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# Maximizing Diagnoses on Claims: Overview and FAQ

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## Maximizing Diagnoses on Claims: Overview and FAQ

Traditionally medical practices were taught to only report ICD diagnoses that were explicitly related to the reason for the visit. As payers have begun to risk adjust patients, they are looking to have *the whole picture* related to the patient. Currently, most payers are getting this information from claims data. Chart review is expensive, and the payer community is now looking to get as much information from the claim as possible.

Medicare drives most of this functionality. And once you are a Medicare beneficiary, you are a Medicare beneficiary for life. This means that if Medicare paid for your heart transplant 3 years ago, or your knee above the knee amputation for complicated diabetes 5 years ago, they have that information in their database. They know all of the claims they have paid on your behalf for everywhere you have received care since you were receiving Medicare benefits. They can more accurately risk adjust patients because they have a more comprehensive view of the patient's medical conditions.

This is not true for children who change insurance companies frequently based on parent employment/non-employment and being on/off different Medicaid MCO panels. Many times the payer only has a year or less worth of claims data on a pediatric patient. They are attempting to *make up their information gap* by requesting additional data. The least expensive way to do this is to gather additional data through claims submitted for current services.

For many years, the electronic claims standard (5010) has only allowed 4 diagnoses (ICD) per CPT and a total of 12 diagnosis per claim. This has made it challenging for practices to send more

complete information about the patient to the payer via claims. There is a proposed improvement to the 5010 standard to increase the allowable diagnoses to 12 per CPT, but that is several years away from implementation at best.

OP now allows up to 12 ICD diagnoses to be submitted to the payer electronically, including diagnoses not directly linked to a CPT code. How does this work?

As part of documenting a visit note, providers are able to list as many diagnoses in the assessment as they feel are relevant or necessary. They should make sure the most important are ranked the highest so they can be confident to be part of the electronic claims file since only 12 total diagnoses are able to be sent. It is also important to understand that OP adds ICD codes attached to CPTs that are reflective of work that is done by other members of the practice team. Consider that every vaccine administered by the clinical staff is automatically added to the superbill with the appropriate Z23 ICD. If your staff performs a hemoglobin at a visit, the CPT 85018 may be automatically associated with ICD Z13.

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## Which ICDs end up being sent with the claim?

Any ICDs directly linked to a CPT get first priority. Remember, only 4 diagnoses can be directly linked to any given CPT. When the superbill is converted to a claim, OP collects all CPT codes and their associated ICDs. If there is any leftover room, up to a total of 12 diagnoses, the additional open ICD slots are filled in ranking order until the maximum of 12 has been reached. Additional information is available on the Help Center: [Adding and Sorting Dx for Claims](#).

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## What is the best way to organize ICD codes on WELL VISITS?

It is important to first understand what ICDs your payers are looking for in order to fulfill their HEDIS measures and those that may lead to pay for performance (P4P) bonuses for your practices. Many payers are looking for evidence that during a well visit you have performed counseling regarding diet, counseling regarding exercise and for the appropriate BMI category. Some payers are looking for this information on CPTII codes, but many are looking for them as part of your E/M preventive medicine services.

If your payer is looking for the exercise/diet counseling codes, the best practice is to attach them

directly to age appropriate well visit templates:

Diagnoses:	Prim?	ICD-10 Description	ICD-10
<a href="#">Click here to add</a>			
<input type="checkbox"/>		Encounter for routine child health examination w/o abnormal findings	Z00.129
<input type="checkbox"/>		Dietary counseling and surveillance	Z71.3
<input type="checkbox"/>		Exercise counseling	Z71.82

OP automatically computes the appropriate BMI diagnosis and adds it to the well visit assessment if the appropriate preference is selected:

Template used: 4 years (default) <span style="float: right;">Complete List   Prior</span>			
Diagnoses: <input checked="" type="checkbox"/> Auto-calculate BMI code			
ICD-10 Description	ICD-10	SNOMED Description	Sort
<a href="#">Click here to add a new diagnosis</a>			
Encounter for routine child health examination w/o abnormal findings	Z00.129	Well child	21
Dietary counseling and surveillance	Z71.3	Dietary management surveillance	22
Exercise counseling	Z71.82	Exercises education, guidance, and counseling	23
BMI pediatric, 5th - 85th percentile for age	Z68.52		1000

The sort order on the right of the grid, gives relative ranking. The sort orders that come from well visit templates are always in the 20s. The BMI code is always 1,000. Any additional codes that are added to the note are ranked in order below the 1,000.


As part of a well visit, click the Mark Reviewed button on the Problem List, adds all of the problem list items that are active and tracking to the note. This is because the CPT definition of a well visit is to review all of the patients problems as part of the comprehensive well visit.

Flag as incomplete

**Problem List** + - ➔ Mark Reviewed 🖨 "No Problems"  Active only  Include EFR (0)

Problem List | Scanned Records

**PMFS History / Meds reviewed:**  Auto-copy problems to encounter diagnosis list

 Problem List Reviewed by Susan Kressly (305) 09/11/2019 21:48:45

- ECZEMA
- MILD PERSISTENT ASTHMA
- CELIAC DISEASE
- GLOBAL DEVELOPMENTAL DELAY
- SALMON PATCH NEVUS
- ACTIVE DENTAL CARIES
- CHRONIC CONSTIPATION
- 22Q11 PARTIAL MONOSOMY SYNDROME
- RECURRENT ACUTE OTITIS MEDIA

recurrent OM prior to BMTs 3/17

In addition, if the Auto-copy problems to encounter diagnosis list checkbox is selected (either saved as a preference for a well visit, or selected for any particular patient prior to reviewing the problem list/clicking the Marked Reviewed button), those same problems are added to the assessment in the same order as they are ranked in the problem list.

**Diagnoses:**  Auto-calculate BMI code

ICD-10 Description	ICD-10	SNOMED Description	Sort	Add PL
Click here to add a new diagnosis				
Encounter for routine child health examination w/o abnormal findings	Z00.129	Well child	21	<input type="checkbox"/>
Dietary counseling and surveillance	Z71.3	Dietary management surveillance	22	<input type="checkbox"/>
Exercise counseling	Z71.82	Exercises education, guidance, and counseling	23	<input type="checkbox"/>
BMI pediatric, 5th - 85th percentile for age	Z68.52		1000	<input type="checkbox"/>
Atopic dermatitis, unspecified	L20.9	ECZEMA	1001	<input type="checkbox"/>
Mild persistent asthma, uncomplicated	J45.30	Mild persistent asthma	1002	<input type="checkbox"/>
Celiac disease	K90.0	Celiac disease	1003	<input type="checkbox"/>
Delayed milestone in childhood	R62.0	Global developmental delay	1004	<input type="checkbox"/>
Congenital non-neoplastic nevus	Q82.5	Salmon patch nevus	1005	<input type="checkbox"/>
Dental caries, unspecified	K02.9	Active dental caries	1006	<input type="checkbox"/>
Constipation, unspecified	K59.00	Chronic constipation	1007	<input type="checkbox"/>
Di George's syndrome	D82.1	22q11 partial monosomy syndrome	1008	<input type="checkbox"/>
Otitis media, unspecified, bilateral	H66.93	RECURRENT ACUTE OTITIS MEDIA	1009	<input type="checkbox"/>

*Notice sort orders in order increasing from the BMI 1,000 sort position as problem list items were added to the assessment*

## What if I don't think the most important diagnoses are ranked highly and might not make it to the claim?

There are several choices. If providers are thoughtful about keeping their problem list ranking in order of importance, the most important diagnoses are on top when viewed on the chart as well as fall to the assessment with the most important ICDs ranked on top.

#	Subsection	Onset Date	Problem List Note	Status	Resolved	Updated	Privacy	Sort	Hide
Status: Active									
	PAST MEDICAL HISTORY		22q11 partial monosomy syndrome	Active		09/11/2019	Any staff member	1	<input type="checkbox"/>
	PAST MEDICAL HISTORY	09/11/2019	Celiac disease	Active		09/11/2019	Any staff member	2	<input type="checkbox"/>
	PAST MEDICAL HISTORY	09/11/2019	Mild persistent asthma	Active				3	<input type="checkbox"/>
	PAST MEDICAL HISTORY	09/11/2019	Global developmental delay	Active				4	<input type="checkbox"/>
	PAST MEDICAL HISTORY	09/11/2019	Active dental caries	Active				5	<input type="checkbox"/>
	PAST MEDICAL HISTORY	09/11/2019	Chronic constipation	Active				6	<input type="checkbox"/>
	PAST MEDICAL HISTORY	09/10/2019	ECZEMA	Active				7	<input type="checkbox"/>
	PAST MEDICAL HISTORY	09/11/2019	Salmon patch nevus	Active		09/11/2019	Any staff member	8	<input type="checkbox"/>
Status: Tracking									
	PAST MEDICAL HISTORY	09/11/2019	RECURRENT ACUTE OTITIS MEDIA recurrent OM prior to BMTs 3/17	Tracking	03/10/2017	09/11/2019	Any staff member	10	<input type="checkbox"/>

Sort numbers can be typed in this column on the problem list to place the most important diagnosis on the top of the list

Alternatively, providers can resort the diagnoses on the assessment tab. Exact numbers are not important. It is a relative position in the list that determines which ICDs are most likely to reach the payer via the electronic claim.

ICD-10 Description	ICD-10	SNOMED Description	Sort	Add PL
Encounter for routine child health examination w/o abnormal findings	Z00.129	Well child	21	<input type="checkbox"/>
Dietary counseling and surveillance	Z71.3	Dietary management surveillance	22	<input type="checkbox"/>
Exercise counseling	Z71.82	Exercises education, guidance, and counseling	23	<input type="checkbox"/>
BMI pediatric, 5th - 85th percentile for age	Z68.52		1000	<input type="checkbox"/>
Di George's syndrome	D82.1	22q11 partial monosomy syndrome	1001	<input type="checkbox"/>
Celiac disease	K90.0	Celiac disease	1003	<input type="checkbox"/>
Mild persistent asthma, uncomplicated	J45.30	Mild persistent asthma	1010	<input type="checkbox"/>
Delayed milestone in childhood	R62.0	Global developmental delay	1020	<input type="checkbox"/>
Otitis media, unspecified, bilateral	H66.93	RECURRENT ACUTE OTITIS MEDIA	1025	<input type="checkbox"/>
Dental caries, unspecified	K02.9	Active dental caries	1030	<input type="checkbox"/>
Constipation, unspecified	K59.00	Chronic constipation	1100	<input type="checkbox"/>
Atopic dermatitis, unspecified	L20.9	ECZEMA	2000	<input type="checkbox"/>
Congenital non-neoplastic nevus	Q82.5	Salmon patch nevus	2001	<input type="checkbox"/>

Numbers can be typed in this sort column and only their relative position to each other is meaningful in order to determine which are most likely to make the 12 ICDs that are part of the electronic claim file

The provider should always review which ICD codes are associated with the CPT on the coding tab and make any necessary adjustments.

CPT Code	Mod	CPT Description	Procedure Note	PN Edit	Units	DX 1	DX 2	DX 3	DX 4	EPSDT
99392		PREV VISIT, EST, AGE 1-4			1.0	Z00.129	Z71.3	Z71.82	Z68.52	

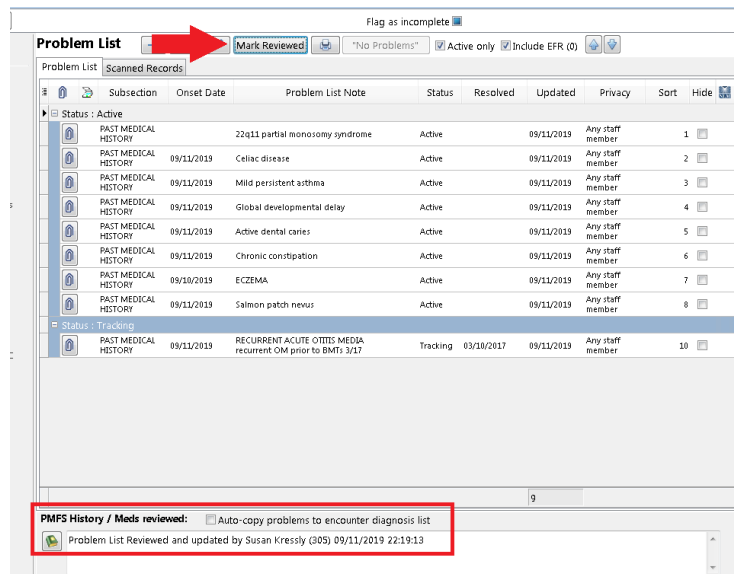
In general, well visits are the most appropriate time to give the payer the most complete picture of the patient's problems. Eventually, the payers are likely to ask us to provide additional information including social determinants of health ICD codes via the annual visit.

## What is the best practice for adding additional ICD codes to SICK VISITS?

Unless your payer is requesting comprehensive information as part of every visit (sick or well), there are additional considerations and implications for sick visits. It is likely appropriate and relevant to do a comprehensive review of the patient's problems as part of a new patient/initial sick visit, it is more

appropriate to include any relevant chronic/current medical problems which may have implications for the reason for the particular sick visit.

## Why does the Mark Reviewed button on the sick visit, only include a brief notation that the information was reviewed but does not add the entire problem list to the visit note?




This is intentional behavior for 2 reasons: review of history (which includes the problem list) needs to be relevant for the reason for the visit/chief complaint. If a patient is seen for a wart, review of chronic constipation is not relevant for the visit. In addition, adding an individual problem list item is equivalent to marking a history item *pertinent* and counts in the Coding Decision tab. This may cause unintentional overcoding if the problem reviewed is not relevant to the reason for the visit.

## How do I most appropriately add relevant problem list items to a sick visit note?

Based on the chief complaint and the reason for the visit, the provider should determine which relevant items should be added to the note by using the paperclip attachment on the problem list. If the provider wants these same diagnoses attached to the assessment to be sent with the claim, they should select the Auto-copy problems to encounter diagnosis list checkbox (either saved as a preference for an encounter/sick visit, or checked for any particular patient prior to attaching the problem to the note via the paperclip.)

**PMFS History / Meds reviewed:**  Auto-copy problems to encounter diagnosis list

 Problem List Reviewed and updated by Susan Kressly (305) 09/11/2019 22:19:13

Problem List Reviewed and updated by Susan Kressly (305) 09/11/2019 22:28:48  
 Pertinent for:  
 - CELIAC DISEASE

Problem List Reviewed and updated by Susan Kressly (305) 09/11/2019 22:28:50  
 - CHRONIC CONSTIPATION

In the example above, including celiac disease and chronic constipation would be relevant if this patient presented for a sick visit with the chief complaint of weight loss or abdominal pain. Notice that the word *Pertinent* is included in the notation.

## How are the sort order numbers added to the assessment tab in the sick note?

For sick visits, if problem list items are added prior to a template being selected for the visit, numbers are added in order as items are entered. Often in sick visits, the history and problem list is reviewed with the patient prior to the provider having a working diagnosis and choosing a template. Those problem list items are given sort numbers beginning with 1,001. The layered template item for sick visits starts with 1,021.

All templates: ABDOMINAL PAIN: GENERAL Complete List Prior Notes

**Assessment:** abdominal pain - with no signs of appendicitis nor obstruction Diag tests reviewed

**Diagnoses:**

ICD-10 Description	ICD-10	SNOMED Description	Sort	Add PL
Click here to add a new diagnosis				
ICDs from problem list items	K90.0	Celiac disease	1001	<input type="checkbox"/>
ICD from template	K59.00	Chronic constipation	1002	<input type="checkbox"/>
	R10.84	Generalized abdominal pain	1021	<input type="checkbox"/>

If the provider feels the primary diagnoses for the visit should be in the first position, they should adjust the sort numbers accordingly either in the assessment tab by typing appropriate sort numbers. The simplest way to reorder these diagnoses in the sort column is to remove the 10 in the beginning of the 1021 to make that template's sort number 21, which places it in the first position.

**Diagnoses:**

ICD-10 Description	ICD-10	SNOMED Description	Sort	Add PL
Click here to add a new diagnosis				
Generalized abdominal pain	R10.84	Generalized abdominal pain	21	<input type="checkbox"/>
Celiac disease	K90.0	Celiac disease	1001	<input type="checkbox"/>
Constipation, unspecified	K59.00	Chronic constipation	1002	<input type="checkbox"/>

Alternatively, the provider can choose more appropriate ordering for diagnoses on the coding tab:

Visit type:  Estab  New pt  Consult CPT code supported by documentation: **99214**

CPT Code	Mod	CPT Description	Procedure Note	PN Edit	Units	DX 1	DX 2	DX 3	D
99214		OFFICE/OUTPATIENT			1	K90.0	K59.00	R10.84	

K90.0	Celiac disease
K59.00	Constipation, unspecified
R10.84	Generalized abdominal pair
	[not applicable]

In reality, if there are only 4 ICD codes, the order is unlikely to be meaningful. If there are more than 4 diagnoses which are essential to convey the appropriate information to the payer, up to 12 total are be sent in the electronic file, even if they are not all attached to the CPT code.

Currently if the template is used prior to the problem list being reviewed in sick visits, the behavior is similar to the well visit. The template diagnoses begin with sort number 21 and the problem list items start with 1,0001.

**Diagnoses:**

ICD-10 Description	ICD-10	SNOMED Description	Sort	Add PL
Click here to add a new diagnosis				
Generalized abdominal pain	R10.84	Generalized abdominal pain	21	<input type="checkbox"/>
Celiac disease	K90.0	Celiac disease	1001	<input type="checkbox"/>
Constipation, unspecified	K59.00	Chronic constipation	1002	<input type="checkbox"/>

**NOTE:** Attempts will be made to change future versions of OP so that the template sort numbers are lower independent of whether problem list items attached prior to the template is applied or after.

## What happens if the provider adds an additional diagnosis that is not part of the problem list or the template?

Additional diagnoses hand-entered are assigned a sort order number sequentially after the problem list items. This is true for both well and sick visits.



Diagnoses:					
ICD-10 Description	ICD-10		SNOMED Description	Sort	Add PL
Click here to add a new diagnosis					
Generalized abdominal pain	R10.84		Gener:	21	<input type="checkbox"/>
Celiac disease	K90.0		Celiac	1001	<input type="checkbox"/>
Constipation, unspecified	K59.00		Chroni	1002	<input type="checkbox"/>
Anxiety disorder, unspecified	F41.9		Anxiety	1003	<input type="checkbox"/>

**Additional diagnoses hand entered, will be assigned a sort order in the next sequential order after added problem list items**

## What if my staff reviews and updates the problem list prior to the provider seeing the patient?

Since a comprehensive review of the problem list is relevant to the well visit, it is appropriate for team members to perform this work during well visits if this is your practice workflow. If your clinical team assists providers by reviewing the problem list at sick visits, the best practice is to do this work (on the patient chart, or within the sick visit note), but not attach every problem to the visit note via the paperclip. Non-provider clinical team members editing, reviewing and updating problems on the problem list can be accomplished, but the paperclip action to attach a particular problem to the visit note should be avoided by non-provider staff, or inappropriate information that is not relevant to the visit may be inadvertently added to the note and be counted in the coding calculator.

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