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Escalation policy addendum added to new AHIMA/ACDIS query practice brief

Third-party regulatory agencies often question the clinical validity of a physician's diagnosis. Most hospitals have had a Recovery Auditor deny a claim due to lack of documentation identifying supportive clinical indicators in the medical record. But until recently, CDI specialists and coders had little guidance about what to do in these instances.

The ACDIS/AHIMA "Guidelines for Achieving a Compliant Query Process" released earlier this spring added "lack of clinical indicators" to its previous guidance of when to query. It states that "[t]he 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"

A recently released addendum to the practice brief outlines two sample policies facilities can adapt to help staff navigate the often murky



waters surrounding queries for medical validity, shifting the responsibility to a secondary reviewer and/or oversight committee, says **Susan Wallace, MEd, RHIA, CCS, CDIP, CCDS, AHIMA-**Approved ICD-10 Trainer and director of compliance/inpatient consultant with Administrative Consultant Service, LLC, in Shawnee, Okla. (See p. 4 for the addendum.)

"When something is clearly and consistently written in the medical record and yet the diagnosis is wrong, what is a coder or CDI specialist supposed to do?" says **Paul Weygandt, MD, JD, MPH, MBA, CCS, FACPE**, vice president of physician services at J.A. Thomas & Associates in Johnstown, Pa. Weygandt served on the joint ACDIS/AHIMA committee that drafted the practice brief and helped compose the "Internal Escalation Policy" addendum.

Rather than questioning physicians' clinical judgment and risking their ire, coders often simply do not code the questionable condition, Weygandt says. Changing a diagnosis, or neglecting to code a documented diagnosis, however, is "equivalent to making a diagnosis and could be construed as practicing medicine without a license," he says.

Yet coders' "lack of clinical acumen is a

myth,” says Weygandt. “The coders are on the ball. They have a lot of experience [and so] have often expressed anxiety about coding what is in the record if they do not agree with it.”

Previously, “you simply did not question a physician’s diagnosis,” says **William E. Haik, MD, FCCP**, director of DRG Review, Inc., in Fort Walton Beach, Fla., who also served on the joint committee that authored the brief.

“We are way past those rudimentary days. Coders frankly have a far greater understanding of the clinical picture than most are willing to acknowledge. If third-party regulatory agencies are questioning the validation of the physician’s documentation, of their diagnosis, then the hospital needs to be looking for that also. This new policy gives guidance as to how to codify that process,” Haik says.

Essentially, the sample policies provide a separate avenue for CDI specialists and coders, removing them from the physician’s potential line of fire while nevertheless solidifying their responsibility for raising any clinical concerns they may have stumbled across during their review of the medical record.

The CDI specialist may still decide to query the physician directly. The “Guidelines for Achieving a Compliant Query Process” state that “[w]hen 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.” (Emphasis added.)

The Guidelines offer a couple of sample query scenarios, such as the attending physician documenting hypernatremia while laboratory findings show serum sodium of 120 mmol/L. The CDI specialist could then query the physician simply by quoting the laboratory findings and asking the physician to confirm the diagnosis.

Alternatively, the CDI specialist or coder can choose to follow the facility’s escalation policy. According to the sample policies included in the recent addendum, facilities can opt to refer the case to the CDI/HIM manager, who would then review the case and determine whether to refer it to an appropriate administrator, such as a chief medical officer, for example. Or they can create a multidisciplinary committee,

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which would review situations on a case-by-case basis and determine the appropriate course of action.

Although previous query guidance referenced ways to handle situations requiring additional insight, they typically called on CDI specialists to pass the review along to the program's physician advisor, says Wallace. That wasn't always practical or even possible.

"What do you do if your facility doesn't have a physician advisor? That's where the multidisciplinary committee can work out well," she says.

Addressing a lack of documented clinical indicators is "more pertinent now than in the past," says Haik, who sees the problem as twofold: either the physician documented items that may not have been treated, or they neglected to document the supportive information to back up their diagnosis.

"Obviously, anyone can make a mistake," Weygandt says. Perhaps the physician treated a patient in a certain way but simply forgot to "empty that information out of his head and include it in the medical record."

Part of the reason for a lack of supporting documentation could be overly aggressive CDI education efforts, where a particular CDI specialist always queries for sepsis and so the physicians suddenly start documenting sepsis for all their

patients, for example. Or it could be due to the physician's lack of awareness of either the CDI efforts or the various payment methodologies, says Haik.

"Some of it [lack of appropriate documentation] is a response to the pressures of CDI efforts, but it also reflects the evolution of the physician payment system as well," Haik says.

To capture the highest level of E/M codes, physicians need to document that the patient had a critical care level (e.g., respiratory failure, shock), so "they have had motivation internally as well as from external pressures" to document these conditions, Haik says.

The escalation policy can also be used to address incomplete or lack of physician response to queries, says Wallace. "A lot of facilities have been uncomfortable addressing this, but external reviewers are looking at the documentation in the record for consistency. We all have to make sure the record is as accurate and complete as possible," she says.

"I really feel like this portion of the practice brief was one of the biggest wins for the industry. We live in a health-care environment that simply requires an increased level of collaboration. I think this helps to address the ways we can more effectively do that," says Weygandt. 🌸

Sample escalation policy chart



Source: "Guidelines for Achieving a Compliant Query Practice."

Internal Escalation Policy

Editor's note: ACDIS/AHIMA recently published the following addendum to its "Guidelines for Achieving a Compliant Query Process" released earlier this spring.

The intent of this practice brief is to maintain the integrity of the coded healthcare data. The purpose of the query process outlined is to ensure appropriate documentation appears in the health record. Additional policies may need to be implemented when questions arise regarding the clinical validity in practitioner documentation.

The ACDIS/AHIMA-developed Internal Escalation Policy includes sample policies that require a CDI specialist or coder to escalate issues regarding clinical documentation validity to a manager or steering committee.

One example of an escalation policy would route these types of cases to the manager of coding or CDI. It would be the responsibility of the coder or CDI specialist to refer any clinical validity questions to their manager, who would then determine if the case would need to be referred to an appropriate administrative representative. In another example, a multidisciplinary committee would be implemented and tasked with reviewing the cases in which clinical validity of documentation is in question. This committee would be responsible for providing guidance and next steps depending on each case reviewed.

The Internal Escalation Policy samples are to be viewed as guidance only and not a mandatory practice unless the facility or entity institutes such a policy.

Internal Escalation Policy

When the question of clinical validity is identified in practitioner documentation, the facility may wish to follow its internal escalation policy rather than requiring the CDI specialist/coder to query the practitioner. Sample escalation policies are outlined below.

Sample 1

When the question of clinical validity is found in practitioner documentation, the case should first be referred to the CDI manager/coding manager for review.

- » The CDI manager/coding manager determines if the case should be referred to the appropriate administrative representative (whether a physician advisor/physician champion, CPO, VPMA, medical director, corporate compliance officer, or designated designee) for further review.
- » The administrative representative notifies CDI manager/coding manager of their concurrence with practitioner.
- » The administrative representative does not agree with the existing documentation and discusses the case with the practitioner. The practitioner provides clarifying documentation when indicated.
- » If significant disagreement cannot be resolved by the administrative representative, the case escalates to the appropriate medical staff or administrative physician leader for further review.
- » Steps in the escalation process are tracked for internal compliance purposes, such as in a query tracking log or CDI worksheet/internal coding worksheet communication.

Sample 2

An organization may wish to implement a multidisciplinary committee (consisting of physicians, quality, compliance, and HIM staff) to review cases submitted by CDI and coding when diagnoses are inconsistent with the patient's clinical picture, or the clinical picture is inconsistent with the diagnoses. The committee can provide guidance on the best course of action on a case-by-case basis.