FORESIGHT
Optometric Documentation & Coding Consultants

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Who are you trying to impress with all those diagnosis codes?

As optometry became more advanced and we took on the care of more and more ocular disease, our lists of diagnoses continued to grow…and GROW! As good historians, we seem to feel obligated to list every diagnosis the patient has in the assessment & plan, but but then we also link them to our billed procedure codes. Part of this process may be appropriate, but the later part is not necessary.

If you see any patients over the age of 65, you could likely create a huge list of diagnoses for each one of them. Even healthy patients with no complaints will often have cataracts, blepharitis, dermatochalasis, dry eye, MGD, pinguecula, etc. The question becomes: do you need to list every one of these in the A&P? What about during billing? Does it even matter? Some of it does matter, but not everything.

The appropriate questions to ask are:

1. What was the reason for visit?
2. Is the condition significant?
3. Did you address it with the patient that day?

A common condition we see every day is dermatochalasis. Most of the time it does not bother the patient, nor is it a health issue. You may make a note in the record, but if neither you nor the patient mention it, you may note it in the A&P. But there certainly is no reason to link it to the billed CPT code if nothing was done about it, and it was not the reason for visit. But what if the condition is more significant and it is an active disease? Does it need to be billed at every visit? The situation I'll often see when more diagnoses are billed than necessary is during short follow-up visits. Let's say a patient has AMD, cataracts, and glaucoma. They presented for a 6 month evaluation where you addressed everything, but her IOP's were elevated. You changed glaucoma therapies and asked her to return in 2-4 weeks for an IOP check. During the follow-up, the patient reports no new concerns and the new therapy is working. Do you need to list all her conditions again? The answer is no. During that follow-up you only assessed the glaucoma. Despite you actively monitoring several things, that day's visit was only for glaucoma and therefore that is the only diagnosis that would be listed.

Similarly, if a patient presents for a corneal abrasion and no other concerns, the only diagnosis that needs to be coded would be the abrasion. That was the reason for visit and why the care was provided. You would certainly document other findings, but if they were not addressed that day, there is no need to fill the claim with a slew of diagnoses. It doesn't help the claim get paid or increase your reimbursement.

Along with being precise in coding just the pertinent conditions, we often find charts will list not only the condition, but also symptoms. There are many ICD10 codes that describe the patient's symptoms. These are codes such as: ocular pain (H57), blurred vision (H53.8), headache (R51), diplopia (H53.2), etc. There are absolutely times for these codes, but that time is when no explanation for the symptom can be found. We don't need to code ocular pain if we found a corneal abrasion, or blurred vision when cataracts are the cause. Coding to the highest specificity is the proper way to report the reason for visit, not a list of conditions.

Taking a "need-to-know" position is a good way to looking at coding. Does the payer really need-to-know the patient has ten conditions? Or do they just need to know the primary Dx? Just because a condition has a code, doesn't mean you must code it. Providing accurate information to the payer is necessary, but listing a dozen conditions does nothing to improve patient care or the reimbursement outcome.