrates with breakfast and lunch, 1 unit for every 4 g of carbohydrates with supper. She is on Symlin 120mcg with each meal. Metformin 1000mg BID. She has a history of hypertension and her blood pressure is rather high today. Dr. Lewis just added HCTZ to her regimen. She is being treated for hyperlipidemia with Simvastatin 40mg daily. Microalbumin was 34.0 on 03/23/11 and she has never seen a nephrologist. Dilated eye exam was performed 2 months ago and she has had retinopathy. She has a history of retinal detachment and she is blind in the left eye. She received a flu shot in September 2010. Recently, she had some trouble swallowing and a thyroid ultrasound was performed on 04/06/11. On the right lobe, there was a 1.5-cm and a 1.7-cm nodule.

Assessment:
Benign essential hypertension
Hyperlipidemia
Nontoxic multi-nodular goiter
Type 2 diabetes with neurological complications—uncontrolled
The patient is a 64 year old female who presents for a recheck of diabetes. Patient states the problem is unchanged. Patient has been compliant with adequate exercise, alcohol avoidance, low carbohydrate diet, low cholesterol diet, low fat diet, medication as directed and smoking cessation. Current medication use: experiencing no side effects. Purpose of visit: requesting medication refills. The patient has had a diagnosis of diabetes for 7 years. Patient does exercise, but does not use alcohol or smoke. Patient reports no hypoglycemia and is doing well. Weight gain noted.

Recheck of hypertension is described as the following: Patient states the problem is unchanged. Patient has been compliant with adequate exercise, alcohol avoidance, low carbohydrate diet, low cholesterol diet, low fat diet, medication and smoking cessation. Patient has been monitoring blood pressure. Current medication use: experiencing no side effects. Note for "hypertension recheck": BP has not been under control and she reports has been taking her meds. Will need to add another med to control BP.

Recheck of hyperlipidemia is described as the following: Patient states the problem is unchanged. Patient has been compliant with adequate exercise, alcohol avoidance, low carbohydrate diet, low cholesterol diet, low fat diet, medication and smoking cessation. Current medication use: experiencing no side effects.

Recheck of chronic kidney disease. This is classed as Stage 2 – being seen by nephrology and has been stable. Meds reviewed.

Assessment and Plan: DM uncomplicated, Type II, uncontrolled; Hypertension; benign essential; Hyperlipidemia; Chronic Kidney disease; stage II
Conclusion

• Documentation must support medical necessity
  • Coding tells the story of the patient, the more detail, the better
• Beneficial to use Clinical Concepts in feedback to provider
• Open lines of communication are important between coder and provider
• Communication with the provider is crucial
• Clear, concise and detailed documentation is the key

Details?
Sited Sources

- AAPC
- www.cdc.gov
- ICD-10 Monitor
- www.CMS.gov
- www.diabetes.org
- www.heart.org
- www.nlm.nih.gov