



# Diagnosis Documentation

- Diagnosis indicates to payers **why** a patient was treated
- It also indicates the **severity** of the complaint or injury being treated
- The more specific the diagnosis the better picture the payer has of the condition of the patient
- Providers who document higher level encounters could be denied based on diagnosis
- Example – knee strain 3<sup>rd</sup> visit post MRI now found to have **medial meniscus tear**.
- Diagnosis not updated to reflect **severity** of case can cause claim to deny



# Diagnosis Sequencing

- Providers should document diagnosis in order of severity – **highest to lowest**
- If the order changes this should be updated in provider documentation and on the **work status report**
- Front desk trained to update and re-sequence diagnosis as necessary
- Only **first 4 diagnosis** codes can go on claim form
- **Resolved** conditions should be sequenced **secondary** to an actively treated condition
- Sequencing for a service with a procedure i.e. laceration repair should sequence the **medical necessity diagnosis for the procedure as primary**



# Diagnosis Documentation Rules

- Document **all changes** in patient condition
- Document any **new diagnosis** added for the patient
- Indicate the **primary diagnosis** for the encounter
- Document **rule out or suspected conditions** – although they cannot be coded they can add weight to your medical decision making
- List any **underlying conditions** that may impact the patients complaint
- Document to the **highest level of specificity** for the patient's condition – the more specific your documentation the more specific the ICD-9 code



# State Variations

- In states that deal with allowed diagnosis approval may need to be obtained prior to changing or adding diagnosis
- Those cases may require use of non-specific codes to meet carrier and payer requirements
- Discuss assignment of ICD-9 codes realizing some states the providers do not assign



# Using the ICD-9 Book

- ICD-9 books are updated annually on **October 1<sup>st</sup>**
- Each USHW center required to have at least 1 current ICD-9 book
- Use the Alphabetic Index to look up your ICD-9 code
- Use the Tabular Index to validate the code and assure correct number of digits
- Tabular index will also show if the code you want to use is allowed with that category
- Example – Rotator Cuff Tear



# Finding your specific diagnosis

- Look up Tear in the Alphabetic index and it directs you to see sprain/strain by site
- Look up Strain, Shoulder it gives code category 840
- Go to the Tabular list under code category 840
- Code 840.4 is for rotator cuff
- Notes with code 840 state that the code category also includes tear
- This example indicates the importance of using both ICD-9 index
- If selecting only from the alphabetic list you would not know category 840 included rotator cuff tear



# Diagnosis Documentation

- Be as specific as possible when documenting diagnosis of patient condition.
  - Example: [Shoulder Strain Unspecified 840.9](#)
  - This category has 9 specific shoulder strain codes
    - 840.0 – Acromioclavicular (joint) (ligament)
    - 840.1 – Coracoclavicular (ligament)
    - 840.2 – Coracohumeral (ligament)
    - 840.3 - Infraspinatus (muscle) (tendon)
    - 840.4 – Rotator cuff (capsule)
      - Excludes complete rupture of rotator cuff (727.61)
    - 840.5 - Subscapsularis (muscle)
    - 840.6 - Supraspinatus (muscle) (tendon)
    - 840.7 – Superior Glenoid Labrum Lesion (SLAP)
    - 840.8 – Other specified sites of shoulder and upper arm



# Code Category Inclusions

- The category of shoulder sprain in ICD-9 coding includes many types of conditions
- Code category 840 also includes:
  - Avulsion
  - Hemarthrosis of: } joint capsule
  - Laceration ligament
  - Rupture muscle
  - Sprain tendon
  - Strain
  - Tear



# Highest specificity of diagnosis

- Shoulder strain vs. rotator cuff tear
- Importance of documenting specific location, injury type, severity
- Understand the official ICD-9 code category may not appear as expected
- Goal to have specific information for checkout staff to assign highest level of ICD-9 code
- Will support medical necessity for level of service



# Diagnosis and Mechanism of Injury

- The diagnosis should logically relate to the “mechanism of injury.”
- Example - A mechanism of sudden bending and experiencing back pain wouldn't be initially related to a Grade 2 Spondylolithesis.
- The diagnosis of lumbar strain (or some variant) with an accompanying diagnosis of Spondylolithesis would be more appropriate



# Common Main Terms

- When looking in the alpha index do not look under anatomical sites
- Use **Common Main terms** to look up code
  - i.e. Liver Disorder – look under **disorder** (main term) not Liver
- Other common main terms include:
  - Anomaly
  - Disease
  - Findings (abnormal)
  - Syndrome
  - Infection
  - Injury



# Supplementary Classifications

- V Codes

- Classification of factors influencing health status and contact with health services
- Can be used as primary or secondary diagnosis

- E Codes

- Classifying external causes of injury and poisonings
- Use to identify how and where an injury occurred
- Especially important with Urgent Care cases
- Never use E-code as primary diagnosis



# V Codes for Asymptomatic Patients

- Patient presents with no symptoms or complaints
- Use codes from V71 series
- Codes identify observation for suspected conditions
- Used when employer requires patient seen post accident i.e. MVA
- Document why patient was sent i.e. possible exposure to TB



## V - Codes

- Explain **reasons** for services when a patient is not currently ill, including:
  - Preventive care, including immunizations i.e. V70.0
  - Patient referred for screening tests
  - Follow-up services
  - Therapy treatment
- May show situations that influence a patient's health status but are not a current illness or injury
  - family **history or personal history of** cancer or other disease
  - **counseling** for family problems
  - **screening or observation** for suspected condition



# Non-Specific Codes

- Checkout staff instructed to avoid using non-specific codes whenever possible
- They are instructed to query the provider for more specific information if necessary
- Many times the condition requires a greater level of specificity
- This will assist in getting paid on subsequent visits as it identifies the medical necessity for follow up.
- If necessary document patient condition in narrative form instead of check off diagnosis on follow up visits



# Multiple injuries

- The most **severe** injury is the **principal** diagnosis
  - If injuries are equal in severity, use the code for which **definitive treatment** was provided as the primary diagnosis
  - Interpret "with" as indicating both sites are involved in the injury, and the term "and" means and/or (that either or both sites are involved)
  - Mention of fingers usually includes the thumb (but there are a few separate codes for injuries of the thumb).
  - Use E codes to document how injury or poisoning occurred, the intent (accidental or intentional), and the place where the injury occurred.



# Burn Coding Example

- **942** Burn of trunk
- *Excludes: scapular region (943.0-943.5) with fifth-digit 6*
- The following fifth-digit sub classification is for use with category **942**:
  - 0 trunk, unspecified site
    - 1 breast
    - 2 chest wall, excluding breast and nipple
    - 3 abdominal wall, Flank, Groin
    - 4 back [any part], Buttock, Interscapular region
    - 5 genitalia - Labium (majus) (minus), Penis, Perineum  
Scrotum ,Testis, Vulva
    - 9 other and multiple sites of trunk
- **942.0** Unspecified degree
- **942.1** Erythema [first degree]
- **942.2** Blisters, epidermal loss [second degree]
- **942.3** Full-thickness skin loss [third degree]



# Documentation for Burn Coding

- The preceding example indicates importance of **anatomic location** and **severity** of burn being documented
- Without this information correct ICD-9 code cannot be assigned.
- Documentation should also include area of **body surface burned** i.e. 20% of back, complete arm.
- Category 942 codes out to 5 digits
- 942 plus 4<sup>th</sup> digit for degree and 5<sup>th</sup> digit for location
- Example – second degree burn of the back would be 942.24



# Laceration Repairs

- Anatomic location, size and type of closure are required
- Specify if single or multiple layers were sutured
- Document condition of the wound i.e. heavily contaminated, infected
- Document if any reconstruction or re-approximation needed to be done
- If wound is irregular shape the size is the sum of all sutured edges



# Medical Necessity

- Diagnostic testing performed in the center should have the medical necessity for the testing documented
- Results from all diagnostic testing within the center should be documented in the medical record
- Any abnormal findings must be documented
- If performing a test to 'rule out' a condition, document condition being ruled out
- For testing being ordered outside of the center medical necessity for the order must be documented
- For x-rays the number of views taken must be documented



# Concise diagnosis documentation

- For each encounter, an assessment, clinical impression, or diagnosis should be documented.
- It may be stated or implied in documented decisions regarding management plans and/or further evaluation.
- For a presenting problem with an established diagnosis the record should reflect whether the problem is:
  - a) improved, well-controlled, resolving or resolved; or,
  - b) inadequately controlled, worsening or failing to change as expected.



# Concise diagnosis documentation

- For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of
  - differential diagnoses or
  - possible,
  - probable, or
  - rule out (R/O) diagnosis."
- The initiation of, or changes in, treatment should be documented.
- Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies and medications.



# Concise diagnosis documentation

- If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the encounter, the type of service, e.g., lab or X-ray, should be documented.
- The review of lab, radiology and/or other diagnostic tests should be documented.
- A simple notation such as 'WBC elevated' or 'chest X-ray unremarkable' is acceptable.
- A decision to obtain old records or decision to obtain additional history from the family or other source to supplement that obtained from the patient should be documented.



# Concise diagnosis documentation

- Relevant findings from the review of old records, and/or the receipt of additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.
- If there is no relevant information beyond that already obtained, that fact should be documented.
- A notation of 'old records reviewed' or 'additional history obtained from family' without elaboration is insufficient.
- The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.



# Supporting Level of Service

- All of the preceding documentation recommendations can assist in supporting level of medical decision making
- ICD-9 code alone may not indicate level of decision making
- i.e. patient has knee strain, provider ordering testing for suspected meniscal tear.
- Diagnosis is still knee strain but documentation of suspected condition and decision making can support level of service



# MA/Nurse Visit Documentation

- MA/Nurse visit documentation requires, at a minimum, the following information:
  - Reason for encounter – diagnosis
  - Name of treating provider
  - Documentation of services provided i.e. dressing change, blood pressure check
  - Documentation of communication to provider
  - Name and credentials of person performing the service.



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