Pocket Coding Adviser

Coding Chronic Conditions

Coding correctly for diabetes, hypertension, or other chronic conditions depends on several circumstances, including the following:

- whether the diagnosis has been confirmed,
- whether the patient's current symptoms stem from the chronic condition, and
- whether the condition affects treatment choices for the current complaint.

Initial Visits "Rule-out" and suspected or probable diagnoses are not reportable in an outpatient or office setting. Until the diagnosis is confirmed, code the condition to the highest degree of certainty for the visit, e.g., signs and symptoms (780.0-799.9) or abnormal test results (790-796). Once a diagnosis has been established, choose the most precise code available. If possible, avoid ICD-9 codes that are designated as "unspecified" (usually those ending in a 9). Choosing the correct code for your claim makes it less likely that payors will deny payment after one or two visits, or will ask to review your progress notes.

Subsequent Visits Chronic diseases can be coded as often as a patient receives care and treatment for the condition, but that doesn't mean that you should code the condition every time the patient comes into the office. Too often, the same code is reported visit after visit when, in fact, progress notes show that a different problem was addressed during the encounter. Under these circumstances, list the chronic condition as an additional diagnosis on the claim only if it affects your management or treatment options for the presenting complaint. If it has no bearing, leave it off the claim.

TIP

Use V Codes to Tell the Whole Story

Noncompliant patients often require extra visits. In these cases, it is appropriate to code symptoms as well as the extenuating circumstances for the encounter. Example: Mr. Smith has been under your care for benign essential hypertension (401.1). He comes in complaining of headaches and dizziness. His blood pressure is elevated, and you learn that he has not been taking the medication you prescribed. On the claim you will report 784.0 (headache) and 780.4 (dizziness) followed by V15.81 (noncompliance with medical treatment). Your coding will clearly convey to the payor that this was not a routine follow-up visit.

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