

Coding Tips for Physicians



PART OF AN OCCASIONAL SERIES OF TIPS FOR PHYSICIANS PREPARED BY SHC AND LPCH'S COMPLIANCE DEPARTMENT.

Did you know that. . . ICD-9 diagnosis and procedure code assignment rules are precise and demanding and apply to facilities and health care professionals alike. Here are some key issues and related examples:

Coders cannot make assumptions.

- When a patient presents with a history of recent large-volume blood loss and resultant "anemia," the coder cannot code the type of anemia as due to blood loss without physician documentation supporting the cause/ effect relationship of these two events.

Diagnosis codes cannot be assigned for abnormal laboratory values.

- For example, arterial blood gas levels of 7.23/56/178 cannot be coded without accompanying physician documentation of the associated diagnosis. A patient who presents with shock will not have this condition coded when it is described in terms of abnormal vital signs and laboratory values alone; the term "shock" *must* be noted in the record before it can be recorded.

Diagnoses listed as Pathology and Radiology reports cannot be coded in the inpatient setting unless the attending physician documents such diagnoses in the record.

- If the attending physician does not validate diagnoses from these sources in the content of the inpatient record, the coder must request validation of such conditions by way of a physician query.

Diagnoses stated by house staff members can be coded if there is no contradicting documentation by the attending physician.

- Be certain to closely evaluate house staff notes and clarify any conflicting or incorrect documentation by them.

Be careful, precise and consistent in using seemingly similar words that for coding purposes are not interchangeable.

- For example, "sepsis," "septicemia," and "bacteremia" each have significant implications in code/DRG assignment. Descriptors such as "insufficiency" and "failure" have different codes. Please be consistent and precise in your documentation regarding such conditions.

The term "urosepsis" is to be coded as a urinary tract infection only, unless it is also stated as "sepsis due to UTI" or other similar diagnostic statement within the record.

- If you use the term "urosepsis" alone, you will likely be queried to clarify whether or not the patient had sepsis in addition to his/her urinary tract infection.

Codes can be assigned for "presumed," "possible" or "probable" conditions.

- In the event, for instance, that a septic-appearing patient has negative blood cultures but all other clinical indicators point to being septic, "presumed sepsis" would be an appropriate diagnostic statement, and the diagnosis code for sepsis would be assigned in the inpatient setting.

Why is it important?

- Complete, accurate documentation and code assignment have far-reaching benefits in the health care environment.
- Accurate codes support your level of billing, assist in accurate reimbursement, and provide meaningful data in outcomes assessment and other quality indicators.
- Specificity in code assignment provides the full picture of treatment rendered to the patient and can impact the reimbursement for all care providers.

Please feel free to contact the SHC/ LPCH Facility Fee Auditor/Trainer, Jean Stone, Compliance Department, (650) 724-3849 ❖

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