

Insights to Coding and Data Quality

AHA Coding Clinic guidance: Code number in lieu of a diagnosis

by Girolamo “Jerome” Ingrande, RHIT, CCS, CHC

For those of you who are avid readers of the *CHIA Journal*, you may recall an article that was written as part of the March 2013 publication that centered around the advice published in the 1st Quarter 2012 *Coding Clinic* regarding a code number in lieu of a diagnosis. As a reminder, the exact language appearing in the 1st Qtr. 2012 publication read as follows:

Question

Since our facility has converted to an electronic health record, providers have the capability to list the ICD-9-CM diagnosis code instead of a descriptive diagnostic statement. Is there an official policy or guideline requiring providers to record a written diagnosis in lieu of an ICD-9-CM code number?

Answer

Yes, there are regulatory and accreditation directives that require providers to supply documentation in order to support code assignment. Providers need to have the ability to specifically document the patient’s diagnosis, condition and/or problem. Therefore, it is not appropriate for providers to list the code number or select a code number from a list of codes in place of a written diagnostic statement. ICD-9-CM is a statistical classification, per se, it is not a diagnosis. Some ICD-9-CM codes include multiple different clinical diagnoses and it can be of clinical importance to convey these diagnoses specifically in the record. Also some diagnoses require more than one ICD-9-CM code to fully convey. It is the provider’s responsibility to provide clear and legible documentation of a diagnosis, which is then translated to a code for external reporting purposes.

Because there was much debate and confusion among HIM/coding professionals, particularly from those within my own organization, I decided to seek clarification from the AHA Central Office in order to determine whether or not the published guidance was geared towards inpatient electronic health record (EHR) documentation and computerized physician order entry for inpatient services versus physician orders and requisitions for ancillary services in the outpatient setting. In a letter response, the AHA clarified that the advice published regarding the use of ICD-9-CM diagnosis codes instead of a descriptive diagnostic statement was referring specifically to “*appropriate health record documentation*” and went on to state “*Whether diagnosis codes are acceptable in lieu of a narrative diagnosis on provider orders for outpatient diagnostic services such as laboratory or radiology examinations is outside the purview of Coding Clinic.*”

However, because it is understood that when writing to the AHA Central Office, the subsequent advice provided can be applied only to the organization that was seeking clarification, members of the CHIA Coding and Data Quality Committee thought it would be best to write to *Coding Clinic* and seek clarification of our own. And the letter response received this past year provided the same guidance in that the AHA reiterated that “*Whether diagnosis codes are acceptable in lieu of narrative diagnoses on provider orders for outpatient diagnostic services such as laboratory or radiology examinations is outside the purview of Coding Clinic.*” As you can see,

the response provided to CHIA was consistent with the advice provided to my organization as well. And when comparing both pieces of guidance from the AHA, one can conclude that the original advice published in the 2012 *Coding Clinic* was in fact geared towards inpatient electronic health record (EHR) documentation and not necessarily outpatient ancillary services.

This is crucial because it is standard practice at many facilities to base outpatient code assignment on the physician order or requisition received which may contain only a numerical code instead of hand-written sign(s) or symptom(s). Both CMS and the OIG have been silent with respect to whether or not signs or symptoms must specifically be documented on the order or requisition up to this point. Therefore it may be in the best interest of your facility or organization to refer to specific payer policy or regulatory directives with regard to billing requirements.

References

AHA *Coding Clinic* for ICD-9-CM, First Quarter 2012, Page 6, American Hospital Association Central Office

Girolamo "Jerome" Ingrande, RHIT, CCS, CHC, Member, Coding and Data Quality Committee, is the System Director Coding Compliance, Dignity Health, San Diego, California.

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