

Q. Has anyone considered whether or not patient requests for diagnosis code or procedure code changes would fall into the amendment provision? For example, insurance company denies a lab test because it is linked to diagnosis 1 instead of diagnosis 2. If you have documentation that supports both in the record, the claim is resubmitted with the proper diagnosis linked to the lab. I do not see this as requiring any type of amendment because by policy it would not be changed if not documented.

However, you have the gray areas of preventive medicine vs. office visit. Often the documentation can read either way. IF the procedure code is changed, does an amendment have to be formally done. Of if it is not changed and the patient requests the amendment, does the formal process have to begin.

A. I believe that the patient has the right to request amendment of diagnosis/procedure codes. Under HIPAA, the patient has the right to request amendment of PHI (may deny if not a part of DRS). PHI is individually identifiable health information. Health information is any information that . . . (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual. A primary purpose of assigning the diagnosis/procedure code is to obtain payment and it relates to the health or condition of the individual. (Sheila Wrobel, Privacy Officer, Nebraska Health System)