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ICD-10-CM-Getting In Sync on Coding Based on Provider's Statement

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Work From the Official Guideline Wording

The 2019 ICD-10-CM Official Guideline (OG) we're discussing here is I.A.19:

Code assignment and Clinical Criteria

The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

In other words: Coding is based on provider documentation because the provider (not the coder) is the one responsible for diagnosing the patient.

So What's the Issue?

Confusion may set in when it appears that the documentation for the case does not support current clinical criteria for the diagnosis that the provider records.

As a coder, your starting point should be this: "While physicians may use a particular clinical definition or set of clinical criteria to establish a diagnosis, the code is based on his/her documentation, not on a particular clinical definition or criteria." This quote is from AHA Coding Clinic® for ICD-10-CM and ICD-10-PCS (2016, vol. 3, no. 4).

Ex. If the doctor documents neuropathy, you should report the ICD-10-CM code for neuropathy regardless of whether the diagnosis is based on new clinical criteria, old clinical criteria, personal judgment, or something else.

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Don't miss: If a clinical validation reviewer later disagrees with the provider's diagnosis that you coded, that is not a coding error. That is a clinical issue.

Remember the flip side: Coders shouldn't be coding neuropathy in the absence of physician documentation because they believe the patient meets neuropathy clinical criteria.

Plan Ahead for Problem Cases

To sum up, the basic rule for the coder is to assign codes based on the provider's diagnostic statement. But the real world isn't always so straightforward. Consider the case of an experienced coder who has been working in a specialty for many years. If she can't follow how a doctor got to the final diagnosis based on what's documented, then it's possible an auditor for a payer won't be able to follow it either. And in that case, the auditor may determine that payment was inappropriate, meaning the payer will demand the money back. Such documentation is likely to be a problem in legal cases, too.

Consequently, it is to an organization's advantage to have a clear process for handling documentation that seems to not support the final diagnosis. Each person's role should be clearly defined, including coder, documenting provider, and possibly a provider assigned to be the reviewer in such cases. Additionally, documentation training can address specific weak areas that have been seen. Some examples may include making sure the record states why certain diagnostic criteria may not be relevant to the specific case, and spelling out the review of labs and other tests in the context of the patient's personal health status.

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Final note: If the coder thinks the diagnosis is clearly wrong, that's another issue all together. For instance, if the documentation shows a right toe fracture and the record indicates the patient has had his right leg amputated, then it's time for a query.