Adding and Sorting DX Codes for Claims

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Overview

Adhering to CMS guidelines, OP allows up to 12 diagnosis codes per claim with a max of 4 per CPT code. Previously, only the diagnosis codes that were attached to a CPT code would be transmitted on a claim. Currently, the inclusion of the 12 codes has been expanded so that they are now all generated on the claim regardless of whether or not they are attached to a CPT code.

Additionally, users have the ability to auto-include BMI and Problem List diagnosis codes. This means that Providers should carefully consider the order in which the diagnosis codes appear in the Assessment section of their visit notes to ensure that the most relevant codes are being passed to the claim. Both of these settings can be saved as a preference using the **Save Active Form** button located in the Personalize tab, but this should be done with caution as Providers will then always need to sort diagnosis codes (see below).

How do diagnosis codes get to claims?

- As templates are applied
- As vaccines are administered
- As in-house labs are completed
- As surveys are completed
- If the **Auto-calculate BMI code** checkbox is checked in the **Assessment** section of the note and vitals are entered during the visit

- If the **Auto-copy problems to encounter diagnosis list** checkbox is check in the **Problem List** section of the note and problems are marked reviewed (either individually with the paper clip or by clicking **Mark Reviewed**).

📌 **Note**: With the exception of Labs and Surveys, all diagnosis codes are displayed in the Assessment section of the note.

How do I make sure my most important codes are included in the 12 spots on a claim?

OP first includes diagnoses that are attached to CPT codes. The remaining order is up to the provider coding the visit.

Remember, if you chose to **Auto-copy problems to encounter diagnosis list** for a patient with a number of problems, each diagnosis code will be added to the claim.

To sort the diagnosis codes, simply click in the **Sort** field of the **Assessment** section of the note and change the number to be higher or lower depending on where you want the code to appear in the list of importance.

Example:

Patient, Mariah Brown is seen for a Well Visit.

- Her visit is charted with a template containing 3 diagnosis codes: Z00.129, Z71.82, Z71.3
- Upon examination, the provider assesses that Mariah has a cough and ear infection. Using the "add encounter", the provider starts a sick note and applies the appropriate templates adding R05 and H60.92 to the encounter.
- The Provider chooses to auto-calculate BMI and add the diagnosis to the note: Z68.52
- Upon review of the Problem List, the Provider clicks the Mark Reviewed box and sends the diagnosis code for 5 problems listed in her Problem List to the superbill: F79, J45.31, J30.9, K21.9, L20.9.
- During the visit, 2 labs were completed and diagnoses were passed to the superbill: Z11.1 and Z41.8.
- A survey was completed during the visit: Z13.4
- Mariah was sick during her Well Visit and the diagnoses were passed to the superbill: R05 and H60.92.

There were a total of 14 diagnosis codes added to the visit.

Assessment
DX 1: Z71.82 Exercise counseling
DX 2: Z71.3 Dietary counseling and surveillance
DX 3: Z68.52 BMI pediatric, 5th - 85th percentile for age
DX 4: F79 Unspecified intellectual disabilities
DX 5: J45.31 Mild persistent asthma with (acute) exacerbation
DX 6: J30.9 Allergic rhinitis, unspecified
DX 7: L20.9 Atopic dermatitis, unspecified
DX 8: R05 Cough
DX 9: H60.92 Left otitis externa
DX 10: Z00.121 Encounter for routine child health exam with abnormal findings
DX 11: K21.9 Gastro-esophageal reflux disease without esophagitis

+ Survey = Z13.4
+ Labs = Z11.1 + Z41.8
=
14 DX Codes

We know that:

- Encounter diagnoses will be added because they are attached to the E/M Code - 3
- Lab diagnoses will be added because they are attached to the respective CPT Codes - 2
- Survey diagnosis will be added because it is attached to the CPT Code - 1
- Sick diagnoses will be added because they're attached to an encounter E/M - 2

That means that 8 of the 14 diagnosis codes will automatically hit the superbill.

Now, with 4 spots left and 6 more diagnosis codes, the Provider has a decision to make. What 2 codes are the least important to include on the claim? It may not always be very obvious what diagnosis codes are going to land on the superbill. For that reason it is recommended to always order the most important diagnosis codes at the top of the sort (or with the lowest sort number). The sort should be changed to the highest value for the 2 that are decided to be left off the claim.

Use this box to call out an example of the workflow being described in the section of the article that the note box is displayed.