Beware Claims Coding Automation and Other Pitfalls

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Over the last several years, I have reviewed many provider records, claims and claim denials. I have noticed a few patterns, particularly in coding and with submitted claims that I find problematic. Some of these problems may stem from the electronic health records (EHR) automatically choosing the diagnosis codes and the order in which they appear on the insurance claim and/or in the medical record. I would caution providers to carefully review any auto-coding choice in their EHR systems.

In my experience, providers seem confused and conflicted on the type of care they are indicating they provide when it comes to the diagnoses on their claims and the documentation in their charts. The reason for any examination should be clearly documented in the medical record and should include the patient views of their condition(s) and/or symptoms. If a patient has multiple medical eye issues, all of the conditions should be documents in the visit record. Providers should not ignore or omit any of the patient's conditions during a visit, even if the visit is meant to focus only on one of the conditions. For example, if a patient coming in primarily for a glaucoma follow-up but has dry eye syndrome (DES) and dry ARMD, the provider might consider stating something similar to the following in the Problems section:

> Patient in for IOP check – glaucoma follow-up today. States taking drops regularly, mild stinging upon insertion but tolerable. Vision seems unchanged. Has DES, reports taking drops PRN when symptoms flare typically early am and end of day. Vision seems little changed with mild glare issues- has mild dry ARMD evaluated 3 months ago at last visit.

The examination should be appropriate for the purpose of the visit – IOP check. Typically, the provider would perform a slit lamp evaluation along with an IOP check during this visit and should evaluated the status of the DES during this examination. The final diagnoses should be listed in appropriate order – Glaucoma, DES and ARMD. If using Evaluation and Management codes, the coding choice would be based on the problems evaluated, the risk involved with treatment and, if any, the data reviewed. if using the General Ophthalmologic Codes), be based on the number of elements for the ocular evaluation performed. This example is more straight forward than a visit where a more comprehensive service is necessary. If the ARMD is not actively evaluated, this would NOT count toward the final code choice.

An examination for a patient with ongoing medical eye conditions and needs a refraction can also be problematic. Claims are often sent in with the refractive diagnosis listed as primary and only some of the medical eye conditions are listed second, third or even fourth on the claim. The medical conditions for which the examination is truly being performed should be listed in order of importance of the underlying reason for the visit and the impact on the ocular health of the individual. If a refraction is necessary and is performed, only then should the refractive diagnosis even be listed and is typically the last diagnosis on the claim. However, if the patient came in specifically for the refraction without other new or ongoing medical eye conditions, then the refractive diagnosis can be listed as primary.

I recently reviewed a medical record with the visit reason as glaucoma and the patient needed a refraction. The first two diagnoses on the claim, listed as A and B were refractive with the glaucoma diagnosis listed as C. The first diagnoses should have been H40.123 and then the two refractive diagnoses. The main reason(s) for the examination should never be the second or third diagnosis listed.

In another example, the patient was seen for a glaucoma follow-up. However, per the chart review, the patient also had keratitis sicca, Diabetes, cataracts and dermatochalasis. None of these other conditions were listed in the problems section of this examination even though a comprehensive service with dilation was performed with these issues evaluated. The problems section should have detailed each of these conditions. Each of these conditions should have been included in the Assessment and Plan. Each of these conditions should have been listed in the diagnosis section of the claim, with glaucoma being first on the list. Another example was a patient with Keratoconjunctivitis Sicca in for a follow-up also had a history of cataracts. Even though evaluated, there was no mention of the cataracts in the problems section of the examination nor in the Assessment and Plans section or the claim diagnoses.

In this time when insurance payors are utilizing AI to determine if a claim was properly coding, the diagnoses on that claim, along with the order of the diagnoses listing are more important than ever. All of the patient problems should be noted along with patient perceptions of their conditions, the A&P and the completeness and order of the diagnosis listed on the claim are vital. Do not “fall victim” to the ease of letting your EHR auto-coding lull you into complacency.
Happy Coding…