DX Codes in PT, OT, and SLP Visits

Guidelines for Best Practice and Compliance

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Best Practice

1–4 DX codes per visit is standard.

Always include a primary diagnosis that best supports the treatment that day.

Add 1–3 supporting codes if they directly impact the plan of care, goals, or medical necessity.

Why This Matters

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Medical Necessity & Coverage

- The primary code justifies the skilled therapy.
- Supporting codes show complicating factors (e.g., comorbidities, functional limitations).
- Payers check that treatment matches diagnosis.

Payer Guidelines

- Medicare allows multiple DX codes but requires tie to covered diagnoses.
- Commercial/Medicaid/WC typically limit to 4 codes per visit.

Clinical Accuracy

- Too few codes may understate complexity.
- Too many codes may look like 'diagnosis dumping.'

Why Avoid More Than 8 DX Codes

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Claim Rejections: Many payers accept only 8–12 codes, extras may be cut off.

Audit Risk: Too many codes can look like claim padding.

Medical Necessity Issues: Unrelated codes confuse payers and may lead to denials.

Documentation Burden: Each DX requires justification, creating extra work.

Rule of Thumb

Always list the most relevant primary diagnosis first.

Use only diagnoses that support the therapy provided that day.

Keep it concise: ideally 1–4 codes, rarely more than 8.

Keeps documentation clean, compliant, and defensible.

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? FAQ: DX Code Usage

Q: Do I need to use the same DX codes every visit?

A: Not necessarily. Use the codes that support the treatment provided that day.

Q: What if the patient has many comorbidities?

A: Only list those that impact therapy goals or treatment.

Q: Can I rotate codes between visits?

A: Yes, if different codes better support the skilled care on that date of service.

Q: Why not list every diagnosis the patient has?

A: Unrelated codes increase audit risk and may cause claim denials.

Q: What's the safe maximum?

A: 1–4 is ideal; avoid more than 8 per visit.