Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Diagnosis Coding: No Dx Code on Claim? Find It Yourself With These 3 Tips

Coders may need to delve into the doctors' notes to find diagnoses.

If you're presented with an incomplete superbill, you don't have to say goodbye to reimbursement. In reality, if the doctor in your office fails to indicate the ICD-9 code for the condition that he treated, you should read through his documentation to find which diagnoses you should report.

Open the Notes When You Have to and Even When You Don't

Suppose your physician hands you a superbill with the procedures circled and the diagnosis left blank.

You could ask the physician which diagnosis to report, or you could examine the documentation yourself. If your office has a policy that includes "coding by abstraction" by certified/qualified coders, then submitting charges based on what is supported (documented) in the note is appropriate. The physician should be signing off on these charges as part of your internal policy.

Some practices choose to review the documentation and compare it against any diagnoses recorded on the superbill, even when they aren't required to. This ensures that the documentation matches the code selection every time.

When in Doubt, Confirm With the Physician

If you are new at coding diagnoses from the physician's notes, you should double-check your code selections with the practitioners before submitting your claims.

Until a coder feels comfortable with the ICD-9 books and the codes used more often in their office, it's a good idea to run the choices by a clinician. You never want to give a patient a disease or symptom they don't have, or one more severe (or less) than what they have. This is also beneficial to the physicians, as if you select unspecified codes a lot they may learn how to better document the patient's condition into their notes.

Tip: Make sure your office creates a policy in writing that spells out what you should do when you encounter a superbill with no diagnosis listed. Some physicians prefer that you ask them for information, while most others rely on their coders to select an accurate code.

Check the Notes for Clues

Consider this example of a situation in which the coder must fill in the gap when the doctor has not written a diagnosis on the patient's superbill.

Example: The physician's superbill shows a level-three office visit with a patient wearing a lumbar orthosis. It also shows a date of injury of three days prior to the date of service and is missing the diagnosis code.

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First step: You refer to the dictation, which reads: "The patient is a 13-year-old female being evaluated as a consultation at the request of Dr. Jones for lumbar pain. The low back pain started on 12-9-09 when she did splits during cheerleading." The physician completes the remaining history, review of systems (ROS), past family and social history (PFSH), and exam.

Moving down through the chart note, you see that the patient brought an MRI and x-ray with her, which demonstrated a hairline fracture to the patient's third lumbar vertebra (L3).

Under a separate heading, the doctor has given his assessment, which states: Closed L3 fracture, benign.

Next step: You look up "fracture" in Vol. 2 of the ICD-9 book and the most specific body area listed is "vertebra, lumbar (closed)," which is 805.4 (Closed fracture of lumbar vertebra without spinal cord injury).

You turn to Vol. 1 and read the information under the "fracture of vertebral column" heading to check for exclusions and see that none apply in this case. You search under 805.4 to see if by chance the book lists codes for benign or traumatic fractures, which it does not.

In addition, ICD-9 does not instruct you to add a fifth digit to 805.4. Therefore, you know that 805.4 is the most accurate code for your doctor's visit.

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