Physician Querying . . . Being Successful and Compliant

Webinar
March 20, 2018

Speaker

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AHIMA-Approved ICD-10 PCS/CM Trainer
Independent HIM Coding Consultant
HIM Coding Subject Matter Expert

Ms. Bryant is a sought-after advisor, mentor, national educator, speaker and author on healthcare compliance, ethics, reimbursement, clinical documentation improvement, physician querying, coding regulations (ICD-10 -CM/PCS , CPT, MS-DRGs, and HCCs), coding compliance and ethics.

She serves as a volunteer on several levels and is a catalyst for quality coded data, integrity, and improvement in HIM & Coding across all of healthcare.

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Disclaimer

- This material is designed and provided to communicate information about compliance, ethics and coding in an educational format and manner.
- The author is not providing or offering legal advice, but rather practical and useful information and tools to achieve compliant results in the area of compliance, ethics, clinical documentation, data quality, and coding.
- Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful.

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Goals/Objectives

- **Review** the history of industry *Query Guidance*.
- **Understand** key compliance risks and vulnerabilities.
- **Enhance** knowledge of key AHA Coding Clinic advice.
- **Learn** Physician Query improvements for success and being compliant.

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Background: Query History & Regulatory Scrutiny

HIM Coding has since DRGs started (1983/84) been utilizing a physician query – Physician Attestation was also used .

- This might be verbal or … as the years went by, in the 1990's "forms" and notes were created .

- Concerns in 1998-2000 rose with "Up Coding" and OIG investigations
- "Some" Clinical Documentation Improvement activities began to focus on the concurrent timeframe
- **CMS January 2001** PROs (QIO) directed not to accept Query Forms and addendums
- PROs were concerned and CMS held Town Hall Meeting on July 2001
- **CMS October 2001** directive allowed consideration of Query Forms… **if** … Certain steps and elements were in place and they were "Not leading"

- **2001 Per DHHS (Department of Health & Human Services) Office of Clinical Standards and Quality – (PRO 2001-13)**
  - Query forms should be:
    - Clearly and concisely written
    - Contain precise language
    - Present the facts and identify why the clarification is needed
    - Present the scenario
- **2001 AHIMA Practice Brief on Physician Query**

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AHIMA Practice Brief 2001

AHIMA Developing a Physician Query Process (2001)

This practice brief has been updated. See the latest version here. This version is made available for historical purposes only.

Editor's note: An updated version of this practice brief was published as "Managing an Effective Query Process".

Principles of Medical Record Documentation

Medical record documentation is used for a multitude of purposes, including:

- serving as a means of communication between the physician and the other members of the healthcare team providing care to the patient
- serving as a basis for evaluating the adequacy and appropriateness of patient care
- providing data to support insurance claims
- assisting in protecting the legal interests of patients, healthcare professionals, and healthcare facilities
- providing clinical data for research and education

To support these various uses, it is imperative that medical record documentation be complete, accurate, and timely. Facilities are expected to comply with a number of standards regarding medical record completion and content promulgated by multiple regulatory agencies.

Joint Commission on Accreditation of Healthcare Organizations

The Joint Commission's *2000 Hospital Accreditation Standards* state, "the medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity among health care providers" (IM.7.2). The Joint Commission Standards also state, "medical record data and information are managed in a timely manner" (IM.7.6).

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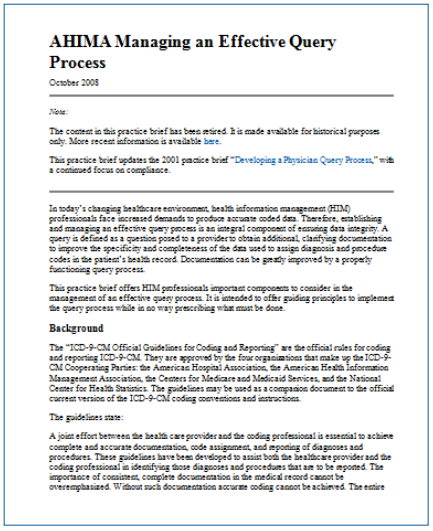
History (cont.)

- Between 2001 and 2008 HIM and Providers were "doing the best they could"
- Real emergence of Clinical Documentation Improvement Programs or CDI 2000-2008
- Greater compliance scrutiny with HIM Coding Queries and CDI
- **AHIMA 2008** Practice Brief on "Managing the Physician Query Process "
- AND ….Greater scrutiny compliance again with HIM Coding Queries and CDI
- **AHIMA 2010** CDI Program Guidance



AHIMA Managing an Effective Query Process

October 2008

Note:

The content in this practice brief has been retired. It is made available for historical purposes only. More recent information is available here.

This practice brief updates the 2001 practice brief "Developing a Physician Query Process," with a continued focus on compliance.

In today's changing healthcare environment, health information management (HIM) professionals face increased demands to produce accurate coded data. Therefore, establishing and managing an effective query process is an integral component of ensuring data integrity. A query is defined as a question posed to a provider to obtain additional, clarifying documentation to improve the specificity and completeness of the data used to assign diagnosis and procedure codes in the patient's health record. Documentation can be greatly improved by a properly functioning query process.

This practice brief offers HIM professionals important components to consider in the management of an effective query process. It is intended to offer guiding principles to implement the query process while in no way prescribing what must be done.

Background

The "ICD-9-CM Official Guidelines for Coding and Reporting" are the official rules for coding and reporting ICD-9-CM. They are approved by the four organizations that make up the ICD-9-CM Cooperating Parties: the American Hospital Association, the American Health Information Management Association, the Centers for Medicare and Medicaid Services, and the National Center for Health Statistics. The guidelines may be used as a companion document to the official current version of the ICD-9-CM coding conventions and instructions.

The guidelines state:

A joint effort between the health care provider and the coding professional is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coding professional in identifying those diagnoses and procedures that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire

AHIMA Practice Brief 2008

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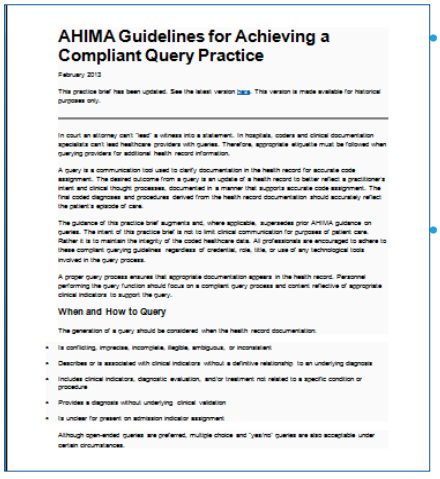
AHIMA Guidance: CDI Programs

- **May 2010 - Guidance for Clinical Documentation Improvement Programs**
- Healthcare consumers are unique. Each person has his or her own combination of medical conditions that organizations must somehow standardize for data comparison. One way to capture these data is by translating clinical documentation into codes such as ICD-9-CM and CPT.
- Historically, in the inpatient setting, data collection occurred after the patient was discharged. After discharge, HIM professionals checked the record for discrepancies that could hinder code assignment. HIM professionals would then query the provider for clarification. (For purposes of this practice brief, the term "query" will be used to identify any physician communication tool.)
- However, with the implementation of the prospective payment system, coded data took on greater significance and became a mechanism for reimbursement, quality measure reporting, and profiling. The increased need for interpreting coded data for meaningful comparison and quality reporting has led to the expansion of the HIM professional's role in clinical documentation improvement (CDI).
- The focus of most CDI programs is on improving the quality of clinical documentation regardless of its impact on revenue. Arguably, the most vital role of a CDI program is facilitating an accurate representation of healthcare services through complete and accurate reporting of diagnoses and procedures

AHIMA Practice Brief 2013



AHIMA Guidelines for Achieving a Compliant Query Practice

February 2013

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In court an attorney can't "lead" a witness into a statement. In hospitals, coders and clinical documentation specialists can't lead healthcare providers with queries. Therefore, appropriate etiquette must be followed when querying providers for additional health record information.

A query is a communication tool used to clarify documentation in the health record for accurate code assignment. The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment. The final coded diagnoses and procedures derived from the health record documentation should accurately reflect the patient's episode of care.

This guidance of this practice brief augments and, where applicable, supersedes prior AHIMA guidance on queries. The intent of this practice brief is not to limit clinical communication for purposes of patient care. Rather it is to maintain the integrity of the coded healthcare data. All professionals are encouraged to adhere to these compliant querying guidelines regardless of credential, role, title, or use of any technological tools involved in the query process.

A proper query process ensures that appropriate documentation appears in the health record. Personnel performing the query function should focus on a compliant query process and content reflective of appropriate clinical indicators to support the query.

When and How to Query

The generation of a query should be considered when the health record documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
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Although open-ended queries are preferred, multiple choice and "yes/no" queries are also acceptable under certain circumstances.

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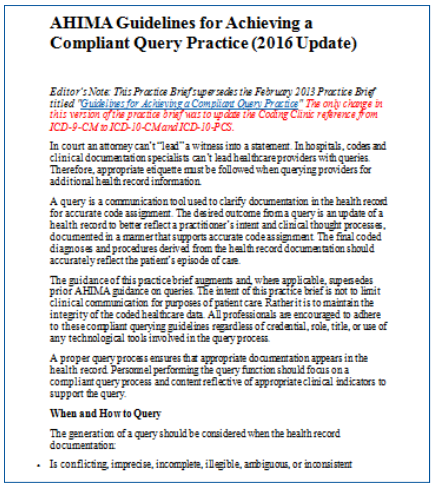
AHIMA Practice Brief 2016



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Risk and Concerns with "Leading Queries. What is *"leading"*?

- "Leading" is implied when the expected answer is in the question.
- Giving the expected answer to the question
  - Examples:
    - Was the chest pain caused by unstable angina?
    - Was the patient on Lasix to treat CHF?
    - The patient was dehydrated, correct?
- Caution with wording of both written and verbal queries.

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Do We Really Have A Problem . . . ?

- There are 1.2 billion outpatient and physician office visits per year in the U.S. Research shows that between 10 and 70 percent of patient medical records contain documentation that is of poor quality, or on average about 45 percent.
- **Therefore, each year, about 500 million patient record entries are created that contain poor quality clinical documentation.**
- Source: CDMatters

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Do We Have A Problem? . . . Study Related to Documentation

- In a survey conducted by DJ Iber Publishing, a third of organizations reported that their concurrent query rates were between 10 and 24 percent, and another 22 percent of organizations reported that their concurrent query rates were between 25 and 35 percent.
- In a study published in the *Journal of Bone and Joint Surgery*, the researchers note that a possible reason for the widespread lack of proper documentation is a lack of emphasis on careful documentation in medical school, residency, and physician practices.

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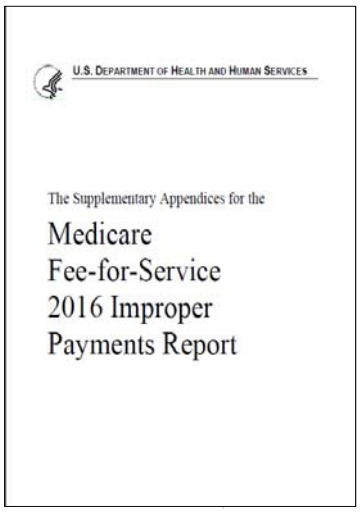
HHS Report: Medicare FFS Improper Payments



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Supplementary Appendices for the

Medicare Fee-for-Service 2016 Improper Payments Report

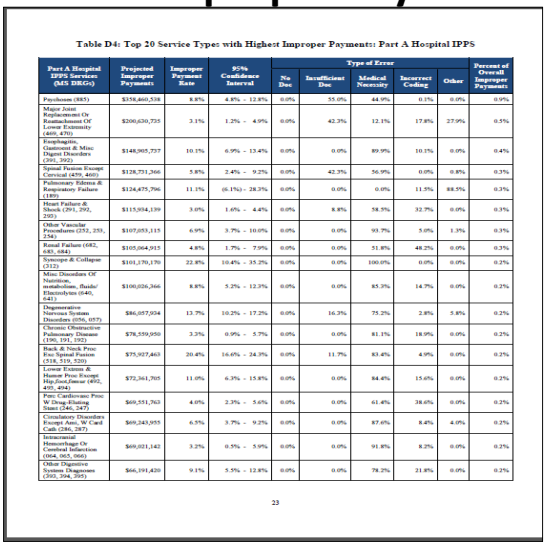


Table D4: Top 20 Service Types with Highest Improper Payments: Part A Hospital IPPS

Part A Hospital IPPS Services (MS DRGs)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Type of Error					Percent of Overall Improper Payments
				No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Psychoses (885)	$358,460,536	8.8%	4.8% - 12.8%	0.0%	55.0%	44.9%	0.1%	0.0%	0.9%
Major Joint Replacement Or Reattachment Of Lower Extremity (469, 470)	$200,630,735	3.1%	1.2% - 4.9%	0.0%	42.3%	12.1%	17.8%	27.9%	0.5%
Esophagitis, Gastroent & Misc Digest Disorders (391, 392)	$148,905,727	10.1%	6.9% - 13.4%	0.0%	0.0%	89.9%	10.1%	0.0%	0.4%
Spinal Fusion Except Cervical (459, 460)	$128,731,366	5.8%	2.4% - 9.2%	0.0%	42.3%	56.9%	0.0%	0.8%	0.3%
Pulmonary Edema & Respiratory Failure (189)	$124,475,796	11.1%	(6.1%) - 28.3%	0.0%	0.0%	0.0%	11.5%	88.5%	0.3%
Heart Failure & Shock (291, 292, 293)	$115,934,139	3.0%	1.6% - 4.4%	0.0%	8.8%	58.5%	32.7%	0.0%	0.3%
Other Vascular Procedures (252, 253, 254)	$107,053,115	6.9%	3.7% - 10.0%	0.0%	0.0%	93.7%	5.0%	1.3%	0.3%
Renal Failure (682, 683, 684)	$105,064,915	4.8%	1.7% - 7.9%	0.0%	0.0%	51.8%	48.2%	0.0%	0.3%
Syncope & Collapse (312)	$101,370,170	22.8%	10.4% - 35.2%	0.0%	0.0%	100.0%	0.0%	0.0%	0.2%
Misc Disorders Of Nutrition, metabolism, fluids/ Electrolytes (640, 641)	$100,026,366	8.8%	5.2% - 12.3%	0.0%	0.0%	85.3%	14.7%	0.0%	0.2%
Degenerative Nervous System Disorders (056, 057)	$86,057,934	13.7%	10.2% - 17.2%	0.0%	16.3%	75.2%	2.8%	5.8%	0.2%
Chronic Obstructive Pulmonary Disease (190, 191, 192)	$78,559,950	3.2%	0.9% - 5.7%	0.0%	0.0%	81.1%	18.9%	0.0%	0.2%
Back & Neck Proc Exc Spinal Fusion (518, 519, 520)	$75,927,463	20.4%	16.6% - 24.3%	0.0%	11.7%	83.4%	4.9%	0.0%	0.2%
Lower Extrem & Humer Proc Except Hip,foot,femur (492, 493, 494)	$72,361,705	11.0%	6.3% - 15.8%	0.0%	0.0%	84.4%	15.6%	0.0%	0.2%
Perc Cardiovasc Proc W Drug-Eluting Stent (246, 247)	$69,551,763	4.0%	2.3% - 5.6%	0.0%	0.0%	61.4%	38.6%	0.0%	0.2%
Circulatory Disorders Except Amc, W Card Cath (284, 285)	$69,243,955	6.5%	3.7% - 9.2%	0.0%	0.0%	87.6%	8.4%	4.0%	0.2%
Intracranial Hemorrhage Or Cerebral Infarction (064, 065, 066)	$69,021,142	3.2%	0.5% - 5.9%	0.0%	0.0%	91.8%	8.2%	0.0%	0.2%
Other Digestive System Diagnoses (202, 204, 205)	$66,191,420	9.1%	5.5% - 12.8%	0.0%	0.0%	78.2%	21.8%	0.0%	0.2%

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Medicare Payment Accuracy: Linked to "Coding"

Government publishes information on federal programs that are targeted for payment accuracy.

- This information shares the findings from government audits.
- Improper payments occur when either:
  - Federal funds go to the wrong recipient,
  - the recipient receives the incorrect amount of funds (either an underpayment or overpayment),
  - **documentation is not available to support a payment**, or
  - the recipient uses Federal funds in an improper manner.

https://paymentaccuracy.gov


Payment Accuracy.gov

HIGH-PRIORITY PROGRAMS | FAQ | RESOURCES

High-Priority Programs

OMB has designated the following programs as "high-priority". The criteria for determining when a program is high-priority are found in OMB Guidance Circular A-123, Appendix C. The high-priority programs are those programs that report $750 million or more in improper payments in a given year, did not report an error amount in the current reporting year but previously reported an error amount over the threshold, or have not yet established a program error rate and have measured components that were above the threshold.

Select a program from the list below to view program details:

Program	Agency	Total Payments (outlays)	Improper Payment Amounts	Improper Payment Rates
Retirement, Survivors, and Disability Insurance (RSDI)	Social Security Administration	$911.2B	$2.6B	0.28%
Medicare Fee-for-Service	Department of Health and Human Services	$380.8B	$36.2B	9.51%
Medicaid	Department of Health and Human Services	$363.8B	$36.7B	10.1%
Medicare Advantage (Part C)	Department of Health and Human Services	$172.8B	$14.4B	8.31%
William D. Ford Federal Direct Loan Program	U.S. Department of Education	$95.4B	$3.9B	4.05%

PaymentAccuracy.Gov

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- Under the Medicare Advantage (MA) Program, also known as Medicare Part C, there are more than **19 million beneficiaries enrolled.**

Total Payments	Improper Payments	Improper Payment Rate
$172.8B	$14.4B	8.31%

Supplemental Measures		
High-Risk Hierarchical Condition Categories	**Current Measure**: 3.3% **Target**: 3.3%	**Update Frequency**: Annually **Data Current as of**: November 2017

PaymentAccuracy.Gov - cont.:

- This annual supplemental measure analyzes the ten CMS Hierarchical Condition Categories (CMS-HCCs) that **have the highest rates of error**. CMS-HCCs are the disease groups that determine the disease component of **risk-adjustment payment.**
- **The ten condition categories that make up this measure for FY 2017 are:**
  1. Ischemic or Unspecified Stroke
  2. Cerebral Hemorrhage
  3. Aspiration and Specified Bacterial Pneumonias
  4. Unstable Angina and Other Acute Ischemic Heart Disease
  5. End-Stage Liver Disease
  6. Diabetes with Opthalmologic or Unspecified Manifestation
  7. Drug/Alcohol Psychosis
  8. Lung, Upper Digestive Tract, Other Severe Cancers
  9. Vascular Disease with Complications
  10. Major Complications of Medicare ad Trauma

Documentation and Diagnostic Coding Risk Areas.

Do We Need to Query the Physician? . . . Yes!

- Fact and Reality is: Clinical terminology and the **classification system** terminology in coding (ICD-10-CM And CPT):
  - Lack of sufficient documentation or no documentation to support the healthcare claim/charges;
  - Documentation and charges did not meet medical necessity;
  - Documentation that is conflicting, contrasting, or ambiguous;
  - Documentation is nonspecific;
  - Reimbursements systems are “CODE DEPENDENT”;
  - Quality Reporting is becoming “Code Dependent” also.

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Yes, We Need to Query The Physician!

- Querying for proper documentation is crucial to patient care, risk management, Quality scores (measures), coding, and billing.
- Not all documentation is complete at the time of the encounter/visit or at the time of coding.
- Joint Commission and Medicare both require documentation of the clinical significance of abnormal test results.
- Healthcare compliance (fraud, waste and abuse).

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Yes, We Need To Query (cont.)

- OIG audit findings
  - DRG reports and others
- Recovery Audit Contractor (RAC) findings.
- AHA *Coding Clinic guidance—direction to query.*
- MS-DRGs and HCCs require greater coding specificity, thus, the documentation also needs to be specific and detailed … querying is needed.
- Healthcare is complex and the rules can be confusing!

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Clinical Documentation Can Have Risks

- The physician uses symbols: plusses, minuses, up arrows, down arrows.
- In the clinical situation, it is incumbent on coders to seek clarification if that "Na" with an up arrow means hypernatremia or something else, such as sodium levels returning to normal.
- If the "Hb" with a down arrow and a level of 6.8 grams indicate that the transfusion was for anemia, what was the cause of the anemia if that's indeed what was meant?
- Does "ETOH" with a plus mean the patient is an alcoholic, an alcohol abuser, drinks socially, or had a positive blood alcohol level?
- There are codes for many of these and no code should be assigned to others.

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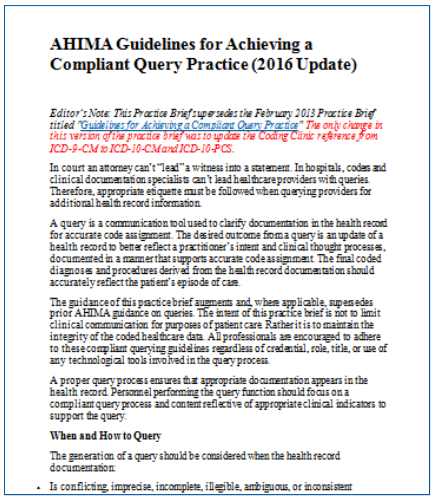
AHIMA Practice Brief 2016



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A proper query process ensures that appropriate documentation appears in the health record. Personnel performing the query function should focus on a compliant query process and content reflective of appropriate clinical indicators to support the query.

When and How to Query

The generation of a query should be considered when the health record documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent

- Utilize and follow to help being successful and with compliance.
- This is the gold standard in the industry.

AHIMA's Guidelines for Achieving a Compliant Query Practice (2016 Update)

AGAIN . . . When and How to Query…if documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
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Compliant Query

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- Although open-ended queries are preferred, multiple choice and "yes/no" queries are also acceptable under certain circumstances
- The "yes/no" query format should be constructed to include the additional options associated with multiple choice queries (i.e., "other", "clinically undetermined", and "not clinically significant and integral to")

Compliant Query

AHIMA's Guidelines for Achieving a Compliant Query Practice (2016 Update)

- "Yes/no" queries may not be used in circumstances where only clinical indicators of a condition are present and the condition/diagnosis has yet to be documented in the health record.
- New diagnoses or procedures cannot be derived from a "yes/no" query

Compliant Query

AHIMA's Guidelines for Achieving a Compliant Query Practice (2016 Update)

EXAMPLE: "Yes/no" Format

SCENARIO: In the impression of the pathology report, ovarian cancer is documented; however, only ovarian mass is documented in the final discharge statement by the provider.

QUERY: Do you agree with the pathology report specifying the "ovarian mass" as an "ovarian cancer"? Please document your response in the health record or below.

Yes_____

No_____

Other_____

Clinically Undetermined_____

Querying

- Following the AHIMA Practice Brief guidance:
- All queries must be accompanied by the relevant clinical indicator(s) that show why a more complete or accurate diagnosis or procedure is requested.
- Clinical indicators should be derived from the specific medical record under review and the unique episode of care.
- Clinical indicators supporting the query may include elements from the entire medical record, such as diagnostic findings and provider impressions.
- Multiple choice query formats should include clinically significant and reasonable options as supported by clinical indicators in the health record, recognizing that there may be only one reasonable option.

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Querying (cont.)

- Providing a new diagnosis as an option in a multiple choice list-as supported and substantiated by referenced clinical indicators from the health record-is not introducing new information.
- Multiple choice query formats should also include additional options such as “clinically undetermined” and “other” that would allow the provider to add free text.
- Additional options such as “not clinically significant” and “integral to” may be included on the query form if appropriate. (read the complete Practice Brief . . .)

Source: AHIMA Practice Brief

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Query Tip . . . Anemia

- If “anemia” is not already documented anywhere in the health record then the written query should not be titled “anemia.”
  - However, if “anemia” is already documented in the health record, then a written query may be titled “anemia” and seek additional specificity regarding the type.
    - Multiple choice selection
- Think of your queries and other Dx or procedures you seek clarification on/for.

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Query Form/Template

- The query form can/should be used "to the extent it provides clarification and is consistent with other medical record documentation."
- The query form should be phrased such that the physician is allowed to specify the correct diagnosis.
- It should not indicate the financial impact of the response.
- The form should not be designed so that the only thing required is a signature.

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Verbal Querying

- Every verbal exchange related to a specific record, must be recorded and stored per hospital policy.
- Summarize every verbal query in writing for compliance purposes.
- Follow the same guidance for written AND verbal querying (queries).

- NOTE: Federal Investigators were onsite at a hospital, they observed interactions between CDI staff and providers and identified noncompliant, leading exchanges, this raised questions and vulnerabilities.

Query Technology

- EHR/EMR now has the ability to generate a physician query
  - Can not lead
- Computer Assisted Coding (CAC) has the ability to generate a physician query
  - Can not lead
- CDI technology has the ability to generate a physician query.
  - Can not lead
- ALL Technology tools must follow the industry standards, ie Practice Brief
- We need HIM Coding compliance oversight!

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AHA Coding Clinic Guidance

AHA CC 2nd Qtr. 2000 pgs. 17-18:

"If there is evidence of a diagnosis within the medical record, and the coder is uncertain whether it is a valid diagnosis because the documentation is incomplete, vague, or contradictory, it is the coder's responsibility to **query** the attending physician to determine if this diagnosis should be included in the final diagnostic statement."

AHA Coding Clinic Guidance (cont.)

AHA CC 2nd Qtr. 2002:

"When the attending physician does not confirm the results of the radiology report for inpatient coding, **query** the attending physician regarding the clinical significance of the findings and request appropriate documentation be provided."

AHIMA Standards of Ethical Coding

- 12/2016 AHIMA Revised Standards of Ethical Coding

AHIMA

American Health Information Management Association Standards of Ethical Coding

Introduction

Coding is recognized as one of the core health information management (HIM) functions within healthcare. Due to the complex regulatory requirements affecting the health information coding process, coding professionals are frequently faced with ethical coding and coding-related challenges. The Standards of Ethical Coding are important established guidelines for any coding professional and are based on the American Health Information Management Association's (AHIMA's) Code of Ethics. Both reflect expectations of professional conduct for coding professionals involved in diagnostic and/or procedural coding, data abstraction and related coding and/or data activities.

A Code of Ethics sets forth professional values and ethical principles. In addition, a code of ethics offers ethical guidelines to which professionals aspire and by which their actions can be expected and be judged. HIM and coding professionals are expected to demonstrate professional values by their actions to patients, employers, members of the healthcare team, the public, and the many stakeholders they serve. A Code of Ethics is important in helping guide the decision-making process and can be referenced by individuals, agencies, organizations, and bodies (such as licensing and regulatory boards, insurance providers, courts of law, government agencies, and other professional groups). The Code of Ethics is relevant to all AHIMA members, students, and CCHIM credentialed HIM and coding professionals, regardless of their professional functions, the settings in which they work, or the populations they serve. All core health information coding activities are performed in compliance with state and federal regulations, and employer policies and procedures.

The AHIMA Standards of Ethical Coding are intended to assist and guide coding professionals whether credentialed or not, including but not limited to coding staff, coding auditors, coding educators, clinical documentation improvement (CDI) professionals, and managers responsible for decision-making processes and operations as well as HIM/coding students. The standards outline expectations for making ethical decisions in the workplace and demonstrate coding professionals' commitment to integrity during the coding process, regardless of the purpose for which the codes are being reported. They are relevant to all coding professionals, regardless of the healthcare setting (e.g., inpatient, outpatient, post-acute care, alternative care, etc.) in which they work or function.

These Standards of Ethical Coding have been revised in order to reflect the current healthcare environment and modern coding practices. This document is in two parts, part one includes the standards and part two contains the standards, guidelines, and examples. Additionally, definitions have been added for some key words and terms used throughout the document. The following definitions relate to and are used within the context of these Standards for consistency and continuity.

DEFINITIONS

The purpose of this definition section is to achieve clarity without needless repetition. These definitions are intended to reflect everyday meaning. It is not within the scope of this document to establish new definitions for the words.

Coding Professional: Individuals whether credentialed or not, including but not limited to coding staff, coding auditors, coding educators, clinical documentation improvement (CDI) professionals, and managers responsible for decision-making processes and operations as well as HIM/coding students.

Coding-related activities: The activities includes selection, research, and completion of code assignment, querying, other health record data abstraction, data analytics and reporting with codes, coding audits, remote coding, and coding educational activities and functions.

Data: All healthcare data elements including clinical, demographic, and financial

Page 1 of 9

- Introduction: all coding professionals and all settings.
- Definitions
- 11 Principles
- How to Interpret the Standards of Ethical Coding: Standards and Guidelines
- Footnotes
- Resources

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Standard and Guideline #4

Query and/or consult as needed with the provider for clarification and additional documentation prior to final code assignment in accordance with acceptable healthcare industry practices. ***(think of the AHIMA Practice Briefs)***

Coding professionals ***shall****:*

4.1. Participate in the development of query policies that support documentation improvement and meet regulatory, legal, and ethical standards for coding and reporting.

Example: Guidelines for Achieving a Compliant Query Practice (2016 Update)

4.2. Use queries as a communication tool to improve the accuracy of code assignment and the quality of health record documentation.

Example: Designing and adhering to policies regarding the circumstances when providers should be queried to promote complete and accurate coding and complete documentation, regardless of whether reimbursement will be affected.

Example: In some situations a query to the provider will be initiated after the initial completion of the coding due to late documentation, etc., this should be conducted in a timely manner.

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Standard and Guideline #4 (cont.)

4.3 Query with established practice brief guidance when there is conflicting, incomplete, illegible, imprecise, or ambiguous information, (e.g., concurrent, pre-bill, and retrospective).

Coding professionals ***shall not****:*

4.4. Query the provider when there is no clinical information in the health record that necessitates a query.

Example: Querying the provider regarding the presence of gram-negative pneumonia on every pneumonia case/encounter.

4.5. Utilize health record documentation from or in other encounters to generate a provider query.

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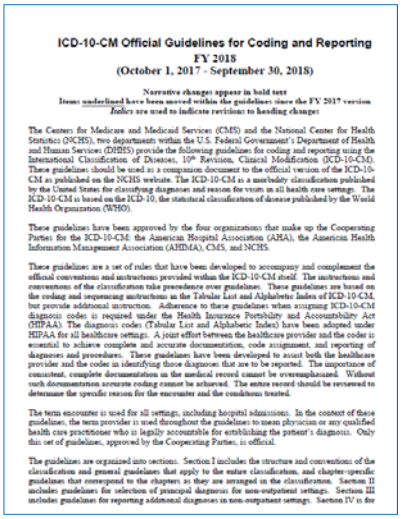
FY2018 Official Coding & Reporting Guidelines



ICD-10-CM Official Guidelines for Coding and Reporting
FY 2018
(October 1, 2017 - September 30, 2018)

Narrative changes appear in bold text
Items underlined have been moved within the guidelines since the FY 2017 version
Italics are used to indicate revisions to heading changes

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of concurrent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

The guidelines are organized into sections. Section I includes the structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Section II includes guidelines for selection of principal diagnosis for non-outpatient settings. Section III includes guidelines for reporting additional diagnoses in non-outpatient settings. Section IV is for

Narrative changes appear in bold text,

Items <u>underlined</u> have been moved within the guidelines since the FY 2017 version.

- ***Italics* are used to indicate revisions to heading changes.**
- **Give instructions to "QUERY"**

NOTE: It's the coding professional responsibility to read through all the guidelines, to understand them and to apply them correctly.

FY2018 Official Coding & Reporting Guidelines (cont.)

- The *ICD-10-CM Official Guidelines for Coding and Reporting*'s suggestion that a "joint effort" between the coders and providers results in the most accurate and complete documentation.
- **<u>Examples:</u>**
- Conventions #13 Excludes 1: If it is not clear whether the two conditions involving an Excludes1 note are related or not, **query** the provider.
- Guidelines: #16 Documentation of Complications of Care: **Query** the provider for clarification, if the complication is not clearly documented.
- #17 Borderline Diagnosis: Whenever the documentation is unclear regarding a borderline condition, coders are encouraged to **query** for clarification.
- Chapter 1 Specific Guidelines: *Acute organ dysfunction that is not clearly associated with the sepsis:* If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, **query** the provider.

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Coding Clinic Reference

- **AHA Coding Clinic 4th Quarter 2015 pages 20-21**
- Applying Past Issues of AHA Coding Clinic for ICD-9-CM to ICD-10
  - Documentation issues would generally not be unique to ICD-9-CM, and so long as there is nothing new published in Coding Clinic for ICD-10-CM and ICD-10-PCS to replace it, the advice would stand.

***NOTE**: Please read the referenced Coding Clinic in its entirety**

How Do We Query the Physician?

- *Without leading the physician to a* diagnosis or procedure wording/language.
  - Be careful and think "compliance"
- Without suggesting a diagnosis or procedure.
- It's a balancing act and it takes knowledge and skill.

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Awareness and education—to Physicians

- Explain . . . Why queries are used.
- Outline the process, including expectations for response (e.g., how, time frame)
- Develop together a Query policy and procedure.
- Provide examples of queries that the physicians might see based on known issues in your facility/practice.
- Emphasize the documentation improvement aspect and how the query may be a learning tool for the physicians to be aware of the necessary documentation for coding in particular clinical situations.

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Communicate to Physicians

- Encourage physicians to document the following:
  - Conditions being empirically treated
  - Diagnoses resolved versus ruled out
  - Interactions between disease processes
  - The possible, probable, or suspected cause of symptoms
  - The reason for patient retention or extended length of stay
  - Their clinical concerns regarding a particular patient
  - Any Uncertain conditions
- Promote an open dialog

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Have Coding Query Policies and Procedures

- Physician Querying – for quality data
- Follow the AHIMA Practice Briefs
  - Gold Standard across the industry
- Query Wording and format – nonleading
- Retain queries (nothing to hide)
  - Monitor and track
- Educate on querying
  - Include CDI and Physicians
- All payers and all settings (including outpatient)
  - Not just Medicare

CDI Policy and Procedures

- Establish CDI P&P to address querying
- Follow the AHIMA Practice Brief for your CDI querying
- Address Written (including electronic) and verbal querying (forms/templates)
- When to query and How to query
- Build a QA process of CDI querying also!
- Don't single out just one payer or one setting

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Quality Assurance (QA) Review/Process of Queries

- There should be a regular quality assurance review process in place (supports compliance)
- Random and focused sampling of Coding and CDI query process and forms
- Discuss Coding query process and forms
  - Include in regular Coding Audits and CDI Reviews
- Check for appropriateness of query
  - Non-Leading (wording/format)
  - Missed opportunities
  - Over-utilizing querying
- Trend findings over time

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Quality Assurance (QA) for Coding and CDI Query Process and Forms (cont.)

- Give feedback to staff and discuss
- Make changes in forms and processes
- Annual Review of Policy
- Annual Review of Forms/Templates
- Education and awareness: continuously
  - Dialog and openness

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Key Documentation

- Unclear documentation can occur when a physician suspects a condition, documents it initially, rules it out mentally (but fails to provide documentation), and then simply stops documenting the condition entirely in the record.
- The physician documentation should describe the patient's condition, using terminology that includes specific diagnoses as well as symptoms, problems, or reasons related to this encounter.
- A physician query process should be in place to assist in obtaining accurate and specific documentation.
- **Remember the documentation MUST support the coding and the claim data.**

Key Documentation (cont.)

Office encounter notes (EXAMPLE):

E&M	History and Physical
ER Physician Notes	Progress Notes (encounter/visit notes)
Consultation	MD Orders
Discharge Summary	Nursing Notes – provide clues
Consultation	Lab/Radiology (provide clues)

- **NOTE:** When documentation is incomplete or imprecise, you should query the physician. Have a physician query process (and policy); follow the AHIMA Practice Brief (industry gold standard).

Remember: guidelines and AHA Coding Clinic DO instruct to query the physician/provider!

- **NOTE:** If the guidelines instruct to "query" then you should follow the guideline!

REMEMBER: Diagnosis supports Medical Necessity!

Key Next Steps . . .

- Know the Query Practice Brief guidance
- Develop written P&P: follow the Practice Briefs
- Perform Query Reviews/Audits
- Track and trend findings relating to Physician Queries
  - Which Dx or Procedure are being queried the most?
  - Which Physicians have the highest frequency of querying
- Solicit feedback from CDI and HIM: work together
- Annually review the Query Policy
- Annually review any Physician Query forms/templates
- Provide education & feedback
- Build these steps into your success and compliance activities

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Summary

- Queries are an essential tool for a true picture of the patient care encounter and decision making, for compliance, reimbursement and quality improvement because they elicit more documentation from physicians on patient diagnosis and treatment.
- Have a QA process within your CDI and HIM Coding operations.
- Look at industry standards (AHIMA) to help guide you and your staff or your program.
- Be successful is being compliant!

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Any Questions?

- Are there any questions from our attendees?

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Thank you!

- We appreciate you attending today and hope you will attend another AHA Webinar!

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References/Resources

- HCCA, The Physician Query Process, 2010, G. Bryant
- AHIMA Practice Brief—Physician Query 2001
- AHIMA Practice Brief – Managing the Physician Query Process 2008
- AHIMA Practice Brief – CDI 2010
- AHIMA Ethical Standards for Coding
- AHIMA Ethical Standards for CDI

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Complete the Evaluation – Your Input is Important!

Please complete survey for CEU verification form.

https://www.surveymonkey.com/r/march_20_webinar

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AHA
Coding Clinic®

March 2018

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This serves as verification for your Continuing Education for the AHA Coding Clinic's webinar *Physician Querying . . . Being Successful and Compliant* by Gloryanne Bryant, RHIA, CDIP, CCS, CCDS. The webinar was held on March 20, 2018 (and available for on-demand viewing after the live date) and was one hour in length.

This program has been approved for 1 continuing education unit(s) for use in fulfilling the continuing education requirements of the American Health Information Management Association (AHIMA). Granting prior approval from AHIMA does not constitute endorsement of the program content or its program sponsor.

Retain this verification in your personal file for audit purposes.

Thank you for your interest and participation.

Chabre Ross
Program Chairperson
American Hospital Association

AHA Central Office

Certificate of Approval

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Name

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