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Part B Insider (Multispecialty) Coding Alert

ICD-10 Coding: Don't Automatically Assign Admitting Diagnosis on Discharge Claims

A patient's diagnosis can change over the course of a hospitalization.

Just because a patient enters the hospital with one condition doesn't mean she'll have that diagnosis for her entire stay. And if you bill for your physician's hospital visits with an out-of-date diagnosis, you could lose money or face fraud charges.

The problem: Diagnoses can change in the hospital due to various reasons, including the following, among others:

- The physician may **narrow down the patient's problem**. For example, a patient may be admitted with chest pain, and the doctor may rule out myocardial infarction and decide the problem is actually gastrointestinal in nature.
- **The patient may develop other problems.** The patient may be admitted for dehydration problems but may start having chest pains.
- The **patient may experience complications** that lead their original complaint to worsen significantly.

You can't wait for the hospital to send you medical records and hope to bill in a timely fashion. You could be waiting six weeks **after** the patient gets out of the hospital for any records. So it's up to your physician to let you know if a patient's diagnosis has changed. Ensure that you have access to your physician's documentation via the EHR or other system so you can bill for his services based on the notes.

In addition, you should educate your physicians, and let them know that just because the patient has been admitted with a particular diagnosis doesn't mean they should bill for that diagnosis for each visit. They should check the diagnosis listed on the EHR or other charting tool for each visit because they could be addressing different conditions at each encounter.

Distinguish Admitting from Treating Dx

If your physician doesn't admit the patient to the hospital, then chances are the diagnosis he treats won't be the admitting diagnosis anyway.

For example: Your doctor performed gall-bladder surgery on the patient two months ago. Your doctor wouldn't know the patient was admitted for pneumonia, unless the admitting doctor called the surgeon in to check on the surgery. So your surgeon would bill under the post-operative gall bladder diagnosis, not pneumonia.

Watch out: If you're not billing with the most up-to-date diagnosis, you may not be able to justify a higher level of service. The patient may have been admitted with a simple problem and then developed complications, so a subsequent visit could have more complex medical decision-making. But you won't be able to justify a higher level code unless you know all the diagnoses.

Your best bet is to stay in close touch with the doctor during the patient's hospital stay, and make sure your entire coding team has access to all of the patient's records￿not just the admitting or discharge notes. This way, you can read

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all of the charts to ensure that you're assigning the right diagnosis code every time.

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