We are currently updating the OP Help Center content for the release of OP 14.19 or OP 19. OP 19 is a member of the certified OP 14 family of products (official version is 14.19.1), which you may see in your software (such as in Help > About) and in the Help Center tabs labeled 14.19. You may also notice that the version number in content and videos may not match the version of your software, and some procedural content may not match the workflow in your software. We appreciate your patience and understanding as we make these enhancements.

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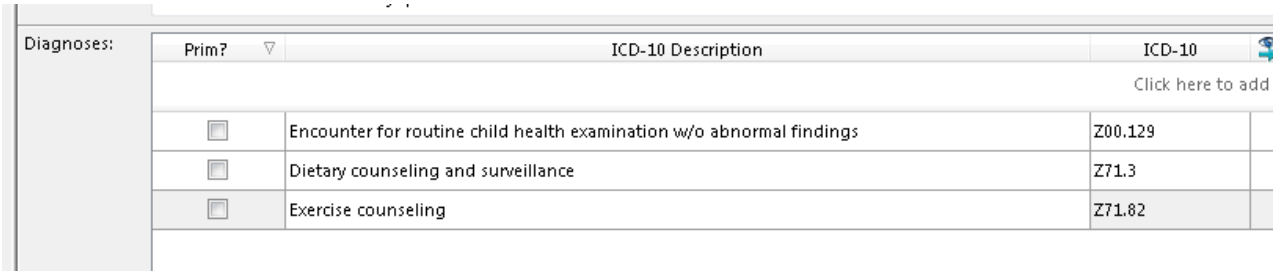
## What is the best way to organize ICD codes on WELL VISITS?

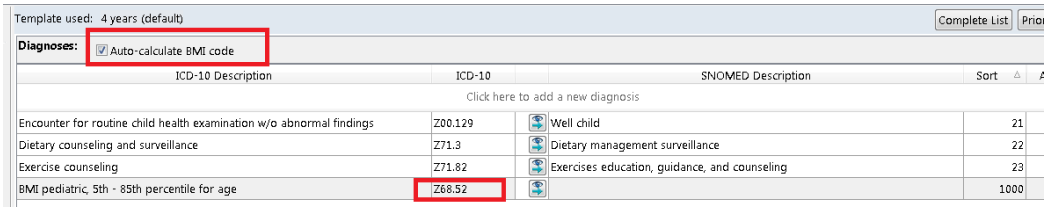
It is important to first understand what ICDs your payers are looking for in order to fulfill their HEDIS measures and those that may lead to pay for performance (P4P) bonuses for your practices. Many payers are looking for evidence that during a well visit you have performed counseling regarding diet, 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:

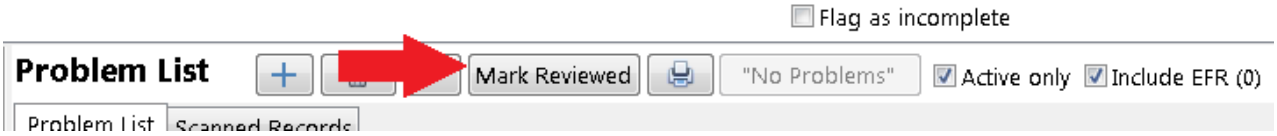


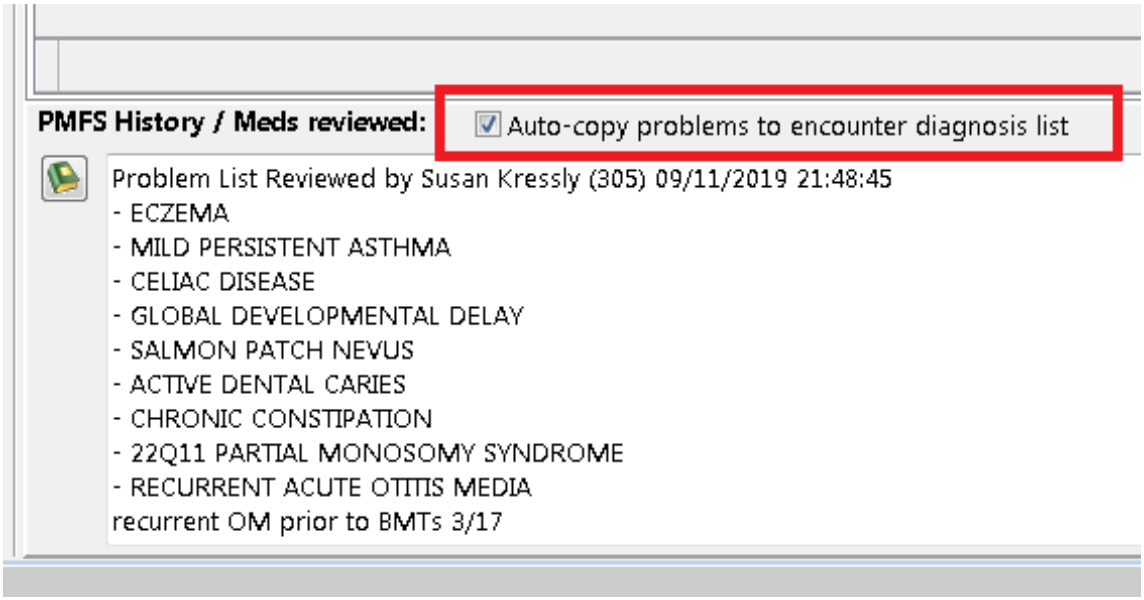

OP automatically computes the appropriate BMI diagnosis and adds it to the well visit assessment if the appropriate preference is selected:



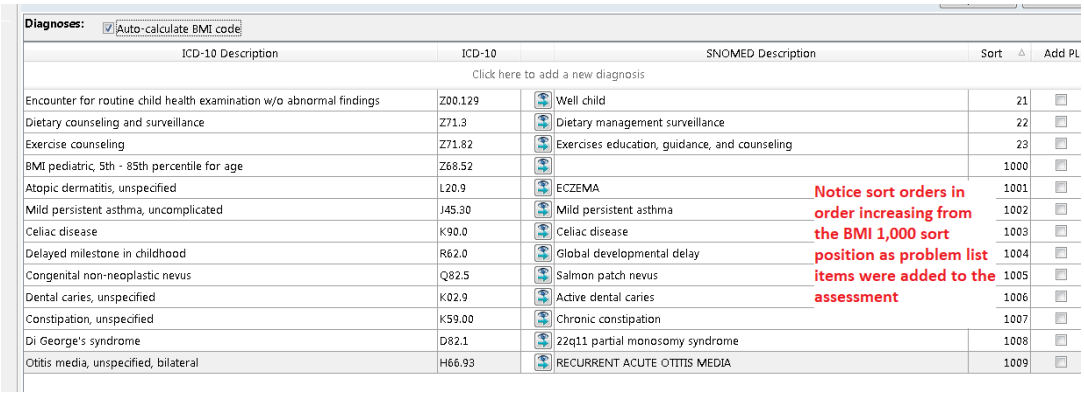

The sort order on the right of the grid, gives relative ranking. The sort orders that come from well visit templates are always in the 20s. The BMI code is always 1,000. Any additional codes that are added to the note are ranked in order below the 1,000.

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.



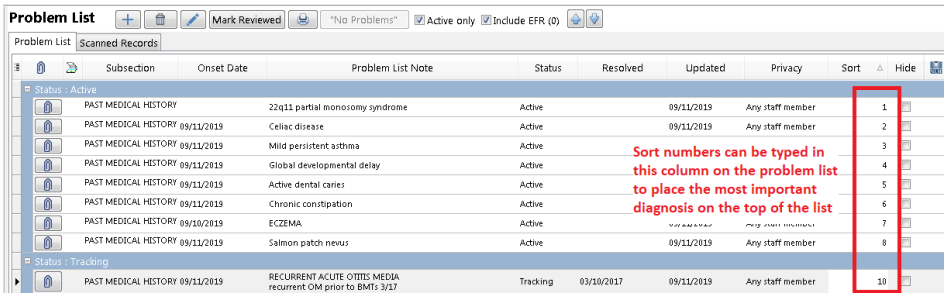



In addition, it the Auto-copy problems to encounter diagnosis list checkbox is selected (either saved as a preference for a well visit, or selected for any particular patient prior to reviewing the problem list/clicking the Marked Reviewed button), those same problems are added to the assessment in the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

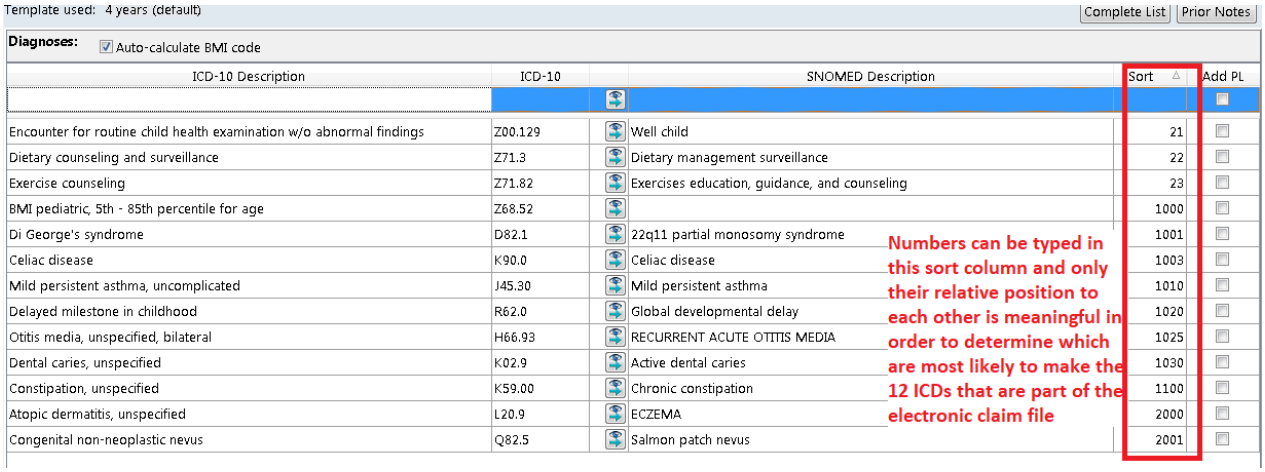



## What if I don't think the most important diagnoses are ranked highly and might not make it to the claim?

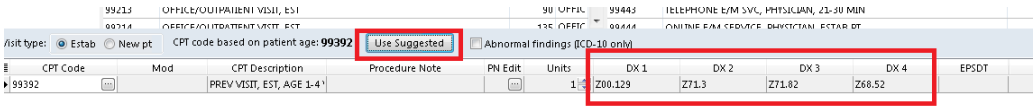
There are several choices. If providers are thoughtful about keeping their problem list ranking in order of importance, the most important diagnoses are on top when viewed on the chart as well as fall to the assessment with the most important ICDs ranked on top.




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.




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



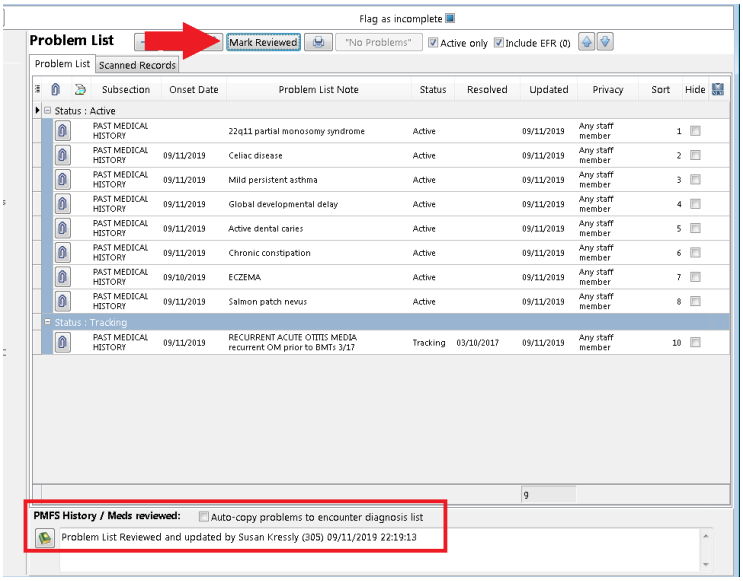

In general, well visits are the most appropriate time to give the payer the most complete picture of the patient's problems. Eventually, the payers are likely to ask us to provide additional information including social determinants of health ICD codes via the annual visit.

## 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.

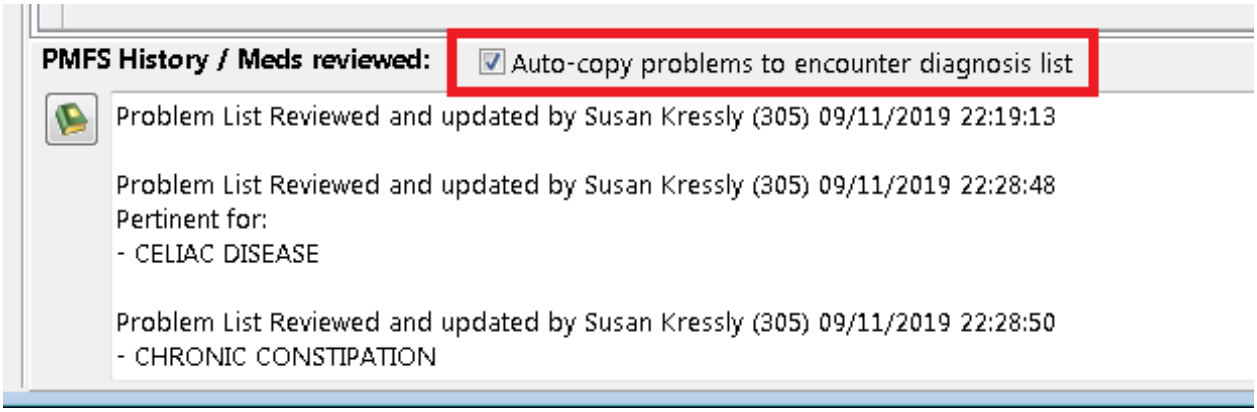
## Why does the Mark Reviewed button on the sick visit, only include a brief notation that the information was reviewed but does not add the entire problem list to the visit note?




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?

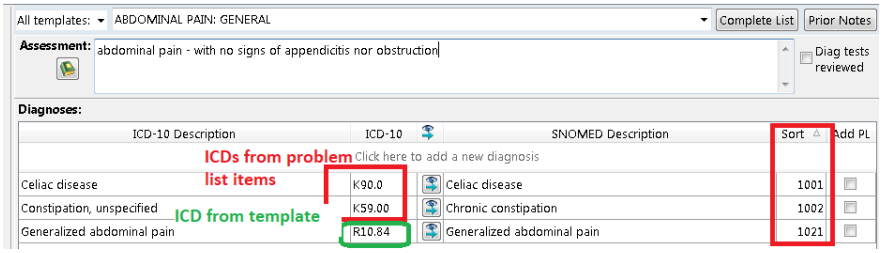
Based on the chief complaint and the reason for the visit, the provider should determine which relevant items should be added to the note by using the paperclip attachment on the problem list. If the provider wants these same diagnoses attached to the assessment to be sent with the claim, they should 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.)



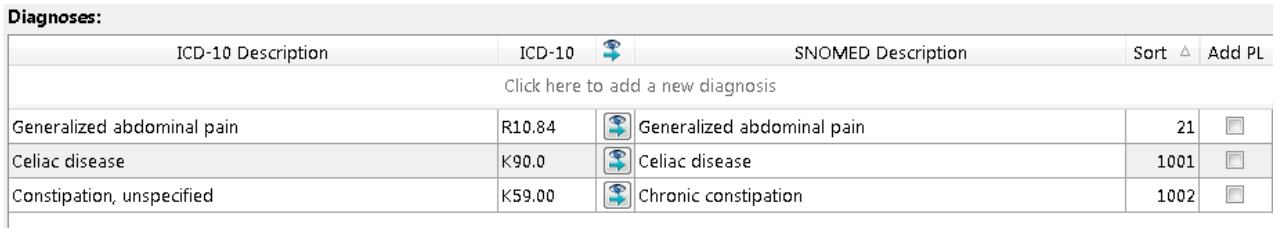

In the example above, including celiac disease and chronic constipation would be relevant if this patient presented for a sick visit with the chief complaint of weight loss or abdominal pain. Notice that the word *Pertinent* is included in the notation.

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

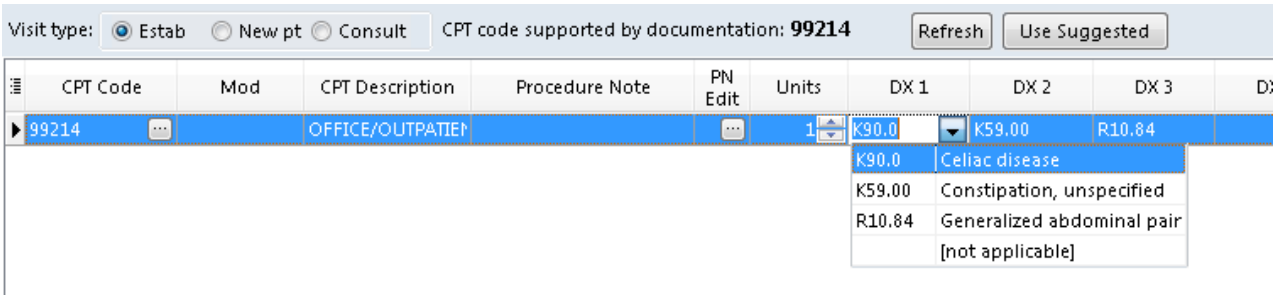
For sick visits, if problem list items are added prior to a template being selected for the visit, numbers are added in order as items are entered. Often in sick visits, the history and problem list is reviewed with the patient prior to the provider having a working diagnosis and choosing a template.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




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.

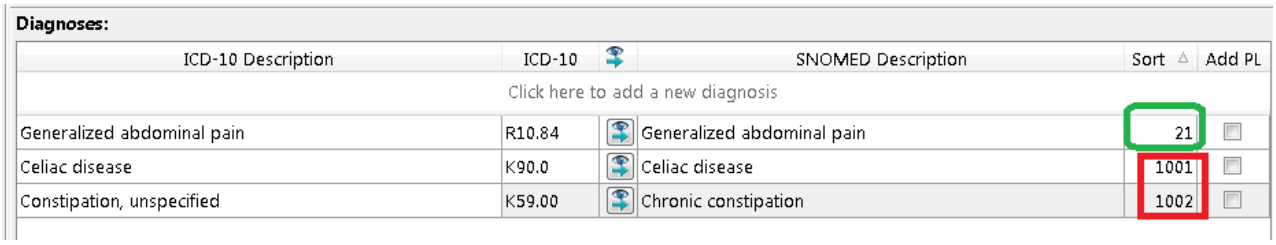



Alternatively, the provider can choose more appropriate ordering for diagnoses on the coding tab:




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.

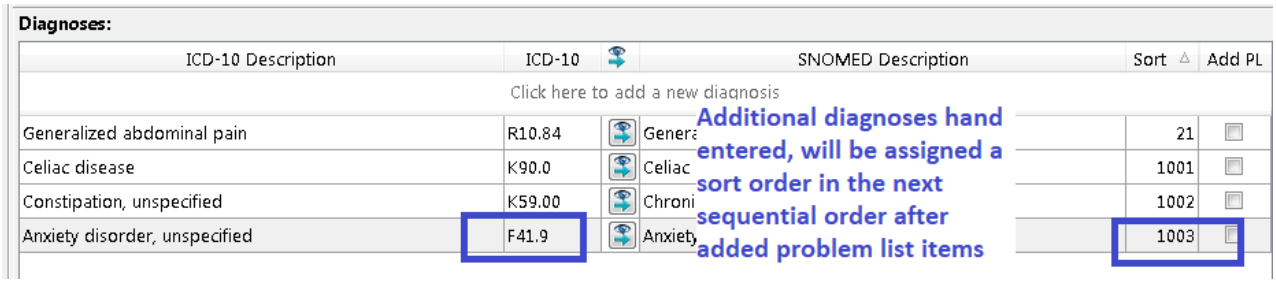
Currently if the template is used prior to the problem list being reviewed in sick visits, the behavior is similar to the well visit. The template diagnoses begin with sort number 21 and the problem list items start with 1,0001.




**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.




## 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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