VIOLENCE FREE
MINNESOTA
THE COALITION TO END RELATIONSHIP ABUSE

Coding and Documentation for IPV

"A well-documented patient encounter should do the following: 1. Detail the reason for the visit, 2. Describe the symptoms or problems (if any) that prompted the visit, 3. Describe related health issues the patient is experiencing, 4. Summarize the patient's overall health history, 5. Record relevant findings from the physical exam, 6. Record results of laboratory and other diagnostic procedures, 7. Record options discussed with patients and referrals offered, and 8. Documents arrangements made for follow-up care"

What to Document

- Description of any physical injuries
  - Include photos when possible
- Description of patient's behavior and demeanor
- Date of incident or time elapsed since incident (if possible)
- Date and time of screening

How and Where to Document

- Use objective and factual wording (i.e. "pt states" or "pt reports")
  - Include only medical terminology
  - Do not use legal terms or suggestive terms and statements as only factual information should be conveyed
- Appropriate Coding
  - ICD-9 Codes
    - Have the *following functions*:
    - To describe the injury/illness for which the patient was seen
    - To describe the procedure(s) done during the visit
    - To establish a level of insurance reimbursement for specific procedures
    - To help researchers identify prevalence, severity, and costs associated with specific illnesses or injuries
    - To assist the health care professional in providing optimal care by better documenting diagnoses and procedures that have previously been performed
  - Interpreting the code:
    - Each code is 5 digits long
    - *First 3 digits*: describe the general problem
    - *Last 2 digits*: describe the situation in more detail - 4th and 5th digit codes describe the type of abuse – sexual, physical, etc.
  - ICD-10 Codes

        - Same function and interpretation as ICD-9 Codes
        - Used to track the prevalence and cost of specific health conditions (ICD-10-CM are the latest version of ICD codes)
    - ICD Coding related to Mental Health and DV/IPV
        - E-Codes
            - Used as modifier codes
            - Provide information regarding:
                - when and where the abuse occurred
                - to whom or by whom
                - how
            - Important in helping to codify the specific details of an abuse incident and the identity of the perpetrator
            - Specifies the problem being documented as DV as opposed to some other form of "adult maltreatment"
        - Providers are NOT REQUIRED to use E-codes in documentation
- History Codes
    - Provides information about the history of abuse or the need for counseling as a result of DV.
        - *cannot be used if the condition being described is still present*
- CPT Codes
    - no specific ICD-9 or CPT code for domestic and intimate partner violence (DV/IPV) screening
    - Possible to use code V82.89 (Special screening for other conditions; other specified conditions)
- Guide for usage
    - Use current ICD9 – CM codes for DV as the primary diagnosis
        - DV must be coded as the primary diagnosis when it has been discovered during a visit, regardless of other presenting conditions.
        - At minimum, DV should be coded as a secondary diagnosis.
        - Always include E-codes and V-codes as modifier codes when appropriate.
- Reimbursement and risks
    - Domestic violence codes yield very low reimbursement.
    - If used as the coding clinic recommends, hospitals, clinics and providers will be penalized for accurately documenting and treating DV
    - Capturing frequency can help identify patterns and possible escalations. If DV-specific ICD-9 codes are not used in combination with the above procedure codes, important information about the frequency of DV will not be captured, nor will we ascertain any information about health problems that are associated with DV
    - This will impact the quality of care you are able to provide when offering

options such as risk assessment, safety planning, or considering lethality risk

- Document in a safe, private place
    - Do not put documentation of abuse in public health records or anywhere that may be visible to partner