

Is it pulmonary edema or pleural effusion? Tips to avoid confusing medical acronyms

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While coders are forever urging physicians to give them more detail so they can use the most specific—and highest paying—codes, I'd like to use this month's column to focus on an even more basic coding issue: legibility problems, ambiguous acronyms, and a combination of the two. In the years I've spent as a coder, I've seen all kinds of abbreviations that are next to impossible to read, and acronyms that can have multiple meanings. When misinterpreted by a coder, these abbreviations and acronyms can not only skew your reimbursement, but create problems in the patient's health record.

The diagnosis codes we assign to patient care and services, for example, go far beyond the issues of getting a claim paid. On one level, they can affect your patients' abilities to obtain life or health insurance. They are also used to track epidemics and determine future research needs.

Here are some examples of the problems that can occur when codes are misunderstood, and some strategies to avoid them.

Legibility and acronyms

Physicians often write PUD to indicate peptic ulcer disease. Coders, however, may mistake this abbreviation for PVD, or peripheral vascular disease, changing the patient's condition to an entirely different body system!

Another huge mishap occurs when coders mistake nausea and vomiting (N/V) for "HIV." When "HIV" is erroneously coded on a record, it can create serious problems for the patient.

These are just two examples of how coders can mistake or confuse acronyms that seem crystal clear to physicians. For more examples of confusing acronyms, see the box on this page.

Downcoded services

When coders cannot identify an acronym or abbreviation, they typically send it back to the physician for clarification. When coders cannot clarify an acronym or abbreviation, the particular diagnosis cannot be coded to justify the hospital service.

In these circumstances, payers may downcode services if medical necessity (as indicated through diagnoses codes) does not support the service that is being billed.

To avoid these situations, make a list of the acronyms you commonly use and what they mean to you. Give this list to your medical coder or any billing service you use.

Coders can keep this list on file and use it when coding records. Make sure you regularly update the list and add any modifications.

The bottom line is that medical coders should never try to make assumptions about the condition that physicians were trying to report. That's why it's critical to give them the information up front. **TH**

Acronyms

Coders frequently come across acronyms that can have several different meanings. Here are a few examples:

- **ARF:** Acute renal failure or acute respiratory failure?
- **CRI:** Chronic renal insufficiency or chronic respiratory insufficiency?
- **PE:** Pulmonary edema, pulmonary emboli or pleural effusion?
- **AVR:** Status post aortic valve replacement or aortic valve regurgitation?
- **MVR:** Status post mitral valve replacement or mitral valve regurgitation?

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