Effectiveness of Quality Queries

Introduction

- Medical coders and reviewers should continually acquire clinical knowledge needed to perform their duties and stay abreast on the latest clinical developments

- Implementation of regular training sessions is vital for coding department to discuss and learn about sign & symptoms, labs/exams, and evaluation/ treatments for various conditions

- Clinicians should be involved in the teaching process of clinical information so coders and reviewers may develop a deeper understanding of the direct correlation between clinical documentation and coding outcomes

Official Coding Guidelines for Coding and Reporting, Section I, Clinical Criteria and Code Assignment

"The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis."

Coding Clinic, Fourth Quarter 2016, Clinical Criteria and Code Assignment

▷ **Question:**

"Please explain the intent of the new ICD-10-CM guideline regarding code assignment and clinical criteria that reads as follows: "The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis." Some people are interpreting this to mean that clinical documentation improvement (CDI) specialists should no longer question diagnostic statements that don't meet clinical criteria. Is this true?"

Answer:

- "Coding must be based on provider documentation. This guideline is not a new concept, although it had not been explicitly included in the official coding guidelines until now. *Coding Clinic* and the official coding guidelines have always stated that code assignment should be based on provider documentation. As has been repeatedly stated in *Coding Clinic* over the years, diagnosing a patient's condition is solely the responsibility of the provider. Only the physician, or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis, can "diagnose" the patient. **As also stated in *Coding Clinic* in the past, clinical information published in *Coding Clinic* does not constitute clinical criteria for establishing a diagnosis, substitute for the provider's clinical judgment, or eliminate the need for provider documentation regarding the clinical significance of a patient's medical condition.**

- The guideline noted addresses coding, not clinical validation. It is appropriate for facilities to ensure that documentation is complete, accurate, and appropriately reflects the patient's clinical conditions. Although ultimately related to the accuracy of the coding, clinical validation is a separate function from the coding process and clinical skill. The distinction is described in the Centers for Medicare & Medicaid (CMS) definition of clinical validation from the Recovery Audit Contractors Scope of Work document and cited in the AHIMA Practice Brief ("Clinical Validation: Next Level of CDI") published in the August issue of JAHIMA: "Clinical validation is an additional process that may be performed along with DRG validation. Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the medical record. Clinical validation is performed by a clinician (RN, CMD, or therapist). Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials."

- While physicians may use a particular clinical definition or set of clinical criteria to establish a diagnosis, the code is based on his/her documentation, not on a particular clinical definition or criteria. In other words, regardless of whether a physician uses the new clinical criteria for sepsis, the old criteria, his personal clinical judgment, or something else to decide a patient has sepsis (and document it as such), the code for sepsis is the same—as long as sepsis is documented, regardless of how the diagnosis was arrived at, the code for sepsis can be assigned. Coders should not be disregarding physician documentation and deciding on their own, based on clinical criteria, abnormal test results, etc., whether or not a condition should be coded. For example, if the physician documents sepsis and the coder assigns the code for sepsis, and a clinical validation reviewer later disagrees with the physician's diagnosis, that is a clinical issue, but it is not a coding error. By the same token, coders shouldn't be coding sepsis in the absence of physician documentation because they believe the patient meets sepsis clinical criteria. A facility or a payer may require that a physician use a particular clinical definition or set of criteria when establishing a diagnosis, but that is a clinical issue outside the coding system. "

Best Practices

- The effectiveness of quality queries is imperative to bridge the gap between clinical criteria and code assignment

- HIM professionals have a vital role in ensuring complete and accurate reporting of diagnoses and procedures

- Physician documentation is the essential component for coding/auditing, yet we must keep in mind to review other key elements of the medical record such as labs, radiology, and meds

- Rule of thumb: two or more relevant clinical indicators are present

- The clinical indicators gives supporting evidence of the patient's diagnosis through lab testing, radiological exams, medications and treatments

- Queries should provide facts from the medical record along with specific clinical documentation (i.e. clinical indicators)

Writing Effective and Compliant Queries

The initiation of a query should be considered when the medical record documentation:

- Documentation is conflicting, nonspecific, incomplete, inconsistent

- Exhibits clinical signs and symptoms without a definitive relationship to an underlying diagnosis

- Gives an associated condition without underlying cause identified

- Describes clinical indicators, diagnostic evaluation, and/or treatment given not related to a specific diagnosis or procedure

- Conveys a diagnosis without underlying clinical validation

- Establish a cause/effect relationship between two documented conditions

- Clarify present on admission (POA) indicator assignment

Of course, open ended queries are preferred, multiple choice and yes/no formats are acceptable in particular cases

Potential Problematic Diagnoses

Diagnosis	Definition	Meds/Treatment	Tests/Exams
Acute Respiratory Failure	Persistent abnormally low arterial oxygen tension (PaO2) or abnormally high carbon dioxide tension (PaCO2)	Mechanical ventilation, Bipap, Cpap, supplemental oxygen	ABGs results
Acute Renal Failure	The inability of a kidney to excrete metabolites at normal plasma levels under normal loading, or the inability to retain electrolytes under conditions of normal intake, so that waste products and metabolites accumulate in the blood	IV Fluids	Creatinine, GFR, Urine Output
Metabolic encephalopathy	When the electrolytes, hormones, or other chemicals in the body are unbalanced it can impact the functionality of the brain	Chemical imbalance is restored	CT or MRI of the brain to detect abnormalities; EEG test to measure the electrical activity of the brain
Sepsis	Systemic disease associated with the presence and persistence of pathogenic microorganisms or their toxins in the blood	Broad spectrum of antibitoics	Blood cultures, WBC>12,000, tachycardia (HR>90), bandemia (>10%), hypothermia, hypotension, and fever

Potential Problematic Diagnoses

Diagnosis	Definition	Meds/Treatment	Tests/Exams
Severe Sepsis	The presence of infection or presumed infection and evidence of organ dysfunction	Broad spectrum of antibiotics	Blood cultures, WBC>12,000, tachycardia (HR>90), bandemia (>10%), hypothermia, hypotension, and fever
Pulmonary Embolus	A blockage in one of the arteries of the lungs	Anticoagulants, IVC filter,	Radiological imaging study (i.e. CTPA) D-dimer
Urinary tract infection (UTI)	An infection in any part of your urinary system (ie. Kidneys, ureters, bladder, urethra)	Antibiotics	Urinalysis (UA), urine cultures
Anemia	Reduction below normal in the concentration of erythrocytes or hemoglobin in the blood	Transfusion of RBC, iron replacement therapy	Low Hemoglobin and Hematocrit

Query sample 1:

- Patient admitted via ER with physical exam showing "Pulmonary/Chest: She has no wheezes. She has no rales," and notes states "transiently hypoxemic off oxygen. Please note patient is maintained on home O2. The History and Physical states "acute hypoxic respiratory failure," but no ABGs were drawn to be evaluated'/monitored as well as no respiratory distress noted. The progress notes state "hypoxia likely due to polypharmarcy," "oxygen therapy as need to keep O2 sat >90%, patient "refusing CPAP for OSA" and no respiratory distress, wheezing noted.

- Based on your clinical judgment, can you further clarify if this patient is being evaluated/treated for respiratory failure? Thanks!

Query sample 2:

▶ While the patient's presentation warranted consideration of Sepsis, a localized infection of pyelonephritis was identified. The pyelonephritis was treated with broad spectrum of antibiotics. Please note patient was hospitalized for only one day. Upon further review of the medical record, the diagnosis of sepsis requires the WBC to be over 12,000, altered mental status, presence of an organism (bacteremia) in most cases, hypotension unresponsive to fluid challenge, and/or evidence of multi-organ dysfunction in order to substantiate clinically.

▶ Based on your clinical judgment, can you further clarify if this patient is being evaluated/treated or has ruled out for "sepsis," septicemia," "SIRS" and document the final diagnosis? Thanks!

Query sample 3:

The History and Physical and progress notes documents metabolic encephalopathy. Of note, there were no signs & symptoms associated with this condition, such as altered mental status, confusion, decrease level of consciousness, as well as, no presence of electrolytes, or other chemicals that have adverse effect on brain function. In your clinical opinion, can you further clarify if this patient is being evaluated/treated or has been ruled out for metabolic encephalopathy?

Query sample 4:

The ED physician documents acute renal failure, and progress note on 02/23 by case management states, "acute renal failure (ARF)." There is no baseline provided, and patient's creatinine was 19.89 on admission, which decreased to 9.62 after hemodialysis. There was acute renal function deterioration documented: hyperkalemia and metabolic acidosis. In your clinical opinion, can your further clarify if this patient is being evaluated/treated or has been ruled out for "acute kidney failure?" Thanks!

Query sample 5:

Per discharge summary dated 04/14/2017 stating, "...postoperative course was notable for acute anemia requiring blood transfusion, as well as, " Hgb dropped from 9 to 7.3. She required 2 units pRBCs and responded appropriately" and "...CTA A/P POD#5 showed a large hematoma in right pararenal space..."

Please specify:

Acute blood loss anemia (please specify causal condition)	Anemia of chronic disease (please specify disease)	Anemia due to antineoplastic chemotherapy	Aplastic anemia (please specify type ie. Drug induced, idiopathi)
Chronic blood loss anemia (please specify causal condition)	Nutritional anemia (specify type)	Pernicious anemia	Postoperative acute blood loss anemia, complication due to surgery
	other (please specify)	Clinically undetermined	

Query sample 6:

Per discharge summary dated 04/14/2017, "On POD#8, she complained for dysuria with positive UA and UC with >100,000 E. Coli. She was started on Macrobid with a total 7 day course." In your clinical opinion, can this data be further specified with a diagnosis that represents the above listed clinical indicators?

Please specify:

Bacteruria

UTI only

Other Urinary infection (please specify)

Clinically undetermined

Query sample 7:

The Discharge Summary dated 07/06/2013, states "pulmonary embolism." Please note that no imaging studies depict a pulmonary embolism as well as any other significant evaluation or treatment given towards this diagnosis. In fact, it is state only on the discharge summary. Based on your clinical judgment, can your further clarify if this patient is being evaluated/treated or has been ruled out for "pulmonary embolism?" Thanks!

The pathology report is now on the medical record. The pathologist states, "Lung, right upper lobe, lobectomy: Large cell neuroendocrine carcinoma." If you agree with the diagnosis, please document within the medical record.

Summary

- It essential to incorporate clinical validation into coding education development programs

- Coders and reviewers should become dedicated to learning more about clinical validation in order to perform at the highest level

- Effectiveness of quality queries are imperative to ensuring accurate documentation as well as coding outcomes (i.e. data reporting, reimbursement) for healthcare facilities

References:

1. American Health Information Management Association. (2013). Guidelines for Achieving a Compliant Query Practice. (2): 50-53. *Journal of AHIMA 84* (2): 50-53.

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3. *ICD-10-CM Official Coding Guidelines for Coding and Reporting*, Section I., Clinical Criteria and Code Assignment.

4. American Hospital Association.(2016). *Coding Clinic*, Fourth Quarter 2016, Clinical Criteria and Code Assignment.

5. Dorland, A. N. (2011). *Dorland Medical Dictionary* (32nd ed).

Thank you

Thank you for your time and attention!
Any questions or comments?