COFFEE & CODING

Monday, January 29, 2024

Toxic diagnosis coding: What you may be missing

Three quick questions:

1. When did you last look in that little section towards the back of your ICD-10 coding book called the Drug Table?
2. How often have you coded an adverse reaction to a bug bite as W57.XXXA (Bitten or stung by nonvenomous insect and other nonvenomous arthropods, initial encounter) when documentation rules state that you should use more specific code sets?
3. What about coding for an actual drug reaction or anaphylactic reaction instead of using T78.7XXA (Unspecified adverse effect of drug or medicament, initial encounter)?

All these questions pertain to correct coding documentation, and proper documentation will save you from denied claims, internal audits from the insurance companies reviewing them, or much bigger and more intrusive audits from CMS.

How to avoid these "adverse outcomes?" In cases of insect bite reactions, the documentation should note the location, type, and reaction for the coder to apply the proper codes. In cases of reactions to prescription drugs, the documentation should note the specific drug and the reaction. If these details are missing, it becomes the coder's responsibility to query the provider so an addendum can be made to the record.

These codes are more important than we might think. The insurance companies need to know if a drug reaction resulted from an overdose (accidental or intentional) by the patient. **Why?** Because additional treatment or therapy is usually the next step and will need to be approved for the correct treatment and management of the patient's needs.

Another reason proper documentation and accurate coding are so important: Allergic reactions to medications must be documented for patients' safety.

This helps ensure that the problematic medication is not prescribed again; if the reaction is not noted, there could be an even more severe reaction the next time that may require hospitalization.

When documentation appears insufficient, the problem creates opportunities to open the door to better communication between the physician and the coder. Both parties have a continuous learning curve, and open dialogue promotes new learning.

So, coders, use that drug table in the ICD-10 manual. If your patient is stung by a bee, be sure to apply that specific diagnosis code. If the patient develops a reaction to sulfur, you are increasing their safety by making sure that that information is in the record.

My constant mantra bears repeating here once again: If it's not in the dictation, it did not happen.

And remember: Better communication makes for better documentation!

A correction:
Due to an editing error, in two references in last week's Coffee & Coding, we incorrectly described the new HCPCS code G0136 as a CPT code.

Got a question about E/M coding? We'd love to hear from you. Submit your questions by emailing us at coders@calmwatersai.com!

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