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ACDIS/AHIMA brief provides additional query guidance

New yes/no query options, rules for introducing new diagnoses, policy recommendations

It's been more than 12 years since AHIMA published its first recommendations governing coder-physician interactions. Since "Developing a Physician Query Process," published in 2001, much in the healthcare industry has changed—and much change is still to come.

Thus the impetus for the latest query practice brief, "Guidelines for Achieving a Compliant Query Practice," published in the February *Journal of AHIMA* and produced in collaboration with ACDIS.

"Those not familiar with the physician query process may wonder why additional guidance is necessary," says **Kathryn DeVault**, RHIA, CCS, CCS-P, senior director of HIM Practice Excellence at the Chicago-based AHIMA, one of the brief's contributors. "However, those of us involved in the process know it's hard. It's difficult to write a compliant query to convey the appropriate information to the provider without leading them to a particular diagnosis."

Guidance for all

Query confusion in the industry is related to what and how a coder or CDI specialist can question about the contents of the medical record, says **Rose T. Dunn**, MBA, RHIA, CPA, FACHE,

Query guidance timeline

The 2013 joint ACDIS/AHIMA physician query practice brief, "Guidelines for Achieving a Compliant Query Practice," is the latest among various industry recommendations governing the query process for coders and CDI professionals. The following is a list of previous publications:

- » 2001 AHIMA "Developing a Physician Query Process"
- » 2004 AHIMA revised "Code of Ethics"
- » 2008 AHIMA "Standards of Ethical Coding"
- » 2008 AHIMA "Managing an Effective Query Process"
- » 2008 ACDIS "Code of Ethics"
- » 2010 AHIMA "Guidance for Clinical Documentation Improvement Programs"
- » 2010 AHIMA *Clinical Documentation Improvement Toolkit*
- » 2010 AHIMA "Ethical Standards for Clinical Documentation Improvement Professionals"

chief operating officer of First Class Solutions, Inc., in Maryland Heights, Mo. Such confusion may have been driven, in part, by the specialists' credentials, she says.

Previously, those who worked in the CDI field fell somewhere between the nursing and coding ranks. These individuals often questioned which rules to follow, if they knew about AHIMA guidance at all. Some believed a CDI specialist should never pose a leading query, whereas others set forth that those with nursing backgrounds could approach a physician as

a fellow clinician, have a clinical discussion, and bring that information back to the medical record. Conversely, coders, who theoretically assign codes for reimbursement purposes and have little or no medical training, could not, the thinking went.

The latest guidance eliminates the confusion in part because of the collaborative nature of the brief, including as it does input from a wide swath of experts from various backgrounds. It states:

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.

The new brief also sets clear boundaries and definitions in areas that previously caused confusion, if not outright consternation, for those in field.

Leading queries

The question of crafting non-leading queries may well be a defining theme of the 2013 brief. Its opening lines state:

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

"The goal is to increase the transparency between the query and the medical record."

—Cheryl Ericson, RN, MS, CCDS, CDIP

information.

While previous practice briefs contained somewhat nebulous definitions for the term "leading," the 2013 brief defines a leading query as:

[O]ne that is not supported by the clinical elements in the health record and/or directs a provider to a specific diagnosis or procedure.

The simplest way to ensure that queries remain non-leading is to include evidence from the medical record and provide the opportunity for the treating physician to offer additional input through the use of multiple response

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options.

“The goal is to increase the transparency between the query and the medical record. [That’s why] over and over again within the latest query practice brief the importance of the clinical indicator, or indicators, is emphasized,” says **Cheryl Ericson, RN, MS, CCDS, CDIP**, CDI education director for HCPro, Inc., in Danvers, Mass.

According to “Guidelines for Achieving a Compliant Query Practice”:

All queries must be accompanied by the relevant clinical indicator(s) that show why a more complete or accurate diagnosis or procedure is requested.

The 2013 brief provides examples of both leading and non-leading query versions and illustrates how clinical indicators should be integrated into the queries. (Read the complete practice brief on p. 7.)

“Because of the increasing scrutiny of queries by external reviewers, it is more important than ever to toe the line and to ensure that ‘leading’ does not occur,” says Dunn.

“A query is not a fishing expedition,” says **William E. Haik, MD, FCCP, CDIP**, director DRG Review, Inc., in Fort Walton Beach, Fla., who spoke with Ericson during the March 4 webcast, “Physician Queries: Comply with new ACDIS/AHIMA guidance.”

Yes/no queries

Previous 2008 AHIMA guidance “Managing an Effective Query Process” limited yes/no queries to those related to present-on-admission conditions. The 2013 guidance, however, opens yes/no queries to use in three new possible situations, including:

1. Substantiating or further specifying “a diagnosis that is already present in the health record”
2. Establishing a cause-and-effect relationship between documented conditions such as manifestation/etiology, complications and conditions/diagnostic findings
3. To resolve conflicting practitioner documentation

“This is a big change,” says Haik. “It is no longer your daddy’s Buick as the saying goes.”

In short, if one doctor mentions a diagnosis, you can ask the attending physician verbally whether he or she

agrees with this diagnosis. However, yes/no queries *may* not introduce new diagnoses and they cannot be used when only clinical indicators of a condition are present and the condition/diagnosis has yet to be documented in the health record.

Even when the information is in the record, the new brief encourages yes/no queries to also include other

Query process considerations

The reasons for submitting a query to a physician have been addressed in previous practice briefs, coding regulations, and other venues. The latest 2013 ACDIS/AHIMA guidance reiterates that queries should be generated when:

- » The documentation is not clear enough to support the rationale for tests that were performed
- » An extended length of stay due to conditions is documented by other patient caregivers
- » A response is needed for a condition identified by another clinician
- » Added specificity is needed for the codes being applied

With the advancement of Recovery Auditors, ICD-10-CM/PCS implementation, value-based purchasing, and other initiatives affecting documentation and coding specialists, **Kathryn DeVault, RHIA, CCS, CCS-P**, senior director of HIM Practice Excellence at the Chicago-based AHIMA, says organizations should also bear in mind:

- » **Severity of illness.** The health record documentation should reflect the severity of the patient’s condition and specific treatment provided. Thorough documentation provides consistency in continuity of care and establishes the severity of a given patient’s illness.
- » **Complete documentation and appropriate reimbursement.** A complete health record with thorough documentation results in a correctly coded account, which ultimately leads to appropriate reimbursement.
- » **Recovery Auditors and other reviewers.** Documentation in the health record should be consistent and appear in the correct context. Diagnoses that are a result of a query should be supported by the appropriate clinical indicators.

options such as:

- » i.e.
- » Other
- » Clinically undetermined
- » Not clinically significant
- » Integral to

“It’s not like you’re pulling a diagnosis out of thin air,” says ACDIS Director **Brian D. Murphy, CPC**, who worked with the committee. “It just makes it easier to have the conversation.”

This new guidance may help CDI specialists query physicians more effectively once ICD-10-CM/PCS implementation takes place, says Ericson, since so many codes depend on capturing the etiology, manifestation, and cause-and-effect relationship between the diagnoses.

Multiple-choice queries

Similarly, the brief indicates that “multiple choice query formats should include clinically significant and reasonable options as supported by clinical indicators in the health record.”

Unlike yes/no queries, however, CDI specialists *can* include a new diagnosis in a multiple-choice query. Although past query briefs have permitted use of multiple-choice queries, many coders and CDI specialists believed that providing a new diagnosis—a diagnosis not otherwise specified within the medical record—was “leading.” The latest ACDIS/AHIMA brief removes that limitation. It states that:

[P]roviding 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.

“The concept of new information has been confusing regarding the use of a diagnosis not previously documented,” says Haik. “This guidance states that you may introduce new information not included in the record as long as it is not in the stem of the question or in the title of the query form.”

Further, multiple-choice query formats should include additional options such as “clinically undetermined” and

“other” that would allow the provider to add free text, according to the brief. “Not clinically significant” and “integral to” may also be included on the query form if appropriate.

Many in the CDI industry were concerned about the use of multiple-choice queries when the reasonable choices were limited, writes Marion Kruse, MBA, RN, a healthcare consultant based in Columbus, Ohio, and author of the forthcoming *Physician Queries Handbook*, Second Edition.

By listing only one diagnosis, they could be accused of leading the physician, even if “other” and “clinically undetermined” were used. So they may have added clinically *unreasonable* options just to make the query form itself *appear* compliant. The latest guidance eliminates those efforts and, essentially, eliminates potential confusion for the physician, Kruse writes.

Policy recommendations

The latest guidance avoids “reinventing the wheel,” Murphy says, drawing on previous rules governing query basics such as when to query the provider. It also readdresses the need for policies and procedures governing the query process.

It suggests that both verbal and written queries should be documented and tracked for effectiveness and to “allow reviewers to account for the presence of documentation that might otherwise appear out of context.”

DeVault admits it’s a struggle to document verbal queries.

“How do you document a conversation that results in a diagnosis?” she says.

Nevertheless, says Ericson, “for verbal queries there has to be a record or memorialization of that interaction [between the CDI specialist and the physician] within the record.”

Physicians really like the verbal query format, she says, because it saves both the physician and the CDI specialist time writing and responding to multiple-part queries, and allows for immediate feedback.

Verbal queries are not without risk, however. They need to include the same clinical indicators and follow the same format and structure as their written counterparts, according to the 2013 brief. This will help “ensure compliance and consistency in policy and process,” the brief states.

Documentation of the verbal query should identify the:

- » Clinical indicators that support the query
- » Actual question posed to the practitioner
- » Time of the discussion

The 2013 guidance also recommends facilities establish policies regarding query permanence, and whether queries will be retained as a part of the medical record. It states:

Organizations that opt to not maintain queries as part of the permanent health record are encouraged to maintain copies as part of the administrative, business record. If the practitioner documents his or her response only on the query form, then the query form should become part of the permanent health record.

When queries are not part of the health record, policies governing permanence should identify how long queries will be kept, how they will be identified and tracked, and where they will be retained.

Auditors increasingly have begun to request query forms as part of their medical record reviews, and regular internal audits of the query forms as part of process improvement measures will require access to those forms.

Spurred by recent Recovery Auditor activities, the 2013 brief addresses concerns of clinical validity of diagnoses and suggests possible procedures for query escalation, too.

Questioning the clinical validity of a diagnosis, however, is tricky business, says Ericson. After all, it is the physician's job to diagnosis and treat the patient. CDI specialists who submit these types of queries may jeopardize their working relationship with that physician.

"Recovery Auditors have changed the game in terms of how auditors are looking at these records," says Murphy. "Physicians may have documented a diagnosis, but if there is no clinical support for that diagnosis, auditors will deny the claim. It puts coders in a tough spot."

Therefore, the 2013 brief recommends that facilities follow "their internal escalation policy rather than requiring the CDI specialist/coder to query the practitioner."

"Auditors don't want to see a diagnosis that appears out of context without supporting documentation," DeVault says. "It's a new normal for documentation. It's not just asking for a diagnosis, but also the clinical validation of the diagnosis."

Applying rules to practice

Like previous briefs, the latest is not binding governmental law but rather industry standards. As AHIMA is one of the four Cooperating Parties responsible for code assignment, its opinion carries some weight and is often invoked by auditors.

It's been wonderful to see the compromising and the evolution of the query practice through these various guidances. I think it's great that the industry as a whole is open-minded enough to realize that we have to continually revise and adjust to improve our processes.

—Cheryl Ericson

Ultimately, the onus is on HIM and CDI professionals to review the recent guidelines and assess them in relationship to earlier guidance, standards of procedure and ethics, and adopt them to their existing query processes, says Murphy.

Murphy recommends that CDI and HIM directors:

- » Update their query forms and policies to conform with the new query practice brief
- » Explain to CDI/HIM staff that yes/no queries are permitted when a diagnosis already appears in the record (review relevant clinical examples from the brief)
- » Remind CDI/HIM staff that it is incumbent on them to query a physician to provide clinical support for a diagnosis if none exists, or to address the situation through their hospital's escalation policy

"It's been wonderful to see the compromising and the evolution of the query practice through these various guidances," says Ericson. "I think it's great that the industry as a whole is open-minded enough to realize that we have to continually revise and adjust to improve our processes. I think that's the goal of it—to always keep in mind what we are here for, to make sure that we have an accurate medical record that reflects the physician's intent and care provided to the patient."

Access the brief at <http://tinyurl.com/agjsjoj>. 🌈



Director's note

ACDIS/AHIMA query brief: Take a bow, members!



“Guidelines for Achieving a Compliant Query Practice” was issued in the February 2013 *Journal of AHIMA* and here in the April edition of the *CDI Journal* beginning on p. 7. It contains new guidance on forming compliant but effective and concise queries to physicians. What

makes this particular practice brief so special? Not only is it helpful new guidance, but it was written by a joint committee of ACDIS and AHIMA, and based on questions from you, the ACDIS membership.

I'd like to thank ACDIS representatives Cheryl Ericson, Dr. William Haik, Fran Jurcak, Cathy Seluke, Sue Belley, and Dr. Paul Weygandt for their professional representation during a series of meetings with AHIMA that started last summer and ran through the end of 2012. These six were the primary authors on the ACDIS side. The ACDIS Advisory Board later reviewed a draft and made further comments.

The new practice brief covers a lot of ground. In particular there are three new pieces of guidance worthy of highlighting.

First, the new brief provides a very definitive statement that multiple-choice queries, when properly constructed, are not leading. According to the brief:

[P]roviding 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.

Second, the brief relaxes the previously strict circumstances for the use of yes/no queries. Prior to this brief, yes/no queries could only be used to determine whether a condition was present on admission (POA). But now, in addition to POA, yes/no queries may be used under specific circumstances. You can read more about this on p. 3 and pp. 8-9.

Third, the latest guidance provides greater emphasis on obtaining clinical support for a diagnosis. Hospitals have been hit hard by Recovery Auditors eager to deny diagnoses that do not appear to be supported in the health record. The brief states that more work needs to be done in these instances. It states:

When a practitioner documents a diagnosis that does not appear to be supported by the clinical indicators in the health record, it is currently advised that a query be generated to address the conflict or that the conflict be addressed through the facility's escalation policy.

There's much more in the brief, as the article on p. 1 outlines. And you can read the complete practice brief here. I encourage you to do so.

Who decided what this new brief would cover? It was you, our ACDIS members. We read the emails you've sent, we listened to you at the ACDIS conference, heard your comments during quarterly conference calls. We compiled those concerns as the foundation for this practice brief. In short, your questions about the query process have been heard, and I hope adequately addressed.

So ACDIS members, take a bow: This new brief wouldn't be possible without you.

Take care,

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Guidelines for Achieving a Compliant Query Practice

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.

The 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
- » Provides a diagnosis without underlying clinical validation
- » Is unclear for present-on-admission indicator assignment

Although open-ended queries are preferred, multiple-choice and "yes/no" queries are also acceptable under certain circumstances. [See query sample I.]

To support why a query was initiated, all queries must be accompanied by the relevant clinical indicator(s) that show why a more complete or accurate diagnosis or procedure is requested.

Although AHA's *Coding Clinic for ICD-9-CM* often references clinical indicators associated with particular diagnoses, it is not an authoritative source for establishing the clinical indicators of a given diagnosis. A recent *Coding Clinic* issue also stated that it is not intended for such a purpose.

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.

A query should include the clinical indicators, as discussed above, and should not indicate the impact on reimbursement. A leading query is one that is not supported by the clinical elements in the health record and/or directs a

Query sample 1: Clarification for specificity of a diagnosis

Documentation: Obtunded patient admitted with three-day history of nausea and vomiting. CXR revealed right lower lobe (RLL) pneumonia. Clindamycin ordered.

Leading query: Is the patient's pneumonia due to aspiration?

Nonleading query: Can the etiology of the patient's pneumonia be further specified? It is noted in the admitting history and physical examination (H&P) this obtunded patient had a history of nausea and vomiting prior to admission to the hospital and is treated with clindamycin for RLL pneumonia. Based on the above, can the etiology of the pneumonia be further specified? If so, please document the type/etiology of the pneumonia in the progress notes.

Source: AHIMA. "Guidance for Clinical Documentation Improvement Programs." 2010.

provider to a specific diagnosis or procedure. The justification (i.e., inclusion of relevant clinical indicators) for the query is more important than the query format.

Because the patient record should provide a sequence of events, best practice is to capture the content of a verbal and/or

written query, as well as any practitioner response to the query. This practice allows reviewers to account for the presence of documentation that might otherwise appear out of context.

If the practitioner documents his or her query response directly into the health record and there is a lack of supporting clinical information, it is recommended the practitioner provide the clinical rationale for the diagnosis (i.e., “Patient transfused four days ago due to acute blood loss anemia”) unless the query is maintained as a permanent part of the health record. Lack of clinical rationale may raise questions in the event of any secondary review. Organizations that opt to not maintain queries as part of the permanent health record are encouraged to maintain copies as part of the administrative, business record. If the practitioner documents his or her response only on the query form, then the query form should become part of the permanent health record.

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. As such, 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.

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”). 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. Also, new diagnoses cannot be derived from a yes/no query.

In such circumstances, open-ended or multiple-choice query formats must be used. It is not considered leading to include a new diagnosis as part of a multiple-choice format when supported by clinical indicators (see “Query examples for yes/no format”). In addition to present-on-admission (POA) determinations, yes/no queries may be utilized under the following circumstances:

» Substantiating or further specifying a diagnosis that

Query examples for yes/no format

Compliant example 1

Clinical 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 _____

Name: _____ Date: _____

Rationale: This yes/no query involves confirming a diagnosis that is already present as an interpretation of a pathology specimen in the health record.

Compliant example 2

Clinical scenario: Consulting pulmonologist documents pneumonia as an impression based on the chest x-ray. However, the attending physician documents bronchitis throughout the record, including in the discharge summary.

Query: Do you agree with the pulmonologist’s impression that the patient has pneumonia? Please document your response in the health record or below.

Yes _____

No _____

Other _____

Clinically undetermined _____

Name: _____ Date: _____

Rationale: This is an example of a yes/no query resolving conflicting practitioner documentation.

is already present in the health record (i.e., findings in pathology, radiology, and other diagnostic reports) with interpretation by a physician

- » Establishing a cause-and-effect relationship between documented conditions such as manifestation/etiology, complications, and conditions/diagnostic findings (i.e., hypertension and congestive heart failure, diabetes mellitus and chronic kidney disease)
- » Resolving conflicting documentation from multiple practitioners

Unlike other qualifiers listed under the official coding guidelines for inpatient reporting of uncertain diagnoses, “possible” is a very broad term and therefore its use in a query is discouraged.

Verbal queries and missing clinical indicators

Verbal queries should contain the same clinical indicators and follow the same format as written queries to ensure compliance and consistency in policy and process. Documentation of the verbal query may be condensed to reflect the stated information, but should identify the clinical indicators that support the query as well as the actual question posed to the practitioner. Verbal queries should be documented at the time of the discussion or immediately following.

The focus of external audits has expanded in recent years to include clinical validation review. The Centers for Medicare & Medicaid Services (CMS) has instructed coders to “refer to the *Coding Clinic* guidelines and query the physician when clinical validation is required.” The practitioner does not have to use the criteria specifically outlined by *Coding Clinic*, but reasonable support within the health record for the diagnosis must be present.

When a practitioner documents a diagnosis that does not appear to be supported by the clinical indicators in the health record, it is currently advised that a query be generated to address the conflict or that the conflict be addressed through the facility’s escalation policy.

CMS recommends that each facility develop an escalation policy for unanswered queries and to address any staff concerns regarding queries. In the event that a query does not receive a professional response, the case should be referred for further review in accordance with the facility’s escalation policy. The escalation process may include, but is not limited

to, referral to a physician advisor, the chief medical officer, or other administrative personnel. [See sample query 2.]

Develop query retention policies

Each organization should develop internal policies regarding query retention. Ideally, a practitioner’s response to a query is documented in the health record, which may include the progress notes or the discharge summary. If the record has been completed, this may be an addendum and should be authenticated. As noted in AHIMA’s toolkit, “Amendments in the Electronic Health Record,” “the addendum should be timely, bear the current date, time, and reason for the additional information being added to the health record, and be electronically signed.”

Query sample 2: Documented conditions without clinical indicators

These examples provide wording for documentation cases that include a diagnosis without an accompanying clinical indicator.

Clinical scenario 1

Documentation: Laboratory finding of serum sodium of 120 mmol/L and the attending physician documents hypernatremia in the final diagnostic statement.

Query: Please review the laboratory section of the present record to confirm your discharge diagnosis of hypernatremia. Laboratory findings indicate a serum sodium of 120 mmol/L.

Clinical scenario 2

Documentation: Four-year-old child sustains a cautery injury to upper lip during maxillofacial surgery. Silvadene and dressing is applied to the affected area at the completion of the procedure and plastic surgery was consulted. The surgeon documented in the operative report that there were “no intraoperative complications.”

Query: Please review the operative note notation of “a cautery lesion to the upper lip,” subsequent treatment with Silvadene and clarify your documentation of “no intraoperative complications.”

Organizational policies should specifically address query retention consistent with statutory or regulatory guidelines. The policy should indicate whether the query is part of the patient's permanent health record or stored as a separate business record. If the query form is not part of the health record, the policy should specify where it will be filed and the length of time it will be retained. It may be necessary to retain the query indefinitely if it contains information not documented in the health record. Auditors may request copies

of any queries in order to validate query wording, even if they are not considered part of the legal health record.

An important consideration in query retention is the ability to collect data for trend analysis, which provides the opportunity for process improvement and identification of educational needs.

Always follow best practices

Healthcare professionals who work alongside practi-

ACDIS/AHIMA acknowledgments

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tioners to ensure accuracy in health record documentation should follow established facility policies and procedures that are congruent with recognized professional guidelines. This practice brief represents the joint efforts of AHIMA and the Association for Clinical Documentation Improvement Specialists to provide ongoing guidance related to querying. It specifies updates to previous AHIMA practice briefs and provides support for an appropriate query process. As healthcare delivery continues to evolve, it is expected that future revisions will be required.

Resources and references

The following resources and references were used in the creation of this advice:

- » CMS. *Medicare Quarterly Provider Compliance Newsletter*. Volume I, Issue 4. July 2011.
- » AHA. *Coding Clinic*, Second Quarter 2012, p. 21.
- » AHIMA. "Amendments in the Electronic Health Record." AHIMA Toolkit. Published August 15, 2012.
- » AHIMA. "Guidance for Clinical Documentation Improvement Programs." *Journal of AHIMA* 81, no.5 (May 2010): 45–50.
- » AHIMA. "Managing an Effective Query Process." *Journal of AHIMA* 79, no.10 (October 2008): 83–88.

The information contained in this practice brief reflects the consensus opinion of the professionals who developed it. It has not been validated through scientific research. 

Appendix: Query examples

Example verbal query documentation

The documentation of verbal queries should follow a standard format to include all necessary information.

Spoke with Dr. X regarding the documentation of (condition/procedure) based upon the clinical indicator(s) found in the health record (list what was found and where).

Example open-ended query

Documentation: A patient is admitted with pneumonia. The admitting H&P examination reveals WBC of 14,000; a respiratory rate of 24; a temperature of 102 degrees; heart rate of 120; hypotension; and altered mental status. The patient is administered an IV antibiotic and IV fluid resuscitation.

Leading: The patient has elevated WBCs, tachycardia, and is given an IV antibiotic for *Pseudomonas* cultured from the blood. Are you treating for sepsis?

Nonleading: Based on your clinical judgment, can you provide a diagnosis that represents the below-listed clinical indicators? In this patient admitted with pneumonia, the admitting H&P examination reveals the following:

- » WBC 14,000
- » Respiratory rate 24
- » Temperature 102°F
- » Heart rate 120
- » Hypotension
- » Altered mental status

- » IV antibiotic administration
- » IV fluid resuscitation

Please document the condition and the causative organism (if known) in the medical record.

Example multiple-choice query

Documentation: A patient is admitted for a right hip fracture. The H&P notes that the patient has a history of chronic congestive heart failure. A recent echocardiogram showed left ventricular ejection fraction (EF) of 25%. The patient's home medications include metoprolol XL, lisinopril, and Lasix.

Leading: Please document whether you agree the patient has chronic diastolic heart failure.

Nonleading: It is noted in the impression of the H&P that the patient has chronic congestive heart failure and a recent echocardiogram noted under the cardiac review of systems reveals an EF of 25%. Can the chronic heart failure be further specified as:

- » Chronic systolic heart failure _____
- » Chronic diastolic heart failure _____
- » Chronic systolic and diastolic heart failure _____
- » Some other type of heart failure _____
- » Undetermined _____

Example 1 compliant yes/no query

Documentation: A patient is admitted with cellulitis around

Appendix: Query examples (cont.)

a recent operative wound site, and only cellulitis is documented without any relationship to the recent surgical procedure.

Query: Is the cellulitis due to or the result of the surgical procedure? Please document your response in the health record or below.

Yes _____

No _____

Other _____

Clinically undetermined _____

Name: _____ Date: _____

Rationale: This is an example of a yes/no query involving a documented condition potentially resulting from a procedure.

Example 1 noncompliant yes/no query

Documentation: On admission, bilateral lower extremity edema is noted; however, there are no other clinical indicators to support malnutrition.

Query: Do you agree that the patient's bilateral lower extremity edema is diagnostic of malnutrition? Please document your response in the health record or below.

Yes _____

No _____

Other _____

Clinically undetermined _____

Name: _____ Date: _____

Rationale: Malnutrition is not a further specification of the isolated finding of bilateral lower extremity edema. An open-ended or multiple-choice query should be used under this circumstance to ascertain the underlying cause of the patient's edema.

Example 2 compliant yes/no queries

Documentation: Congestive heart failure is documented in the final discharge statement in a patient who is noted to have an echocardiographic interpretation of systolic dysfunction and is maintained on lisinopril, Lasix, and Lanoxin.

Query: Based on the echocardiographic interpretation of systolic dysfunction in this patient maintained on lisinopril, Lasix, and Lanoxin, can your documentation of "congestive heart failure" be further specified as systolic congestive heart failure? Please document your response in the health record or below.

Yes _____

No _____

Other _____

Clinically undetermined _____

Name: _____ Date: _____

Rationale: This yes/no query provides an example of determining the specificity of a condition that is documented as an interpretation of an echocardiogram.

Example 2 noncompliant yes/no queries

Documentation: A patient is admitted with an acute gastrointestinal bleed, and the hemoglobin drops from 12 g/dL to 7.5 g/dL and two units of packed red blood cells are transfused. The physician documents anemia in the final discharge statement.

Query: In this patient admitted with a gastrointestinal bleed and who underwent a blood transfusion after a drop in the hemoglobin from 12 g/dL on admission to 7.5 g/dL, can your documentation of anemia be further specified as acute blood loss anemia? Please document your response in the health record or below accompanied by clinical substantiation.

Yes _____

No _____

Other _____

Clinically undetermined _____

Name: _____ Date: _____

Rationale: In this example, a yes/no query is not appropriate for specifying the type of anemia. A multiple-choice or open-ended query is a better option.

Example 3 compliant yes/no queries

Documentation: During the removal of an abdominal mass, the surgeon documents, in the description of the operative procedure, a "serosal injury to the stomach was repaired with interrupted sutures."

Query: In the description of the operative procedure a serosal injury to the stomach was noted and repaired with interrupted sutures. Was this serosal injury and repair:

A complication of the procedure _____

Integral to the above procedure _____

Not clinically significant _____

Other _____

Clinically undetermined _____

Please document your response in the health record or below

accompanied by clinical substantiation.

Name: _____ Date: _____

Rationale: This is an example of a query necessary to determine the clinical significance of a condition resulting from a procedure.

Example 3 noncompliant yes/no queries

Documentation: In the ED, a Foley catheter was inserted for the patient with dysuria and elevated WBCs that was removed two days after admission. The cultures were positive for E. coli and the progress note reflects a catheter-associated urinary tract infection (CAUTI) and this was coded. Quality has requested review of the HAC condition to ensure it should be coded as it does not meet the CDC definition for CAUTI.

Query: The quality department has indicated that your documented diagnosis of CAUTI does not meet the CDC definition, which impacts the hospital-acquired condition statistics for your profile as well as the hospital's. Does your patient have a catheter-associated urinary tract infection?

Yes _____

No _____

Other _____

Clinically undetermined _____

Name: _____ Date: _____

Rationale: This query is inappropriate as it explains the impact of the addition or removal of the diagnosis for the physician and hospital profiles. This query questions the physician's clinical judgment, which may be more appropriate in an escalation policy and/or physician education regarding the CDC definition of CAUTI. 🙅

Pediatric hypertension: The cause or the effect?



by Dan Catalano, MD, FACOG

Is hypertension an important diagnosis in childhood? According to *Nelson Pediatrics*, 19th Edition, there is a less than 1% prevalence of infant and young childhood hypertension. Given this relatively low incidence, should we be concerned about capturing that

diagnosis in the pediatric CDI world?

The answer, in my opinion, is a simple 'yes.' Primary or essential hypertension, defined as hypertension without an identifiable cause and with many possible contributing factors, is increasing among older children.

This is mostly a consequence of obesity, and may portend a future of medical problems within the cardiac and peripheral vascular arenas for these children at rates approaching epidemic proportions and of increasing complexity, according to an article in the November 2012 issue of the journal *Pediatric Nephrology*.

These diagnoses are found within the 401–404 series within ICD-9-CM.

Understand secondary hypertension

Most of the hypertension in younger children is caused by an underlying disease, making it important to identify and/or clarify "secondary hypertension" in the medical record. Ninety percent of secondary hypertension in younger children is due to renal causes, according to *Nelson Pediatrics*.

The 405 series of ICD-9-CM is where secondary hypertension is found. Not only does the accurate documentation of secondary hypertension make the cause-and-effect relationship clear, it also prevents the statistical analysis of hypertension in children from being confounded by mixing primary and secondary causes into one barrel, as though they are one and the same.

In many cases of secondary hypertension, treatment of the underlying cause will also treat the hypertension, while in primary hypertension, treatment of the hypertension itself is mandatory and may be lifelong.

In infancy, causes of hypertension are almost exclusively secondary, as in thrombosis of renal artery or vein, which may be caused by umbilical artery catheterization, congenital renal anomalies, coarctation of the aorta, patent ductus arteriosus, or bronchopulmonary dysplasia.

Between 1 and 6 years of age, we see renal artery stenosis (caused by fibromuscular hyperplasia rather than atherosclerotic disease), renal parenchymal disease (such as in glomerulonephritis), Wilms' tumor, neuroblastoma, and coarctation of the aorta as the common causes.

Between 7 and 12 years of age, essential hypertension is seen, but secondary causes still predominate as in renal parenchymal disease, renovascular abnormalities, and endocrine causes (e.g., pheochromocytoma, aldosteronism, Cushing's syndrome).

Finally, over the age of 12, essential hypertension predominates, but physicians need to look for renal parenchymal diseases and endocrine issues as secondary causes of hypertension.

CDI specialists must look for documentation and clinical indicators related to those diagnoses.

Capture the relationship

In reviews of medical records at pediatric facilities around the country, I have found that a common issue is incorrect capture of the diagnosis of hypertension. This incorrect capture is typically either the result of failure of the provider to note the secondary nature of the hypertension (i.e., stating just "hypertension" without any further diagnostic terminology), or failure of a coding professional to recognize the secondary relationship that is stated within the medical record.

For example, a physician might document, "I am treating the hypertension resulting from the chronic kidney disease with ..." and the HIM/coding professional may not recognize the diagnosis in the documentation.

Such documentation results in a code assignment within the 401–404 series of ICD-9-CM, depending on whether kidney disease or heart disease is documented in some fashion as well. Some encoders may also take the coder down the path of this series because of a built-in rule requiring a specific sequencing with heart or kidney disease, even though the "chicken or the egg" is clearly stated.

The severity inherent in hypertensive disease is not captured within the primary or secondary designation, but rather by the assignment of an "accelerated" or "malignant" status, as opposed to a "benign" or "unspecified" status. While the terms "accelerated" and "malignant" as pertains to hypertension may be archaic, they are currently what

we have within ICD-9-CM to indicate hypertension of a severe nature. As yet, we find that there is no designation for accelerated or malignant hypertension coming in ICD-10-CM.

This raises some concern for the clinician because, whether in the pediatric world or in the adult world, malignant hypertension can be fatal.

Unfortunately, the pediatric coding world, and thus the severity of illness/risk of mortality calculation in the pediatric world, is hampered by the fact that the terms "malignant" or "accelerated hypertension" are not commonly used by pediatric specialists and may be difficult to bring into the day-to-day jargon even with education.

Pediatric specialists stage hypertension based on blood pressure (BP) being greater than (>) the 95th percentile and by how much. They also use the term "prehypertension" for those with BP > the 90th percentile and less than (<) the 95th percentile.

While those children considered to have prehypertension most likely do not meet the criteria for accelerated or malignant hypertension, those with hypertension Stage 2 may very well have eyeground vascular changes and/or evidence of end-organ damage/failure. If so, CDI specialists must clarify this documentation so the coding professional can arrive at the proper ICD-9-CM code, thus capturing the severity.

In summary, CDI specialists must clarify whether documented hypertension is primary (essential) or secondary. In most pediatric cases, it is secondary, but the ratio is changing, mostly due to childhood obesity. If secondary, report the hypertension using the 405 series of hypertension codes, not the 401–404 series. In addition, CDI specialists must clarify whether the hypertension present is accelerated/malignant in order to capture the appropriate severity of illness.

Unfortunately, in ICD-10-CM, as noted above, much of the hypertensive severity will be lost as it currently stands. This will result in a degradation of our ability to measure outcomes and interventions accurately. Whether or not this will change as ICD-10-CM evolves is anybody's guess. 🌸

Editor's note: Dr. Catalano has more than 25 years of experience as a physician, physician executive, and consultant. While at DCBA, Inc., he has directed the implementation of more than 15 CDI programs. Contact him at dcatalano@dcbainc.com.

Meet a member

Thirty-two-year career ends with CDI efforts



Janet Emanuelson, RN, has been a CDI specialist at Dominican Hospital - Dignity Health in Santa Cruz, Calif., for nearly six years. She joined ACDIS in 2007 and became a member of the California ACDIS Chapter in 2010, helping the ACDIS national administration to better understand networking needs in the area. We're all very envious of

her, however, because after 32 years in healthcare, Emanuelson retired in February.

CDI Journal: How did you spend your first day in retirement?

JE: At the very hospital that I retired from! My husband needed to have a total knee replacement done and had the surgery the day before I retired. I retired on a Friday and he came home on Sunday. So I get to play nurse again right away.

CDI Journal: How long have you been in the CDI field?

JE: Almost six years. I was an intensive care nurse for many years and then became the clinical information specialist working on core measures.

CDI Journal: Why did you get into this line of work?

JE: I had the feeling it was time to do something different, and at the time CDI was something that was very different.

CDI Journal: How has the field changed since you began working in CDI?

JE: There have been a number of changes occurring for the last couple of years in clinical documentation, I think. There has been more focus on money and less on severity, in my opinion.

CDI Journal: What has been your biggest reward?

JE: Getting a physician who was very resistant to start documenting the way I taught him.

CDI Journal: Can you mention a few of the "gold nuggets" of information you've received from colleagues on "CDI Talk" or through ACDIS or the California Chapter?

JE: I think I've found it interesting that across the nation, we all have similar problems. It's been enlightening learning how other CDI professionals do their jobs.

CDI Journal: If you could have any other job, what would it be?

JE: To go back to a "modified patient care" job such as in

a clinic or stand-alone outpatient surgery center.

CDI Journal: What was your first job?

JE: When I was 15, my mother was an administrator of a convalescent home (we call them skilled nursing facilities or SNFs today) and I worked as a helper in the kitchen and then went on to be a nurses' aide.

CDI Journal: Tell us about your family.

JE: I've been married for 46 years. We have three grown children and eight grandchildren and they all live within two hours of us.

CDI Journal: What are your retirement plans?

JE: We would like to get a motor home and travel around the country and see where we would like to live. California is so expensive and with a fixed income we might as well go to a less expensive area such as Arizona. We would want to stay near California, though, to be close to the kids and grandchildren.

CDI Journal: Tell us a few of your favorite things.

- » Vacation spots: Yosemite, Santa Barbara, Turks & Caicos in the Caribbean, and Cancun
- » Hobbies: Knitting, crocheting, and other needlework
- » Non-alcoholic beverage: Lemonade and orange soda
- » Foods: Mexican food, Indian food, salmon, soups, and salads 🍷

Editor's note: CDI Journal introduces an ACDIS member in each issue. If you would like to be featured or know someone who would, please email ACDIS Member Services Specialist Penny Richards at prichards@cdiassociation.com.

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Do not let documentation disconnect fester

Four principles to help you explain your CDI program's value to unsure physicians



*by Wendy Whittington,
MD, MMM*

Physicians are grappling with understanding what all of the changes in healthcare mean for their patients and themselves, and CDI efforts are part of that equation.

I am privileged to be part of the faculty group that teaches physicians in the Masters of Medical Management program at Carnegie Mellon University in Pittsburgh. As we just wrapped up with a group of new graduates, it was really interesting to hear their take on how hospitals and physicians get paid and on the role of good clinical documentation.

I spend a lot of time around physicians who are working on advanced degrees, making an effort to understand our changing environment and, in many cases, to be part of that change.

It amazes me that even among this group of physicians, there is still quite a disconnect about the importance of excellent clinical documentation and how that documentation is tied not only to reimbursement, but also quality reporting, pay for performance, and more.

In addition, there is often a lack of understanding about how sound CDI principles should be tied to our efforts to move forward with ICD-10, our race to install and optimize electronic health records (EHR), our participation in health information exchanges, and many other moving parts coming in the era of the American Recovery and Reinvestment Act and the Health Information Technology for Economic and Clinical Health Act.

I agree completely with what has already been written in the **CDI Journal** by other ACDIS contributors. As CDI specialists, we must be cautious that we don't bog physicians down with a level of detail that they don't necessarily need.

In order to maximize physician engagement and enlist the support of an ever-increasing number of physicians who are making the switch into the role of physician executive and leader, I recommend CDI professionals adhere to the follow-

ing basic principles:

1. We must align CDI programs with EHR installation/optimization and ICD-10 implementation efforts. Although some believe that EHRs will cure all physician documentation ills, unless CDI professionals ensure the needed documentation prompts are actually included within the software, it will not help physicians or coders in the end. Furthermore, the specificity needed to assign codes in ICD-10 will increase exponentially. CDI specialists need to understand these additional documentation needs and incorporate them into their regular practices.

2. We need to help physicians understand that while the coding and payment mechanisms may be different in their private practice than they are in the hospital, we can work together to find a common language that serves us well in various environments (read a related article by Glenn Krauss on p. 15). Furthermore, CDI specialists must reinforce the fact that providing excellent clinical documentation is an integral part of providing the best patient care possible. It is not just something to boost hospital reimbursement.

3. The basic principles of clinical documentation remain the same and are in the best interest of patient care. This is true regardless of whether we work in a community hospital, in an academic medical center, or with APR-DRGs, MS-DRGs, or another payment methodology. Clarifying how certain words and phrases are defined by clinicians and then translated into codes by coders can be an excellent exercise for team building as we define clinical pathways and embrace evidence-based medicine. We need to be clear about the use of our language for reasons that extend beyond proper DRG placement.

4. Physicians need to understand why CDI specialists do what they do. This is the most important concept of all. Physicians are more likely to embrace a CDI program when they are part of a collaborative process that rolls out CDI efforts in an organization. 🌸

Editor's note: Whittington is a director with Navigant Healthcare in Dallas. Contact her at wendy.whittington@navigant.com.

Avoid the DRG 'grab bag' mentality: Help the physician instead



by Glenn Krauss, BBA, RHIA, CCS, CCS-P, CPUR, FCS, PCS, C-CDIS, CCDS

The No. 1 struggle most CDI specialists face is getting physicians engaged in CDI, to provide accurate, specific, consistent documentation in the record.

Unfortunately, unless healthcare is reformed to the point where bundled payments are provided for both the physician and the hospital, CDI will always be a difficult sell for physicians who get paid under a separate fee-for-service system.

Furthermore, CDI efforts will continue to be a difficult sell if CDI specialists only seek specific diagnoses to help improve the hospital DRG. That's because physicians have a natural tendency to prejudge the merits of a CDI program from the perspective of whether the program is of benefit to *their* business of the practice of medicine.

So how do you get physicians to buy into CDI? By offering up real-time helpful documentation tips and strategies that benefit *their* practice—and *their* pocketbooks. As CDI professionals, we certainly cannot directly discuss reimbursement with physicians; however, it is perfectly permissible to engage in a candid conversation with physicians regarding CDI strategies that best capture their thought processes and regarding medical decision-making for ordering and performing a diagnostic test or procedure. Physicians indeed have a vested interest in accurately capturing and reporting this information since their own personal reimbursement for the performed procedure is at stake.

Consider the following clinical scenarios and documentation strategies as you embark on showing physicians that there is certainly "something in it for them."

Colonoscopy: A case study

Although colonoscopies do not impact a hospital's DRG assignment, physicians often don't include enough clinically relevant documentation to get paid for this procedure. Here is a typical case:

A patient is admitted through the emergency department (ED) with weakness, lethargy, and supposed unwitnessed

"presyncope." In the course of the ED workup, the labs reveal a significantly low hemoglobin and hematocrit; the patient receives two units of packed red blood cells. The patient reports loss of appetite and unintentional weight loss of 25 pounds in the past six months. In addition, the patient's sister just was diagnosed with colon cancer and is in the process of scheduling surgery for removal of the tumor.

Once the patient is clinically stabilized, the attending physician calls in the gastroenterologist to perform a colonoscopy to determine whether the source of the significant anemia is from the gastrointestinal tract. The result of the colonoscopy is within normal limits, and the patient is discharged the same day with planned follow-up to include a hematological workup as a possible clinical explanation for the patient's recurrent anemia. The discharge summary indicates a principal diagnosis of syncope with the following secondary diagnoses:

- » Anemia
- » Hypertension
- » Lipidemia
- » Family history of colon cancer

Following protocol, a CDI specialist will typically review the record upon admission or shortly thereafter and determine that the clinical description of the case does not warrant a query, and accordingly, will move to the next record for review. Final DRG assignment by the coding staff with adherence to principal diagnosis selection is MS-DRG 312, syncope and collapse, and all is well that ends well for the case.

Not so fast! There is more than meets the eye here. There are additional query opportunities in the record that will benefit the physician and the hospital, provided the CDI specialist is able to recognize the clinical clues that are often overlooked. These clues serve as prompts for CDI staff to query the physician asking him/her to clarify his/her thought process. Such clinical thinking is an integral part of the decision to order the colonoscopy.

So with that in mind, let's take a closer look at the above clinical scenario. A colonoscopy ensued that failed to definitively identify the gastrointestinal tract as the source of the anemia. The documentation plausibly leads an outside reviewer

to a reasonable conclusion that the physician was considering a possible colon malignancy as an etiology for the patient's anemia and contribution to the presenting sign and symptom of weakness and syncope.

This is due to the patient's sex (female), age (72), family history of colon cancer, and unexplained weight loss over the course of the past six months.

Unfortunately, the physician failed to explicitly outline his clinical thought process and judgment in his documentation, and did not adequately represent his analytical and problem-solving skills in support of medical decision-making and ultimate E/M of the patient's care.

While the colonoscopy performed in the inpatient setting does not affect hospital reimbursement, it does affect the physician's reimbursement, since physicians separately code and bill for their individual hospital services and assign their benefits to the hospital if they are employed by the hospital.

The colonoscopy as documented above would be deemed as "not medically necessary" by a payer based on the diagnosis provided by the physician (anemia with a negative workup). If the physician explicitly included in his assessment "clinical concern for colon malignancy," he could legitimately include this diagnosis in his billing, leading to reimbursement from Medicare.

By the way, while anemia would on face value appear to be the clinical rationale for ordering and performing a colonoscopy, only iron deficiency anemia or iron deficiency anemia secondary to blood loss would establish medical necessity and ensure payment for the physician.

Review with healthcare reform in mind

Effective clinical documentation serves numerous purposes beyond reimbursement. Clearly, adequate documentation serves to promote measures of efficiency, defined by the Government Accountability Office as "ordering and providing a level of service that is sufficient but not excessive, given the patient's health status." There is undoubtedly much more we can contribute to documentation improvement than our present efforts.

Discharge statements used to suffice in regards to substantiating and justifying services physicians provided to patients. Unfortunately, the physician's clinical problem-solving and analytical skills culminating in a diagnosis no longer stand on their own; clinical thought processes and decisions driving

definitive and provisional diagnosis are now an undisputable necessary component of documentation in support of conclusive diagnostic statements.

An E/M service is defined as the exchange of clinically relevant and necessary information from the patient and other involved members and the use of that information in managing the patient.

How does this really benefit the physician as well as the hospital? Inarguably, there are numerous synergies of clinical documentation in the inpatient or observation record that are of material benefit to the hospital and the physician. It is incumbent on the physician to clearly demonstrate medical necessity for all patient visits that culminate in an E/M assignment as well as performance of procedures. This same clinical documentation is essential for establishment of medical necessity for inpatient/observation services from the hospital's perspective.

The fact that Recovery Auditors are experiencing bountiful business reviewing hospital short-stay inpatient admissions, defined as two days or less, and recouping millions of dollars from hospitals under the guise of "incorrect setting" is witness to the lack of effective clinical documentation provided by physicians in support of the medical decision-making to admit a patient as an inpatient.

To add insult to injury, many hospitals are experiencing denials for observation services, primarily on the basis of incomplete and inadequate clinical documentation that expands well beyond the borders of CC/MCC and principal diagnosis capture.

Aside from establishment of medical necessity for the hospital and physician, effective, complete, and succinct clinical documentation helps represent and report measures of healthcare delivery efficiency. Healthcare is transitioning away from strict fee-for-service payment methodologies to ones ingrained in quality, efficiency, value-based outcomes, and measures of patient satisfaction.

As CDI specialists, it's vital that we keep this in mind as we review records. It's time to step outside our comfort zone of present-day chart review, reconsider our current CDI initiatives, and take the leap to embracing change. 🌸

Editor's note: Krauss is an independent consultant based in Madison, Wis., a former ACDIS Advisory Board member, and leader of the Wisconsin ACDIS Chapter. Contact him at glennkrauss@earthlink.net.

How to overcome physician resistance to providing complete and accurate documentation for dying patients



by Trey La Charité, MD

Sadly, there are patients who will not survive their current level of illness regardless of the best efforts of their physicians and their medical facility. The providers caring for these patients are often at risk of under-reporting those patients' severity of illness and risk of mortality. CDI professionals must educate facilities and physicians about the importance of accurately capturing the entire disease process description because physicians, unfortunately, are frequently reluctant to document additional disease processes in the charts of patients who are obviously about to die. Let's look at one example before discussing possible causes.

A CDI specialist reviews a case on the floor or in the ICU and notices "prognosis grim" written several times in the medical record. The physician, however, neglected to document one or more strikingly obvious diagnoses from the patient's record. The CDI specialist queries the physician about the absent disease processes, asking whether those diagnoses are present and how they might affect the patient's current clinical situation. The queries go unanswered. The CDI specialist follows up with the physician, which proves unproductive. The physician replies, "I'm not going to write that. That patient is about to die."

There are numerous reasons physicians take this position, and while this is not an exhaustive list, you may have heard some of these excuses at one time or another:

- » "I don't want to 'penalize' the patient."
- » "I don't want to bill the insurance company."
- » "I don't want to stick the family with a higher bill."
- » "It just doesn't feel right."
- » "Why do you need that? They are going to die. How much sicker do you need them to look?"

By examining the faulty and misguided rationale behind these excuses, we can develop an appropriate response when confronted with a similar situation in the future.

1. Your providers are not "penalizing" the patient. When

properly documented, the principal diagnosis and the circumstances leading to the current medical situation are firmly established in the medical record. There is no penalty to the patient for accurately describing how sick he or she is.

On a personal note, I believe patients' families gain some solace, if they choose to review the records, from the documentation of the severity of their loved one's illness simply by knowing the full extent of the condition. Furthermore, there is a clear benefit from an epidemiological standpoint to tracking disease processes and identifying the toll those diseases take on our society. Providing diluted documentation related to the severity of a patient's illness also dilutes our ability to provide that larger societal insight. As providers, our job is to take care of those patients to the best of our abilities. If we do not have a clear and inclusive picture of the various factors that play a role in a patient's potential recovery, how can we effectively manage that patient in the hopes of providing a reasonable outcome?

2. Your facility and its physicians are not going to "bilk" the insurance company. MS-DRGs were created so that hospitals could be appropriately reimbursed for patients who require more resources for their complex medical care. Patients who are about to die are obviously as sick as anyone can get. Dying patients require an incredible amount of resources to help them and their families' transition through this difficult time.

In addition to the medical measures implemented to sustain and prolong life, these patients require other resources such as increased nursing care, comfort care, physician and chaplain time at the bedside, palliative care services, and medications for comfort. These services should be appropriately reimbursed to ensure that they are available for the next patient who desperately needs them.

Furthermore, under the MS-DRG system, if a provider accurately diagnoses and describes the disease processes that a patient displays, there should be no question as to whether the level of reimbursement obtained is appropriate for that patient's care. The insurance company is not getting "dinged," it is covering the legitimate cost of taking care of that patient.

3. The family is not receiving a higher bill from the hospital. As with all health insurance products, patients pay

a fixed annualized premium for their insurance product, regardless of payer. This is set annually, paid on whatever schedule is arranged, and cannot be increased until the following year. Additionally, patients also have standard annualized copay and/or deductible arrangements with their insurance carriers. Once the patient or family has met those required copay or deductible amounts, the insurance carrier picks up the rest of the tab for hospital care. As with yearly insurance premiums, copays and deductibles can only be increased on an annual basis. While the insurance company may get a higher bill based on the DRG submission, the family of the patient who passed away will not.

4. Physicians must obtain a level of comfort with handling the documentation of a dying patient. They need to be reassured when they think they are doing something that “doesn’t feel right,” why such actions are indeed appropriate. While this phenomenon exists among physicians across multiple specialties, resident physicians represent the demographic most prone to expressing this sentiment. I suspect this stems from young physicians’ honest naiveté regarding how their data and their hospital’s data is collected and scrutinized. Resident physicians are also extremely sensitive to anything they perceive as having the slightest chance of being unethical. While these (possibly) young physicians are not acting out of malice or petulance when this unique situation arises, corrective action still must be taken to mitigate this response.

The most important concept to impart to reticent practitioners is that accurate and comprehensive diagnosis descriptions and documentation in these cases is not a financial issue. The reality of why we need our providers to make the charts reflect the imminence of the patient’s death is quite simple: If the patient is about to pass away while on that provider’s service (or their attending physician’s service), the patient’s actual mortality is going to be 100%.

CDI strategies for documenting mortality

In order for physicians to keep their report card looking reasonable, it behooves them to make that death (and every death on their service) look as expected as possible. In other words, the expected mortality needs to be made as high as possible.

How can physicians effectively accomplish this? By simply documenting all of those extra diagnoses they were

initially afraid to document in the chart. Regardless of the cause or the circumstance, it is never good for a physician’s report card when a patient passes away under his or her care. Fortunately, mortality rates, whether actual or expected, are averages; one single death will not sink a physician’s overall standing in the publicly reported data. However, multiple deaths over time that appear to be relatively *unexpected* due to a lack of documented comorbidities and significant disease processes will not benefit them or their host facility.

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I do not condone querying for diagnoses that would be considered part of the active dying process. For example, querying for “acute respiratory failure” or “acute encephalopathy” for a patient who has been transitioned to comfort care measures, including a narcotic drip for pain control, would be unnecessary. If these diagnoses did not exist prior to the institution of that drip, I would consider the attempt to secure that provider’s documentation of those diagnoses to be fraudulent and entirely inappropriate.

I am referring to those patients for whom the provider has recognized that a poor outcome is the most likely scenario and to those cases where the patients will obviously not survive their current level of illness regardless of the provider’s best efforts. It is statistically inevitable that patients will pass away inside our facilities’ walls. However, as CDI professionals, our duty is to ensure those patients’ dire clinical conditions are accurately reflected in the medical record. 🌸

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Ask ACDIS

Answers to questions on hepatic encephalopathy, acute post-op respiratory insufficiency, and more

Editor's Note: The following questions were submitted for the ACDIS quarterly conference call of February 14, 2013, and were answered by Donna Wilson, RHIA, CCS, CCDS, Robert Gold, MD, Sylvia Hoffman, RN, CCDS, CCDI, CDIP, and Donald Butler, RN, BSN, of the ACDIS advisory board.

Q: What are the pros/cons of coding 'hepatic encephalopathy' as a secondary condition? For example, here is a clinical scenario that happened at our facility: A patient is admitted for pneumonia and the history and physical (H&P) states the patient has a 'history of Hepatitis C with encephalopathy controlled with Lactulose, current grade 0 (zero).

In the opinion of the ACDIS Advisory Board members, is it compliant to code the Hepatitis C as with encephalopathy?

Donna Wilson: If a patient is admitted with viral hepatitis and also has hepatic encephalopathy, do not code hepatic encephalopathy (572.2) as a secondary diagnosis. Hepatic encephalopathy/coma is included in the code for the viral hepatitis (see AHA *Coding Clinic* for ICD-9-CM, 2007, 2nd Quarter, p. 6.)

Robert Gold: My concern is that the name of the code is "with coma." When the patient is awake, alert, and not comatose, and therefore not being actively treated for coma, much less active delirium from hepatic encephalopathy (i.e., patient is stable on benchmark lactulose), do not code "with coma" just because the patient is under standard treatment—he doesn't have it now. This is a Recovery Auditor target.

Sylvia Hoffman: I agree with Donna. It would be inappropriate to code the encephalopathy. The *Coding Clinic* referenced also states if a patient is admitted with viral hepatitis and also hepatic encephalopathy, do not list hepatic encephalopathy as a secondary diagnosis. Hepatic encephalopathy/coma is included in the code for the viral hepatitis.

Donald Butler: Although I find the logic of the question very seductive, I've finally realized how to perhaps express why I have not been comfortable with this concept for a

while. Coding for a chronic condition that is under control with treatment, etc., is one thing (i.e., end-stage renal disease [ESRD], congestive heart failure [CHF], etc.). The nuanced difference for me on this particular item is that coding the hepatic encephalopathy would be capturing the acute manifestation of the chronic problem (i.e., the underlying liver disease) that is not currently present but which the patient had previously. Encephalopathy is (per the National Institute of Neurological Disorders and Stroke) a global brain dysfunction, and the patient described in this scenario does not have that. One would not consider coding acute pulmonary edema or acute CHF in an ESRD patient is who stable and compliant with their treatment regime.

Secondly, although there is a non-essential modifier for hepatic encephalopathy (acute), it still suggests that the intent is for an acute problem. Furthermore, there is no index entry for chronic hepatic encephalopathy, and clinically I'm not sure such a condition exists. There are better ways to capture the treatment focused on the chronic liver condition, especially if the liver disease is advanced to the point of chronic failure.

Q: Is there any criteria or guidance for the use of acute post-operative respiratory insufficiency as an MCC, especially for patients with chronic respiratory issues. Our hospital instituted a new protocol for all post-open heart surgery patients in the intensive care unit. The patient is placed on bipap for one hour and then off for two hours. Clinically, the thought is that post-op complications can be avoided. We frequently see 'post-op respiratory failure' documented even when the patient didn't appear to require a longer bipap period above the protocol. Are there clinical parameters that we can use to ensure that we are accurately picking up this diagnosis?

Donna Wilson: *Coding Clinic*, 3rd Quarter 1988, p. 7 states:

"the arterial blood gas pH is also helpful in determining respiratory failure in a patient with known chronic lung disease. When arterial blood gas pH is less than 7.35, this is often associated with respiratory failure in such patients."

Robert Gold: Criteria from *Coding Clinic* for acute

respiratory failure is beneficial when reviewing the chart of a chronic lung patient as evidence of acute hypercapnic respiratory failure (which we'll need in order to code under ICD-10, either hypoxic or hypercapnic). I'd urge folks to identify if a patient has acute respiratory failure or not, and if that acute respiratory failure after an operative procedure is because of the surgery or whether it is due to another condition that happened to occur after the operation. I'd urge physicians to leave insufficiency alone as a word.

If the patient develops acute respiratory distress syndrome (ARDS), that's a different situation. Patients who are purposely maintained on a ventilator after a procedure to prevent them from undergoing the added stress of breathing on their own are being managed on a ventilator. In these cases it is inappropriate to document or code acute postoperative respiratory failure. The 518.52 code is supposed to be for ARDS only and it is misdefined in the books.

Sylvia Hoffman: Other factors to consider are a change in oxygen rate or change in delivery method. If the use of bipap post surgery is new and extends longer than the physician anticipates and is documented by the physician, it qualifies as failure, even if treatment is short lived. The goal is to prevent cardio-respiratory arrest.

Don Butler: You should only be looking for post-op respiratory insufficiency when the clinical course is outside of the expected. Then you should be looking for the same parameters as any case of respiratory failure—i.e., increased difficulty breathing, increased need for oxygen, tachypnea, etc. Documentation of a diagnosis where there are not clinical indicators is often an opportunity for a physician advisor to have an informal discussion with that documenting physician.

Q: Are there coding guidelines with the use of hyponatremia as a secondary CC and how minimal the treatment can be? We see this documented for patients with a sodium (Na) level of I32 or I34, and although intravenous fluids have been ordered, we are not sure if we are able to pick up that code. Sometimes, the physician may document the hyponatremia but only monitors the labs. Is this sufficient treatment to pick it up as a secondary condition?

Donna Wilson: Per *Coding Clinic*, 1993, p. 8:

“Question: How do you code Syndrome of

Inappropriate Secretion of Antidiuretic Hormone (SIADH)? Do you also code hyponatremia, water intoxication, or confusion, to better describe the condition? Answer: Assign code 253.6, Other disorders of neurohypophysis. SIADH, or syndrome of inappropriate secretion of antidiuretic hormone, can be found in the index under Syndrome, inappropriate secretion of antidiuretic hormone (ADH). Do not code hyponatremia, water intoxication, or confusion, as these are conditions integral to the disease process and are therefore not coded separately.”

Robert Gold: Certainly you do not code the hyponatremia in SIADH, as Donna notes above, but I would think that so long as a physician is doing something about a patient's low sodium (i.e., changing the IV from half normal to normal saline or Ringers, giving 3% saline or withholding free water), then it should be picked up. If it's just there and nothing is being done, then it doesn't meet Uniform Hospital Discharge Data Set (UHDDS) criteria. Even following with another sodium level isn't good enough.

Sylvia Hoffman: This scenario does not seem to meet the UHDDS definition if a secondary diagnosis. Hospital HIM departments need to have a policy and procedure for not coding a documented diagnosis when a physician documents a condition, but the indicators are not present or the guidelines not met.

Don Butler: In these instances you should look for identified treatment activity, or change, as documented by the physician. Serial monitoring (not just one repeat) where there is documented rationale expressing a clinical basis of concern might also be enough to capture this secondary diagnosis.

Q: Recently one of our critical care attending physician started documenting [*systemic inflammatory response syndrome (SIRS)*] “SIRS non-infectious, due to surgical trauma” for patients admitted to our surgical intensive care unit for (for example) an esophagectomy and after a gastrectomy. These patients stayed in intensive care for one night and had smooth, uneventful, post-op courses. What is the Advisory Board's feeling about the use of this diagnosis?

Donna Wilson: Per AHA *Coding Clinic* 4th Quarter

2011, p. 184:

“Sepsis due to a Postprocedural Infection:

(a) Documentation of causal relationship. As with all postprocedural complications, code assignment is based on the provider’s documentation of the relationship between the infection and the procedure.

(b) Sepsis due to postprocedural infection. In cases of postprocedural sepsis, the complication code, such as code 998.59, Other postoperative infection, or 674.3x, Other complications of obstetrical surgical wounds should be coded first followed by the appropriate sepsis codes (systemic infection code and either code 995.91 or 995.92). An additional code(s) for any acute organ dysfunction should also be assigned for cases of severe sepsis. In cases where a postprocedural infection has occurred and has resulted in severe sepsis and postprocedural septic shock, the code for the precipitating complication such as code 998.59, Other postoperative infection, or 674.3x, Other complications of obstetrical surgical wounds should be coded first followed by the appropriate sepsis codes (systemic infection code and code 995.92). Code 998.02, Postoperative septic shock, should be assigned as an additional code. In cases of severe sepsis, an additional code(s) for any acute organ dysfunction should also be assigned.

Robert Gold: SIRS is supposed to be a systemic

response to inflammation. There has to be an inflammatory process identified, whether infection or a noninfection/inflammatory process. Variations in vital signs not due to inflammatory processes are just that—variations in vital signs. They are not SIRS. If the condition is sepsis, then it is sepsis—but the physicians are not talking about that.

Note that in ICD-10, all these terms go away. Sepsis will be sepsis, SIRS will be due to a disease that’s not an infection, and it won’t be just modifications in vital signs. However, in ICD-9 you should encourage your physicians to avoid documenting SIRS on a whim. There has to be potential for clinical danger to the patient, not simply a condition that everyone has.

Sylvia Hoffman: I would ask if the SIRS criteria were met (i.e., did the patient have a fever, elevated pulse, increased respiration, etc.).

Don Butler: It sounds like another case where the documentation by the physician is describing something that everyone has, and that is integral to the procedure/immediate post-op course. I strongly encourage everyone to read the recent article in *Critical Care Medicine* on sepsis/SIRS, “Surviving Sepsis Campaign: International Guidelines for Management of Severe Sepsis and Septic Shock,” which published in February 2013 (visit <http://tinyurl.com/cpqzxcly>). It is the latest (extensive) clinical literature. This sounds like another instance where an informal conversation between a physician advisor or champion should occur. 🌸