CDI in a changing technological age
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ACDIS members are entitled to one continuing education credit for reading the CDI Journal and taking this 20-question quiz

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The evolution of query practice takes center stage

by Melissa Varnavas

I’ve written a lot about queries and the evolution of query best practices over the past 10 years, and I’ve been around long enough to remember some of the controversies regarding those best practices.

Some thought the recommendations in AHIMA’s briefs were too limiting, while others felt the guidance didn’t take CDI efforts into consideration—which ultimately led some to suggest that CDI staff didn’t need to follow the advice. At the time, CDI was a new profession born from the implementation of MS-DRGs, which fundamentally changed how the government paid for the care that facilities provided.


In just a few years, the value of CDI seemed unquestionable. So, in 2010, AHIMA published several sets of CDI-related instructions such as “Guidance for Clinical Documentation Improvement Programs,” “Clinical Documentation Improvement Toolkit,” and “Ethical Standards for Clinical Documentation Improvement Professionals,” including various CDI professionals and ACDIS members in the research and discussions leading up to their releases.

By 2012, the need for a collaborative effort between ACDIS and AHIMA had become evident. The CDI and coding communities needed a clear voice with advice for best practices applicable to all who conducted medical record reviews—be they concurrent or retrospective. The following year, ACDIS and AHIMA came together to produce “Guidelines for Achieving a Compliant Query Practice.” This brief was later updated in 2016.

Much has changed over the years—it’s now permissible to ask a yes-or-no question in certain instances, for example—but much remains the same, too. CDI specialists need to understand the progression of these releases if they are to understand the history of their profession.

Today, we have a new release—an updated, joint release from ACDIS/AHIMA of “Guidelines for Achieving a Compliant Query Practice.”
Several elements core to CDI remain, such as the fact that “regardless of the credential, role, title, or use of technology, all healthcare professionals (whether or not they are ACDIS or AHIMA members) seeking to clarify provider documentation must follow compliant query guidelines.” In addition, a query is still a query no matter what you call it (even a “clarification” is still a query). The brief lists several synonyms for “query” and wags its proverbial finger at that (hopefully) faded practice. It lists why queries are important and the common reasons for issuing them.

When CDI began, many professionals worked in paper records on the units. Their queries were often printed on purple sheets of paper to catch physicians’ attention. The staff donned purple nurses’ scrubs to match their queries and were dubbed the “purple paper people.” Today, electronic records are the norm, and with them come a host of new potential pitfalls.

A core addition to the 2019 update is the inclusion of a section devoted to the use of information from prior patient encounters. This development has become necessary as auditors increasingly deny claims for clinical validation reasons, and as EHRs provide potentially seamless access to information from the patient’s current stay as well as previous hospital and private-practice wellness visits. EHRs, whose use is mandatory, allow physicians to retrieve a richer, fuller clinical picture of the patient, and it’s time for the CDI profession to acknowledge this new reality. The brief states:

“Implementation of EHR brings information that was once buried in storage and hard to access to the fingertips of physicians and querying professionals, leading to a more detailed reference and a richer picture of a patient’s medical history…”

It also explains that while coders cannot assign a code for information obtained from prior encounters, such information can be pulled into a query “if the documentation is clinically pertinent to the present encounter.” The brief uses the example of care provided for this stay that required interrogation of a previous encounter.

While the new practice brief does not dig into clinical validation (it points instead to AHIMA’s “Clinical Validation: The Next Level of CDI” and ACDIS’ “Clinical validation and the role of the CDI professional,” publications as source documents), it reiterates the need for CDI professionals to bring forward appropriate clinical indicators to ensure query compliance. As in the 2016 iteration, “[t]here is not a required number of clinical indicators that must accompany a query because what is a ‘relevant’ clinical indicator will vary by diagnosis, patient, and clinical scenario,” the brief states, later adding that “[t]he quality of clinical indicators—how well they relate to the condition being clarified—is more important than the quantity of clinical indicators.”

Recommendations are just that—recommendations for best practices. But, as one of the four Cooperating Parties, AHIMA’s recommendations hold additional sway. As the principal home for CDI professionals, ACDIS’ involvement, too, holds additional import for the industry. While much of the new brief will ring familiar to the ears of seasoned professionals, there is also much to review, from query formats to query policies and procedures, and numerous ways in which CDI teams may wish to revisit their practices.

ACDIS appreciates the diligence of all the contributors and authors involved in crafting the 2019 release. And it extends its gratitude to AHIMA for continuing this important collaboration between HIM and CDI. Thanks to this joint effort, the industry continues to have one source document for compliant physician queries that it can stand behind. 🌟
Five questions to ask when considering prioritization software solutions

Angie Curry, RN, BSN, CCDS

Achieving documentation integrity—which results in positive outcomes for everything from quality and Patient Safety Indicators (PSI) to hospital ratings and scores—means actively involving CDI specialists in organizational documentation initiatives. However, determining which cases to review and how to prioritize them has been a significant obstacle for many CDI programs.

Having spent many years as a CDI professional, I know how difficult it can be to prioritize patient encounters. Few, if any programs, are staffed to review 100% of an inpatient population, so programs might find themselves prioritizing by payer, or just taking an educated guess at which cases might have deficiencies. Managers may rely on their clinical knowledge and expertise to try to quickly analyze the cases that came in the night before, but at the end of the day, manual prioritization is a nearly impossible task.

New software solutions, however, are changing the game. These solutions use artificial intelligence (AI) and machine learning to review the EHR and predict which cases are most suited to have their documentation clarified. By automating prioritization in this way, CDI teams can spend less time figuring out what to review and focus more time on actual review of the most complex cases. That time can be leveraged to expand payer coverage and/or become involved in other strategic initiatives outside of traditional case reviews—something that’s already happening, as indicated by the 2018 CDI Week Industry Survey.

Although the benefits of prioritization software solutions are becoming more widely known, choosing one of those solutions can prove daunting for healthcare organizations. The first step is to have a clear picture of facility priorities and how the CDI program aligns with those goals. From there, CDI professionals evaluating prioritization solutions should ask the software providers these five questions.

**Will the prioritization software interface with our current EHR and CDI software?**

This integration is what enables the time-saving promise of prioritization software—without it, the software may not function the way you want. You may need to do some homework with your IT partners and find out, for example, whether your current EHR sends demographic or registration information to your CDI software, and whether provider documentation is located within the EHR for AI review.

Because implementing and integrating disparate software solutions generally lies outside CDI’s area of expertise, your organization’s IT leaders should meet with the prioritization software provider to determine what’s needed for successful implementation and integration. Make sure that those meetings don’t happen in a vacuum and that the IT staff communicate back to CDI leadership.
What are the software prioritization logics that will triage the caseload?

For example, common prioritization logics include MS-DRGs without CC/MCC, PSI, or hospital-acquired condition codes; procedure codes; long length of stay codes; and sign and symptom DRGs.

Can the logistics be customized to align with facility priorities?

An “out of the box” configuration may not align with facility goals, but not all software can be customized, so this question is critical in software selection.

Does the prioritization software require the working DRG to be assigned to prioritize cases?

If the answer is yes, this does not necessarily solve the dilemma related to prioritization without review, and so the CDI specialist must still review cases to create the working DRG.

Are analytics or reporting available to help CDI teams continually improve their effectiveness?

Data-driven reports or dashboards not only provide the management-level insight to evaluate CDI program results; they also help CDI specialists focus their efforts on effectiveness and identify areas for improvement.

Ultimately, prioritization software can be an asset to healthcare organizations by optimizing CDI productivity and maximizing program efficiency. But understanding the benefits and limitations of the available solutions can be complex, so be sure not only to ask potential providers these questions, but also to ask for references and look for compelling case studies.

Editor’s note: Curry is a client services manager for Nuance Healthcare, based in Nixa, Missouri, and a member of the ACDIS Advisory Board serving through April 2020. The opinions expressed do not represent a consensus agreement of ACDIS or its Advisory Board. Contact Curry at angie.curry@nuance.com.
EHR’s troubled path: Three persistent problems

Technology changes at what can seem like light speed. ACDIS released a white paper on the topic of electronic health records (EHR) in 2013, and anyone working in CDI knows that, though some things remain constant, a lot has changed since then.

The three issues that CDI professionals most often cite when it comes to EHRs are templates, copy/paste, and the problem list. Each of those components can lead to costly mistakes in the record, throwing off coding and reimbursement and possibly introducing patient safety risks.

So, how can CDI professionals limit these types of issues? Three members of the 2018 CDI Practice Guidelines Committee weighed in for this edition of the CDI Journal to light readers’ paths to a better EHR.

Physician template use

To cut down on burdensome documentation requirements, most EHRs incorporate templates for providers to use. These templates may ease the documentation burden for physicians, but if they weren’t set up to capture the information needed for accurate documentation, they can steer CDI professionals reviewing the record in the wrong direction.

“When an organization implements an EHR, everyone is very focused on the processes, access, and learning the new system and not focused on the content of the provider templates,” says Karen DiMeglio, RN, MS, CPC, CCDS, director of CDI and appeals at Lifespan in Providence, Rhode Island. At her facility, “CDI wasn’t involved and now we’re left with templates that have a ton of information in them but don’t always include the necessary information for diagnoses and quality measure capture. In fact, we have found some templates that [auto]populate diagnoses but are not always appropriate for that individual patient.”
The template may also pull information from an incorrect location in the EHR, DiMeglio adds. So, CDI departments should investigate the use of smart links and where in the EHR is getting the information from. Smart links are shorthand words that a physician would use during documentation to automatically pull certain information into the medical record. For example, if physicians need to insert labs into a note, they might enter “lastCBC” and the information pertaining to the patient’s blood work would be inserted into the record.

“We discovered that the providers were using the wrong smart link to pull in the problem list. Diagnoses that weren’t relevant to the encounter were coming into the notes,” she says. “The providers didn’t even know they were pulling in the wrong list. Providers are busy, so when there’s a quick link they can use, they use it.” Making sure that links are set up correctly is paramount.

Knowing the problem exists is the first step to fixing it. The next step, according to DiMeglio, is to work with providers and make sure the templates work for your purposes and theirs. Throughout the process, make sure to highlight the why behind suggested changes.

“We have to consider the burden that the EHR has caused our providers,” she says. CDI professionals need to frame the conversation by acknowledging that burden and explaining how such changes may help reduce the need for additional documentation and/or queries. In addition, CDI professionals need to find ways to leverage the technology for accuracy and efficiency. For example, a smart phase could be implemented to pull in the registered dietitian’s notes when they categorize the patient as having malnutrition.

“CDI needs to be involved with the process of adding new shortcuts in the EHR,” says DiMeglio. Otherwise, the issues are likely to persist.

**CDI template use**

Physicians aren’t the only ones with template issues. When EHRs took hold in the industry, many CDI departments moved their querying process to the electronic system as well, building in query templates and the like to streamline their query processes and reporting. Just as CDI staff generally weren’t involved in developing the physician-facing templates, physicians were rarely asked their opinion on the templates CDI programs developed.

“When we started out and templates were being used, I don’t think any of us had the mindset to sit down with a group of physicians and ask them what they actually thought was important,” says Sharme Brodie, RN, CCDS, CDI education specialist at HCPro in Middleton, Massachusetts. “A lot of the physicians I’ve talked to would do the templates very differently if they had the chance.”

For example, query templates are often formatted with the clinical indicators listed first, followed by the question a couple of paragraphs into the query. According to Brodie, many physicians would prefer that the question be listed first, with the clinical indicators following for reference.

A recent Q&A with the ACDIS Advisory Board reveals that many organizations have switched their query format to put the question first as it helps “busy providers focus and get straight to the issue at hand.” Really, though, this is a matter of preference and has no effect on the compliance of the query itself. “The elements that comprise the entirety of the query, including the supporting clinical indicators, determine its compliance, not the sequencing of those elements,” the Advisory Board wrote.

CDI teams should work with providers to create query templates that are as straightforward and understandable as possible for busy physicians and then work with the compliance and IT departments to implement those changes.

**Copy/paste**

Ask CDI professionals about their EHR woes, and they’re sure to mention copy/paste concerns. In some instances, copy/paste functionality can reduce the time physicians have...
to spend documenting; however, it can lead to dangerous shortcuts when the pasted information is not updated appropriately from day to day.

“When you see the breakdown between what’s new information and what’s been copy/pasted, it’s overwhelming,” says Brodie.

There are a couple ways to combat this issue, according to DiMeglio and Brodie. The first option is to enact policies that limit which parts of the record can be copied from or pasted into. However, unless there’s an option to actually disable the copy/paste function in certain parts of the record, physicians may still find ways to use (and abuse) the functionality.

“Many people will carry over the note and then just update it slightly, which can also get you in a lot of trouble,” DiMeglio says.

The prevalence of denials is putting the copy/paste issue in the spotlight, too, says Lisa Romanello, RN, MSHI, CCDS, CDIP, CDI manager at Prism Healthcare Partners, Ltd., in Glen Allen, Virginia, which makes it a good time to broach the subject and make some changes.

“I saw a denial not too long ago where the medical reviewer said that the whole chart was copy/pasted and nothing was changed each day,” Romanello says. “We took it to the chief and told him that you cannot copy/paste the same information every day without documenting that the level of service has changed.”

“If I was an auditor looking for reasons to deny a claim, I would certainly be paying attention to charts where it appears the bulk of information in the record is copy/pasted from the previous note,” Brodie agrees. “I always suggest that anyone reviewing the medical record pay attention to not only what the body of the progress note states, but compare it to what is documented in the review of systems (ROS). I’ve reviewed many records where the ROS states all systems are within normal limits, but when you read the actual note, it tells a very different story, or vice versa. You may have a copy/paste issue on your hands.”

Because policies around copy/paste may have limited success, Brodie posits that a more extreme approach may be warranted to avoid the worst kind of mistake: patient harm.

“Some facilities have cut off the ability to use that function, and that may be the best option, honestly,” she says. “I think it may take an overwhelming accident where someone is going to give a physician information from the record that they think is new and updated and somebody is going to find out that it’s actually two weeks old. When that happens and results in death, just like the Surviving Sepsis Campaign, that’s when I think there will be real universal change.”

**Problem lists**

It’s a cliché for a reason: There are some serious problems with the problem list. “So many times you look at the problem list and you see diagnoses that could be from 10 years ago,” says Romanello. “I find myself asking why we’re listing a UTI [urinary tract infection] on the list that was cured five years ago.”

The problem list is typically so messy that many organizations have policies that say their coding professionals cannot code from it. “Nobody’s ever able to cite the source for coding or not coding from the problem list, though,” says Brodie, which means the decision is often left to the individual organization. “It amazes me that CDI is not addressing the problem list more.”

That attention is beginning to shift, however, because of increased outside scrutiny, Romanello says. “The volume of denials hospitals are getting because diagnoses are being pulled from the problem list is really highlighting the issue now,” she says.

“We’re very skittish about coding anything from the problem list because we’re heavily audited,” agrees DiMeglio. “There have been mistakes before, and even if the
diagnosis is correct, we’ll still have to write the appeal letter.”

To deal with the problem list, organizations can enact policies laying out who is responsible for adding and removing the list’s diagnoses. This helps CDI professionals know, at the very least, whom to contact with questions about the list.

“I almost wish that a patient’s problem list could be like the HCCs, so that at the end of the year, it would wipe clean besides any chronic conditions and you would have to start fresh.”

Lisa Romanello, RN, MSHI, CCDS, CDIP

For those with EHRs that include artificial intelligence, Romanello encourages CDI leaders to investigate where the problem list is pulling its data from. “A lot of doctors don’t realize that some EHRs pull diagnoses from the outpatient setting and they’re just not appropriate for inpatient stays,” she says.

DiMeglio suggests working with the IT department to correct this issue. “We had to put a fix in place so that the only diagnoses on the problem list are specifically from the hospital list.”

For a unilateral approach, Romanello suggests taking a cue from the annual nature of Hierarchical Condition Category (HCC) capture. “I almost wish that a patient’s problem list could be like the HCCs so that at the end of the year, it would wipe clean besides any chronic conditions and you would have to start fresh,” she says.

If that approach ruffles too many feathers, however, try a scaled-back approach. “There are policies out there where after a certain period of time, all infections will fall off the problem list because, by nature, an infection is temporary,” DiMeglio says. “Getting the healed infections off is a good start, but then you need to get some of the other acute diagnoses removed after a certain period of time if they’ve resolved.”

Education as antidote

While policies and IT fixes will solve some of the most egregious EHR issues, the heart of the issue is education, Romanello says, even if your CDI team is going remote.

“Now that we have the EHRs, many CDI specialists are not leaving their offices to interact face-to-face with the physicians,” she says. “Even if you’re only on the floor a couple days a week, the physicians will become comfortable approaching you when they have questions.”

If you’re already remote, remember to be in constant contact with the physicians over the phone or Skype to maintain the relationship outside of the query process.

And it’s not just the physicians who need EHR education, Brodie says. “You should also get involved with informatics. A lot of organizations are sending their informatics people to CDI and coding education so they know what’s needed in the EHR,” she says. “Have them attend when there’s CDI education or maybe send them when they first start at the organization.”

The CDI team can also be the go-between for the informatics/IT department and the physicians, making sure the physicians understand the new updates and how to use them, Romanello says.

“You have the new information and you can go out there and tell the physicians about it,” she notes. “They’re so busy that they don’t always have time to read all the information coming to their inboxes. And even if they do, they may not really comprehend what it means for them.”

Though the issues with the EHR won’t be solved overnight, and template use, copy/paste, and the problem list will likely continue to make appearances on CDI professionals’ list of grievances, CDI’s involvement in building the solutions to these issues cannot be overvalued. By nature of their daily efforts, CDI professionals are trusted allies for the physicians in the trenches of EHR nuances.

“Remember that the education piece is the part of CDI that separates you from many other departments,” says Brodie. “It’s what makes you valuable to the organization and to the physicians.” 🌟
How to conduct CDI audits and why it’s important

by Jill Dressler, RN, BSN, CCDS and Sandy Frey, RHIT, CCS

CDI has many parts: documentation analysis, provider engagement, program infrastructure, and performance monitoring. One way to monitor staff’s effectiveness is to audit their query practices. This ensures CDI staff capture all query opportunities, doing so compliantly. Queries should be consistent to get providers accustomed to the forms and optimize response rates.

Each audit should have identifying information in addition to audit parameters, as shown in the sample audit forms on pp. 12 and 13. This information will help determine, at a glance or at an executive level, what information needs to be clarified. This list may be revised based on the specific needs of a facility.

The audit parameters need to be established in order to gauge the accuracy of a query. For a list of the possible parameters, review the two sample audit tools included on pp. 12–13. Again, this list may be revised based on the specific interests or needs of a facility.

A good sampling is to review at least 10 queries per month per CDI specialist, or to review five queries plus five charts without a query generated. The charts without a query would be judged on one parameter: whether or not the query opportunities were identified.

You can use an Excel spreadsheet to track audit results. Each parameter on a audit is a “yes” or “no” answer; each parameter is worth 1 point, for a total of 10 points. The accuracy score is based on the total audit score. So, if 10 query audits are performed, the total audit score is 100. A person can have five errors and still attain 95% accuracy, as shown on p. 12.

Another option is to audit five queries plus five charts with no query opportunities identified. In that case, the query charts are worth 10 points each and the non-query charts are worth 1 point each. The audit is based on 55 points, allowing CDI specialists three errors to attain 95% accuracy. See p. 13 for a sample audit.

A full audit has the scoring automatically calculated. The sample available here includes five queries and five non-query charts. Any accompanying comments can be entered below the score so the CDI specialist gets written feedback on every identified error.

Once the audit is complete, the results should be shared with the CDI specialist. The comments from the auditor may provide feedback on why a query was not necessary, how a query could have been better formatted to be more supported with clinical indicators, or how a query could have been issued in a non-leading fashion. This feedback is intended to provide the CDI specialist with a guide for future queries and ensure that internal compliance goals are being met.

After the CDI specialist has had a chance to review the feedback, comments and rebuttals to the audit findings are always encouraged. Internal audits then become a way that the staff can learn from each other and glean insight from each other’s coding and clinical backgrounds. Sometimes, in providing a rebuttal to the auditor, the CDI specialist can explain why he or she issued a query that the auditor may have thought was irrelevant. The auditor should review the CDI specialist’s comments, make scoring changes if necessary, then finalize the audit score. Once this process takes place, the final score is shared with administration.

Appropriate query opportunities should be recognized and seized. Compliant, non-leading queries should be utilized. Queries should be consistent throughout your CDI program. CDI specialists should maintain a 95% accuracy rate for their activities, just as coders are held to their accuracy rate. Auditing is the best way to ensure these requirements are met.

Editor’s note: Dressler is a CDI specialist and Frey is the senior manager of coding and quality review at Ovation RCS. Opinions expressed are that of the authors and do not necessarily represent HCPro, ACDIS, or any of its subsidiaries. Contact Dressler at jdressler@ovationrcs.com and Frey at sfrey@ovationrcs.com
### SAMPLE QUERY AUDIT

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Acct #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Query subject</td>
<td>CKD</td>
</tr>
<tr>
<td>Date of Auditor Review</td>
<td>2-3-19</td>
</tr>
<tr>
<td>Date of Query</td>
<td>2-1-19</td>
</tr>
<tr>
<td>Which of the following was the rational for issuing the query?</td>
<td>b</td>
</tr>
<tr>
<td>a. POA status</td>
<td></td>
</tr>
<tr>
<td>b. Clinical indicators of a diagnosis but no documentation of the condition</td>
<td></td>
</tr>
<tr>
<td>c. Request for clinical validation of a documented diagnosis</td>
<td></td>
</tr>
<tr>
<td>d. Clinical evidence for higher degree of specificity or severity</td>
<td></td>
</tr>
<tr>
<td>e. A cause-and-effect relationship between two conditions or organisms</td>
<td></td>
</tr>
<tr>
<td>f. An underlying cause then the Pdx is a symptom code</td>
<td></td>
</tr>
<tr>
<td>g. Clarification of principal diagnosis</td>
<td></td>
</tr>
<tr>
<td>h. Other</td>
<td></td>
</tr>
<tr>
<td>Did the query contain relevant diagnosis choices?</td>
<td>Yes</td>
</tr>
<tr>
<td>Did the query contain relevant clinical indicators?</td>
<td>Yes</td>
</tr>
<tr>
<td>Was the query written in a compliant and non-leading format?</td>
<td>Yes</td>
</tr>
<tr>
<td>Was the correct working DRG assigned?</td>
<td>Yes</td>
</tr>
<tr>
<td>Were the natural language processing (NLP) generated codes for principal diagnosis, CCs, and MCCs verified and supported?</td>
<td>Yes</td>
</tr>
<tr>
<td>Were all query opportunities identified? (No missed opportunities found using the same date of review)</td>
<td>Yes</td>
</tr>
<tr>
<td>Does the chart contain enough documentation or clinical support to query?</td>
<td>Yes</td>
</tr>
<tr>
<td>Was the query addressed to the appropriate provider?</td>
<td>Yes</td>
</tr>
<tr>
<td>Did the CDIS provide a signature and contact information in the query?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is it a necessary query?</td>
<td>Yes</td>
</tr>
<tr>
<td>TOTAL OUT OF POSSIBLE 10</td>
<td>10</td>
</tr>
<tr>
<td>TOTAL SCORE:</td>
<td>100%</td>
</tr>
</tbody>
</table>
### SAMPLE NON-QUERY AUDIT

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Acct #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Query subject</td>
<td>CKD</td>
</tr>
<tr>
<td>Date of Auditor Review</td>
<td>2-3-19</td>
</tr>
<tr>
<td>Date of Query</td>
<td>2-1-19</td>
</tr>
<tr>
<td>Which of the following was the rational for issuing the query?</td>
<td>N/A</td>
</tr>
<tr>
<td>a. POA status</td>
<td></td>
</tr>
<tr>
<td>b. Clinical indicators of a diagnosis but no documentation of the condition</td>
<td></td>
</tr>
<tr>
<td>c. Request for clinical validation of a documented diagnosis</td>
<td></td>
</tr>
<tr>
<td>d. Clinical evidence for higher degree of specificity or severity</td>
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<td>Did the query contain relevant clinical indicators?</td>
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<td>Was the query written in a compliant and non-leading format?</td>
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<td>Was the correct working DRG assigned?</td>
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<td>Were the NLP generated codes for principal diagnosis, CCs and MCCs verified and supported?</td>
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More than half of the respondents to the 2018 CDI Week Industry Survey use computer-assisted coding (CAC) and/or natural language processing (NLP) software, and another 6% intend to implement the technology in the next year. While many of those respondents said software has improved aspects of their daily CDI work, the technology requires ongoing oversight to ensure efficacy and accuracy.

Even with this necessary oversight, CAC and NLP are tools of the future. Therefore, CDI professionals need to be aware of their potential pitfalls and develop tactics to overcome them. Let’s start with NLP.

NLP

Think of NLP like dictation and transcription, but without the live, in-person transcriptionist. Instead, a physician speaks notes into a computer, recorder, etc. and the NLP software transcribes, word for word, what the physician says in real time.

Then, in an ideal world, the physician goes back through the note and proofreads it to ensure the software captured the documentation accurately.

Karin Killenberger, BSN, RN, CCDS, CDI specialist at Baylor Scott & White Medical Center, based in Howell, Michigan, compares the situation to the animated children’s movie How to Train Your Dragon, playing off the commonly used NLP software called Dragon® Speech Recognition. Organizations need to get to know their particular NLP software before they can harness its usefulness, she says.

“Training your dragon can be a real challenge. The dragon can be really helpful, but not everyone speaks cleanly and succinctly, and speaking into a microphone is even trickier,” she says. “If physicians...
are going to use NLP, make sure they’re educated to read the notes and make sure the system picked up what they said correctly. And, if it’s wrong, go back and train your dragon to pick things up correctly.”

Without this careful oversight, Killenberger says, the facility’s expensive software purchase could end up being in vain.

“I worked at a hospital previously that used the NLP. They spent a ton of money on the software, but it was a total disaster,” she says. Such software typically indicates when it’s been used (think of an email sent on someone’s smartphone), but facilities often neglect to check those notes for clarity.

“I don’t think they ever went back in and checked,” Killenberger says. “It was total gibberish.”

“The words aren’t always picked up as the physician intended, and the person dictating doesn’t always go back and reread the note,” agrees Pauline Rivera, RN, BSN, CCDS, CDI specialist at INOVA Fairfax in Colonial Heights, Virginia. “There’s a real chance for incorrect coding as a result of that.”

With more and more of physicians’ time being consumed by documenting in the EHR, however, the introduction of NLP does seem to let them document more efficiently, says Rivera.

“I haven’t been overly impressed with NLP,” she says, “but I know that many providers are obsessed with it. They would definitely rather dictate their notes than type them.”

With time, CDI professionals need to not only learn the quirks and hiccups of their particular NLP, but also the nuances of how their physicians use, or abuse, the technology.

Armed with that understanding, they can pass along helpful hints to physicians and work with their technology vendors and IT staff to bring their NLP “dragon” to heel.

“\[And as good as artificial intelligence is, our job can’t be done by a lawnmower—\]it takes a human being. You’re going to need that human ability to handle the uniqueness of each chart, even if you have the technology.\”

Teresa Downie, RN, CCDS

CAC

Essentially, CAC software analyzes the documentation in the medical record and suggests diagnosis codes to match that documentation. Initially developed for coding professionals to improve productivity, many organizations opened the software for CDI use to help them ensure the documentation translates correctly to codes.

One of the major difficulties with CAC, however, is that it can be either too sensitive or not sensitive enough when picking up diagnosis terms.

“CAC does help sift through information that may be duplicated from one day to the next and get to the final assessment for that date, thus helping the individual sift through note bloat. The individual would then need to verify the diagnosis for clinical validity,” says Caryn Nowak, RHIA, CDIP, CDI specialist at Rady Children’s Hospital in San Diego, California. “One of the pitfalls, though, is that it sometimes suggests diagnoses from the patient’s history or picks up an unspecified code when there is [already] further specificity in the documentation.”

Sometimes CAC recognizes diagnoses from previous admissions or days—a common complaint of CDI professionals working in EHRs (see the article on p. 7 for more details). CAC doesn’t have the critical thinking ability to differentiate between new versus copy/pasted information. So, CDI professionals can’t take the codes suggested by CAC as gospel.

“I like CAC, but you have to be careful and you have to check for those clinical indicators because sometimes it’ll trigger a code for a diagnosis that’s out of date or incorrect,” Killenberger agrees. “You cannot just take it as written in stone. You have to use your brain. You have to double-check what the CAC is suggesting. A lot of doctors are in the habit of copy/pasting everything that’s happened to the patient since 1987.”

That’s why CDI staff need to remain diligent to their primary role as translator between clinical and coding worlds.

“Consider what the physician is saying in their clinical language. You are the translator between the two
languages,” says Teresa Downie, RN, CCDS, CDI specialist/care manager at TSN Nurse Consulting in Vidalia, Georgia. “Remember, the tool is not smarter than you, and it’s a coding tool, not a clinical tool.”

**Making the best of the situation**

Technology may not be perfect, but when it’s used properly and CDI professionals are attuned to the potential issues, it can be a net positive, says Killenberger.

“I think most of it is really making our lives easier,” she says. “The CAC, in particular, makes things a lot quicker for CDI. You can quickly go through and click on the diagnoses that are pertinent and know which records to check on.”

Nowak suggests working with IT or leveraging the help of a data analyst with CDI experience to fix any issues encountered.

“We bring [our analyst] our issues and have him look at the functionality we need,” she says. “Once you identify what any issues are, you have to report it to make a change rather than just getting frustrated.”

Nowak says one of the most helpful features of Rady Children’s CAC system is that it can automatically highlight the parts of the notes that were taken from previous days, which identifies copy/paste issues without requiring the CDI team to sift through the notes manually.

Outside of working with the IT/analyst team, Rivera suggests that CDI professionals ask themselves a few pointed questions to help guide their reviews and provide physician education:

- What policies does the organization have regarding NLP?
- What policies does the coding team have for when they do and do not code a diagnosis? How do they use the CAC information?
- Are the physicians rereading their dictated notes on a regular basis?

While asking those questions “may slow you down,” Rivera says, CDI professionals need “to make sure the words in the record are clear. Physicians think the message we’re sending is that more words are better, but really what we’re saying is that we want fewer words that are better, clearer, and make the notes more meaningful.”

Asking questions and interrogating the information in the record is what CDI specialists do anyway, Downie says.

“Don’t overvalue the computer assistance or undervalue your CDI specialist,” she says. “Remember what the tool is and who’s using it.”

Killenberger suggests new CDI specialists “have an experienced CDI specialist at their elbow to talk things through” as they use the EHR, CAC, and NLP-dictated records.

Despite the steep learning curve ahead, CDI efforts should not be undervalued—flashy new software often comes with promises of increased efficiency or revenue, but it can’t replace a high-performing CDI professional, Downie says.

“There’s been conversations about CAC replacing CDI, but that’s not going to happen because of patient acuity and differences,” she says. “And as good as artificial intelligence is, our job can’t be done by a lawnmower—it takes a human being. You’re going to need that human ability to handle the uniqueness of each chart, even if you have the technology.”

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If physicians are going to use NLP, make sure they’re educated to read the notes and make sure the system picked up what they said correctly. And, if it’s wrong, go back and train [the system] to pick things up correctly.

Karin Killenberger, BSN, RN, CCDS

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**Editor’s note:** For more information on selecting a software vendor, read Advisory Board Member Angie Curry, RN, BSN, CCDS’s note on p. 5. Additionally, read through the 2018 ACDIS white paper, “Find the right vendor for your organization: Best practices for getting started” in the ACDIS Resource Library.
How to survive travel consulting

by Angela Maxfield, RN, CCDS

Long flights, layovers and connections, lost luggage, ride-sharing, hotels, unfamiliar beds, time zones, and climate changes. The phone calls, video chats, and call-you-when-I-get-there if you’re juggling family life and work life. All can be frustrating for a traveling CDI consultant. So, how do you survive travel burnout?

The tips below helped me over the past five years; I hope sharing them will make your trips more enjoyable.

Air travel

When it comes to booking flights, research airlines that offer the best times and most flights to and from your home base. Also, if you routinely book with the same airline, you can rack up frequent flyer miles and have yourself a lower-cost vacation. Don’t forget to register for the airline’s rewards program and link your rewards number to each flight reservation.

Inclement weather can often delay your flights, so be prepared to spend some time in the airport. Bring books, or download them onto your phone or e-reader. This is a good time to learn another language, study for a certification, or enjoy novels you haven’t had time for. Or maybe puzzles and Sudoku are more your speed. Whatever it is, pack it in your carry-on if you need something to pass the time. And speaking of passing the time, leave a little extra breathing room when scheduling connecting flights. Don’t book them so close together that you must run from gate to gate. It’s not fun, even if you tell yourself you need the exercise.

Always carry a change of clothes, especially underwear, in your carry-on. This way, if you lose your luggage (or the airline loses it), you’ll be covered for the short term until you get it back. Savvy travelers become adept at packing for a week at a time in one carry-on.

Airport food and water can be expensive. To beat the system, carry an empty bottle and fill it at a water fountain inside the terminal once you get through security—this will save you money and is healthier than soda. If you snack en route, choose foods with low sodium and sugar to avoid leg swelling and the rise and fall of a sugar rush at 30,000 feet. If you want to treat yourself to a meal, reserve it for after you land. Avoid foods that cause you an upset stomach.

Ground transportation

Research beforehand how to get from point A to point B once you’ve landed. If you’re renting a car, have your reservation details in hand when you reach the counter. As with airlines, if you book with a particular rental company every time, you can take advantage of their perks later on. Always sign up for the rewards program.

If you opt for a ride-sharing service such as Uber or Lyft, be careful. Once your ride approaches, ask the driver whom he or she is looking for rather than immediately giving out your name. The apps for these services will let you share your ride information with a friend or family member—do this so someone else will know who you are traveling with.

Health

When traveling, deciding what to eat is an everyday battle. Most hotels aren’t equipped for cooking, so eating out becomes the norm. To combat this, my suggestion is to use the refrigerator at your facility to bring in breakfast and lunch, rather than grabbing a donut in the morning or a greasy burger in the afternoon. Make smart choices like veggies and meals that can be kept chilled. Soups, salads, and healthy snacks can be prepared in the break room or kitchen. If you dine out, make healthy choices. Fast food is tempting, but it will compromise your health and pack on the pounds.

In most positions, you’re sitting for hours on end. Remember to get up and move. Try setting a timer on your phone so you move for five minutes every hour. At the end of the day, get some additional physical activity in, such as swimming, running, or walking.
Accommodations and safety

Once you reach your destination, carefully assess your surroundings. Ensure that the area is secure. Many travel agents don’t know the specific locations of the hotels they book with. If you do not feel safe, let your recruiter know immediately.

Be careful with any mail or other documents you travel with. If it’s stolen or left behind in a hotel room, airport, or airplane, you run the risk of identity compromise. Instead, try arranging to receive your credit card statements, banking statements, etc. electronically. You can also use online recordkeeping services to organize your travel, expenses, spending, and receipts.

Keep an eye on your credit card and banking statements as you travel. Better yet, sign up for credit card alerts so you will be notified of spending activity.

Your privacy is your responsibility. Not everyone you work with or meet needs to know where you are housed. Guard your location information and do not discuss your living situation, especially if you are traveling alone—and remember to lock your doors.

Assignments

Your assignment experience will depend on the facility and its employees. As a consultant, you’re expected to know CDI and carry a load that will sometimes be heavier than the full-time staff. You may be asked to lead projects, audits, and education, and brainstorm ideas. Be honest with yourself and know your capabilities.

It has long been said that nurses “eat their young,” and that may also be the case with CDI, so be mindful of your conduct. Full-time employees will know you’re probably making more money than they are, and they may resent your knowledge and position. Stay thick-skinned and try not to take it personally. Instead, think of ways you can get the staff involved in projects and discussions. Don’t put your crown on and walk into the facility like royalty; instead, share your knowledge and watch the young grow up in CDI.

You’ll be excluded from some activities because you’re not a full-time employee, and that’s OK. Team up with other consultants in your area for dinner and discuss your victories, no matter how small, and ideas for growth. Try not to make these meetups into gripe sessions. Networking reminds you that your work makes a difference, even if you’re not part of the facility team.

Family time

Traveling and leaving family behind can be difficult. You and your significant other will have to maintain strong communication with each other and your children, if you have any. Family obligations may mean a given time frame isn’t ideal to take a trip. If you choose to travel, you may have to miss out on sports, school projects, etc. Make sure you are committed to staying in touch through FaceTime, Skype, and/or social media platforms. You can balance consulting life and family life, but it requires communication.

Friendships

Friendships are important for mental wellness. At the end of your workday, make time for family, but also take a few minutes to stay connected with your friends at home. Connect with like-minded people in your assignment area. When you do the things you like to do, you will find others doing the same thing. But, as cautioned earlier, be careful whom you confide in and what you divulge to others. And, of course, don’t check your social media while you’re working.

Be ‘all in’

How often do we travel and let ourselves “live out of a suitcase?” Don’t do it. Hang your clothes in the closet and put your toiletries in the bathroom. Some assignments may have you on-site for a couple of weeks or even longer. If you’re on one of these extended trips, try to maintain your usual home routine. Keep active and join a gym or fitness center if that’s what you’d be doing at home. Or consider volunteer work—there are many opportunities if you enjoy helping in the community.

Traveling work isn’t for everyone, but if it’s for you, there’s so much to look forward to. The experience is all in how you approach life. Teach, grow, and enjoy! 🌟

Editor’s note: Maxfield is a consultant for MAXIM HIM. Contact her at maxfield_angela@yahoo.com. Opinions expressed are that of the author and do not necessarily represent HCPro, ACDIS, or any of its subsidiaries.
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Last day to book a hotel room at the discounted ACDIS conference rate

VISIT THE ACDIS BLOG WEEKLY TO FIND OUT WHAT EVENTS ARE COMING UP IN YOUR AREA!
Many outpatient CDI professionals stepped into their roles blind—not knowing where to begin or how to tell if they were successful. However, as programs mature, they need to be able to track their progress for a number of reasons, including focusing physician education and justifying continued funding from organizational leadership.

“Part of CDI is querying and part is educating,” says Ellen Jantzer, RN, CDI coordinator at Asante in Medford, Oregon. “You can’t educate unless you know what’s not working.”

Unlike the inpatient CDI world, there aren’t many outpatient tracking tools premade and available through vendors—and the ones that do exist are often priced at a level that’s difficult to justify for an unproven program, says Jennifer Boles, CPC, CRC, system manager of ambulatory CDI at Baptist Health in Louisville, Kentucky.

“You can talk to the vendors and it looks great, but then you bring it back to the health system and it’s very hard to justify the price tag if you’re a brand-new program,” she says.

Folks who’ve been in CDI since the beginning remember these days in inpatient as well—the days of paper queries, spreadsheets, and homegrown tools. Though many programs are more than a decade removed from that reality on the inpatient side, outpatient CDI is starting from scratch. And just as with their inpatient predecessors, many programs are opting to develop their own tools to suit their needs.

Choosing metrics to track
Before you can develop any kind of tool, you need to determine
what to track. This decision largely depends on the programmatic focus at your organization. For example, many programs focus on Hierarchical Condition Categories (HCC), so they’ll need to track metrics such as HCC capture rate, potential risk adjustment factor (RAF) scores, and so on.

“We’re only focusing on three HCCs at this time, which I think came from some population health initiatives the organization was starting at the time,” says Caley Wilson, BSN, RN, ambulatory CDI nurse at University of Vermont Medical Center (UVM) in Burlington. “There’s so much content, possibility, and volume in outpatient that we felt like we should just chip off a corner.”

With a programmatic focus identified, determining a baseline wherever possible is helpful, says Cherri Sanders, RHIT, CDI specialist at Lourdes Medical Center in Pasco, Washington. Obtain that baseline data—wherever it is and whatever it states—then keep tracking data against it to compare it with and prove the program outcomes. She suggests going to the billing department to get that information. “We were able to get our hands on some of the billing information. It can be really hard to start a program without access to that,” says Sanders. “That data gave us a lot of information that helped us get our program started.”

In addition to the metrics related to your programmatic focus—such as HCC capture rate—the tracking tool should also incorporate measures of CDI productivity and physician engagement, Jantzer says. At Asante, their Excel-based tracking spreadsheet includes the following columns:

- Date of the review
- Type of visit
- Number of days until the patient visit (Asante’s reviews are prospective)
- Patient identification information
- Physician name
- CDI findings and thoughts
- Type of query
- Physician response
- MEAT (monitored, evaluated, assessed, treated) criteria

Wilson also suggests including information from other departments, such as billing, to flesh out the data picture. “Our worklist is built so that on either side, there are columns that we populate, and the center has columns that are populated by claims data,” Wilson says. The team at UVM tracks the following:

- Cases per day
- Date of the review
- Minutes spent on each case
- Appointment date
- Scheduling department
- Physician name
- Patient identification information
- Diagnosis information
- Community RAF
- HCCs identified
- Potential RAF after CDI review
- Number of queries per patient
- CDI clinical validation (MEAT)
- CDI notes

Though there will likely be tweaks and updates needed after the team has used the tool for a period of time, knowing your program’s focus and having some of the baseline information will help you develop a tool that includes all the necessary fields without being cluttered.

“Start with the end in mind. What do you want to get out of the tool?” suggests Staci Josten, BSN, RN, CCDS, director of CDI/UR services at United Audit Systems, Inc. in Cincinnati. “We didn’t want people to be entering information for the sake of entering information because it’s time-consuming. You have to ask whether you actually need all those fields.”

**Developing a tool**

Though determining what to track is no small order, it’s only part of the battle. Developing the tool itself can be a long, arduous, and sometimes overwhelming process. While there are several options, many programs opt for Excel-based tools because they are easily customizable and affordable.

“We decided on Excel for our tracking tool,” says Wilson. “We have Epic for our EHR, and at the time, there wasn’t really any solution in Epic for what we were doing.
We worked with our ACO [accountable care organization] to determine our HCC capture rate, too, for a baseline.

Like Wilson, Boles also advocates leveraging the information available through other groups and departments at your organization. “When I started in this position, I went and shadowed the inpatient team to see how they do their queries and to find out what’s worked and what hasn’t worked with their system. Learn from their mistakes and don’t make the same ones when you’re developing your own tool,” she says. “Ask them what reports they use and ask if they’ll share them with you.”

Though the inpatient CDI team may have more sophisticated tools and a different focus, outpatient CDI leaders should still evaluate the inpatient processes and see how (or if) they translate to the outpatient setting. “Because we knew our focus was going to be HCCs, that was mainly what I put in that first spreadsheet,” says Karen Frosch, CCS, CCDS, CRC, CPHQ, CDI program manager at Christiana Care System. “I asked myself what I used for metrics on the inpatient side and what that translated to on the outpatient setting.

“There was a lot of trial and error. During our first trial, there were a lot of late nights, You set things up and have great visions, but it’s different when people are actually using the tool. We went through many iterations before finalizing it.”

Staci Josten, BSN, RN, CCDS

she says. After getting this feedback from those “in the field” using the tool, Carrier and Frosch were able to make adjustments for the sake of user-friendliness while still capturing the necessary data for reporting purposes.

“There was a lot of trial and error. During our first trial, there were a lot of late nights,” echoes Josten. “You set things up and have great visions, but it’s different when people are actually using the tool. We went through many iterations before finalizing it.”

Monitoring and pulling reports

As with any tracking tool, you can’t just set it and forget it. Outpatient CDI program leaders should set a schedule for when to pull the data together and whom to report it to, lest all that data entry be for naught. However, consolidating the data can be a time-consuming process for two main reasons: human error and the manual nature of an Excel tracking tool.

“One of the things I don’t like about Excel is that, even when you have drop-downs, people can still freestyle their answers, and that messes up the data,” says Josten, which means whoever is pulling the data will have to manually sort through many free-text entries and group them appropriately. To combat this, Josten suggests providing education to the CDI team up front on how to use the tool correctly.

“Right now, pulling the KPI [key performance indicators] takes at least six hours a month,” says Carrier. “We’re in the process of creating an electronic worksheet that will auto-populate some of the information from our EHR. We’ll still be capturing the information we’ve been trending over the last two years, but there will be less room for human error.”

Because of the involved process inherent in data tracking, some organizations have enlisted the help of a CDI analyst. This individual is dedicated to pulling together the data and handing it over to the CDI leadership in a presentable and understandable manner. (To download a sample job description for a CDI analyst, click here.)
“On a monthly basis, our analyst pulls audits and shows us what providers actually billed for the cases we reviewed,” says Wilson. “We’re able to roughly determine whether they actually addressed the query and whether we made an impact.”

Even if you don’t have an analyst, enlisting the help of other groups in and outside the organization can be helpful to determine whether CDI efforts work. Josten, for example, uses the RAF calculator from HCC University with her program’s Excel spreadsheet to make the calculations easier and remove the risk of human error.

Boles, for her part, requests reports from the ACO and from vendors and compares their numbers with what she’s calculated with the homegrown tracking tool. This process helps validate the data and reveals any issues with the tracking tool or calculations.

**Leveraging results**

Having the right data and reports can help advance outpatient program efforts in several ways. First, having that data available and reporting it to the appropriate leadership (depending on which department the outpatient CDI program reports up through) can work to justify new staff positions, says Frosch.

“We included a field in our spreadsheet for tracking code corrections with the goal of demonstrating the need for coders versus physicians coding their own charts,” she says. Additionally, the reports can help identify educational opportunities, notes Boles. You can’t properly educate physicians without knowing where the problems are. Since she pulls the reports monthly anyway, Boles tries to put out educational materials at the same frequency to correct problems on a rolling basis.

“I definitely use the metrics for leadership, but I also put out an HCC tip of the month in our newsletter,” she says. “I share the data with my director and executive director, so we get an idea of what we need to educate more on too.”

The impetus for tracking outpatient metrics may initially be for gaining leadership buy-in or educating physicians, but Carrier points out that those reports can also help to streamline CDI efforts. Having a benchmark and knowing what sort of effect you’re having is all well and good, but make sure to leverage that knowledge to improve your own processes too.

“These reports help us identify what our most commonly queried diagnoses are so that we can develop query templates, which will save us time since we won’t be typing them up by hand every time,” she says.

While the data gleaned from these homegrown tools can be incredibly helpful to a program, the process won’t be flawless overnight. As with any homegrown process, expect some trial and error before it’s perfect.

“Be flexible and inform yourself as much as you can,” Wilson says. “We’ve had to create and modify over and over again, but just be patient.”
GUEST COLUMN

Technology for a hybrid remote CDI network

By T. Nichole “Niki” Baca BS, BSN, RN, CCDS, and Sydni Johnson RN, BSN

In grade school, your teacher probably asked you to draw pictures of what life in 2020—or some other futuristic-sounding date—would look like. In response, you or your classmates drew things like flying cars, floating houses, and robot maids. It’s now 2019 (how crazy is that?), and while we do have robotic floor cleaners, they’re a far cry from The Jetsons’ Rosie the Robot.

However, we have made so many amazing advances in technology. Where would we be without the internet, for example?

Back at the beginnings of CDI, we had books like DRG Expert and Excel-based programs for DRG selections. More than 10 years later, vendors are offering web-based technologies that use artificial intelligence and machine learning to make us even more productive.

The real question, however, is how we can best leverage those technologies. When our healthcare system decided to implement a hybrid remote work staff, we had a few challenges to overcome. We thought we’d share some of them with you.

Relationships

Our first challenge was maintaining relationships with providers, with facility staff, and within our own department, while working more remotely. After meeting with key stakeholders at each of our facilities, we decided to have one to two CDI staff members rotate in-house daily and work remotely the rest of the week.

On days that CDI staff are in-house, the expectation is that they round in person with providers on the floor and give monthly CDI education to providers. Management also uses remote meeting programs (such as Skype or GoToMeeting) to have monthly one-on-one check-ins, monthly team meetings, and bimonthly department meetings. This allows us to maintain our relationships as facility teams and as a network. Team members also log into an instant messenger application, allowing them to communicate with each other, management, and CDI educators whenever the need arises.

Coverage

The second challenge we faced came a little while after we started: covering facilities that weren’t large enough to support a full-time staff member. We addressed this challenge by analyzing our census and evaluating our staffing needs.

Partnering with our vendor, we were able to leverage technology to create “cohorts” for coverage. The cohorts are defined as the eight facilities with 100% remote coverage by our regular hybrid remote facility-based staff. Due to the remote locations of those facilities, in-house rotations aren’t currently feasible. Creating cohorts allowed our 11 facility-based teams to remotely review charts all at 19 facilities.

We also created worklists for our cohorts, which enabled CDI team members within the network to access and review patient records at those sites.

Census differences

Our third challenge was managing the large variances in census between facilities and at different times of year. As you can imagine, many people leave Phoenix in the summer, when it’s 120°F, for cooler climates.

Despite the decreased census, our department, facility teams, and individual staff members still had monthly metrics to meet. So, we had to determine how to ensure that our team members, facilities, and department met those targets month after month.

To address this challenge, we talked with the coding leaders to discuss the processes they use for remote coverage of multiple facilities—why not learn from...
others? We also engaged our own staff by creating a workgroup composed of CDI team members from each facility to give them a voice in the workflow.

We again explored our CDI application’s capabilities, and after a lot of research and workgroup debate, we created a morning census report. This report allowed facility staff members without enough patients to review to assist another facility in the network, thereby helping both the staffer and the other facility to meet targets.

We also created a “float” team staffed by high-performing CDI specialists that no longer have a “home” facility, but instead review cases at any facility that has extra patients and needs the assistance. This required a workflow redesign within our vendor’s CDI technology.

**Orientation**

Lastly, our fourth challenge was orienting new staff. At the outset, we ensured we had a thorough orientation guide for the preceptors and orientees to use as a reference. We made a basic template available to our team on our intranet education page. We also created a custom, dated plan for each orientee, which was sent via email to the orientee, preceptor, and orientee’s manager, so everyone had the same expectations and timelines.

Managers must be cognizant of preceptor capabilities and make sure there are enough preceptors to capably support the team while avoiding preceptor burnout. Orientation must be done in person initially, and at our network we decided a minimum of one month of in-person preceptorship should occur prior to moving to a more remote-based work environment. After the month is up, the preceptor uses remote meeting tools and instant messaging to support the orientee for the remainder of his or her orientation.

While some of us might still hope for flying cars and robot maids in the future, we’re so lucky to live in a time with internet, email, remote meeting tools, instant messengers—the list goes on. Without these technologies, we would not have remote work environments that allow for a better work-life balance, improved employee satisfaction, and better support for the people in our facilities and the relationships we’ve built with them. Technology allows us many options for staying in touch with those that we’re not able to physically see every day. What a wonderful time we live in! 🌍

**Editor’s note:** Johnson is the CDI educator for Banner Health Network’s CDI program in Phoenix, Arizona. Contact her at Sydni. Johnson@bannerhealth.com. Baca was the senior CDI manager for Banner Health Network at the time this article was authored and is currently working at R1 RCM as the director of CDI. Contact her at tbaca@r1rcm.com. Opinions expressed are that of the author and do not necessarily represent HCPro, ACDIS, or any of its subsidiaries.

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**RESOURCES FOR GOING REMOTE**

If your program is considering going fully or partially remote, take a look at the following resources to get started:

- “Telecommuting: CDI Policy” from Lee Ann Landon, BSN, CCMC, CCDS, CDI manager at Honor-Health in Scottsdale, Arizona
- “Telecommuting: Policy and Work Agreement” from Bonnie Epps-Long, MSN, RN, the director of CDI at Emory Healthcare in Atlanta, Georgia
- “Establishing effective remote CDI takes planning” from the May/June 2017 edition of the CDI Journal
- “Resolutions for making remote CDI efforts effective” from the January/February 2017 edition of the CDI Journal
- “Ask yourself: Could your CDI program work from home?” from the May/June 2015 edition of the CDI Journal
Sepsis sequencing FAQs

Q: I'm a bit confused by sepsis sequencing. Should it always be coded as the principal diagnosis, or are there instances where it wouldn’t be principal?

A: If sepsis is present on admission (POA), sepsis (the systemic illness) is coded first, followed by severe sepsis (and septic shock) if present, followed by the local infection. According to the Official Guidelines for Coding and Reporting, if sepsis was POA, it will almost always be your principal diagnosis, except in instances specified in the code set.

If sepsis is not POA, it cannot be coded as principal diagnosis. Remember the definition of principal diagnosis: “the condition which, after study, was found to have occasioned the admission.” The sepsis could not have occasioned the admission unless it was present when the admission order occurred.

Q: If a patient was admitted with pneumonia and sepsis, I would sequence the sepsis as principal, right?

A: Correct. Since the sepsis was POA and it was the systemic infection, it will be sequenced first, followed by the pneumonia.

Q: What about if the pneumonia is HIV-associated and the patient was admitted with sepsis? Would the HIV be the principal diagnosis, or would the sepsis be principal?

A: In most cases the HIV would be coded as the principal diagnosis, unless the provider indicated that the sepsis/infection was not related to the HIV disease, but that would be very rare. Take a look at p. 19 of the Official Guidelines for Coding and Reporting:

2) Selection and sequencing of HIV codes

(a) Patient admitted for HIV-related condition: If a patient is admitted for an HIV-related condition, the principal diagnosis should be B20, Human immunodeficiency virus [HIV] disease followed by additional diagnosis codes for all reported HIV-related conditions. (b) Patient with HIV disease admitted for unrelated condition: If a patient with HIV disease is admitted for an unrelated condition (such as a traumatic injury), the code for the unrelated condition (e.g., the nature of injury code) should be the principal diagnosis. Other diagnoses would be B20 followed by additional diagnosis codes for all reported HIV-related conditions.

Q: What about if the patient was admitted with a urinary tract infection (UTI) and sepsis? Would the sepsis still be the principal diagnosis? If the patient had a chronic Foley catheter and developed a catheter-associated UTI (CAUTI) with sepsis, would the CAUTI be the principal diagnosis, or would it be the sepsis?

A: In the first instance, when the patient was admitted with a UTI and sepsis, sepsis would be the principal diagnosis as long as it was also POA.

In the second instance, the complication code for the CAUTI (T83.511A) would be the principal diagnosis, followed by the code for the sepsis. If the sepsis is identified as a complication related to an implanted device or medical intervention, the complication would always be sequenced first, followed by the sepsis.

Take a look at p. 24 of the Official Guidelines for Coding and Reporting:

5) 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 a postprocedural infection. For such cases, the postprocedural infection code, such as T80.2, Infections following infusion, transfusion, and therapeutic injection, T81.4, Infection following a procedure, T88.0, Infection following immunization, or O86.0, Infection of obstetrical surgical wound, should be coded first, followed by the code for the specific infection. If the patient has severe sepsis, the appropriate code from subcategory R65.2 should also be assigned with the additional code(s) for any acute organ dysfunction.

(c) Postprocedural infection and postprocedural septic shock. In cases where a postprocedural infection has occurred and has resulted in severe sepsis the code for the precipitating complication such as code T81.4, Infection following a procedure, or O86.0, Infection of obstetrical surgical wound should be coded first followed by code T81.12–, Postprocedural septic shock. A code for the systemic infection should also be assigned.

Q: When would “severe sepsis” be used as the principal diagnosis? I thought that in cases with sepsis and severe sepsis with or without shock, sepsis would still be the principal diagnosis with severe sepsis as a secondary diagnosis. I’ve been told that severe sepsis should never be the principal diagnosis—is that correct?

A: That is correct: Severe sepsis and/or septic shock should never be used as a principal diagnosis. See p. 23 of the Official Guidelines for Coding and Reporting:

3) Sequencing of severe sepsis: If severe sepsis is present on admission, and meets the definition of principal diagnosis, the underlying systemic infection should be assigned as principal diagnosis followed by the appropriate code from subcategory R65.2 as required by the sequencing rules in the Tabular List. A code from subcategory R65.2 can never be assigned as a principal diagnosis. When severe sepsis develops during an encounter (it was not present on admission), the underlying systemic infection and the appropriate code from subcategory R65.2 should be assigned as secondary diagnoses. Severe sepsis may be present on admission, but the diagnosis may not be confirmed until sometime after admission. If the documentation is not clear whether severe sepsis was present on admission, the provider should be queried.

Overall, it’s helpful to go back to the Guidelines whenever you’re feeling confused. They’re always your best resource to set you straight.

Editor’s note: Laurie L. Prescott, RN, MSN, CCDS, CDIP, CRC, CDI education director at HCPro in Middleton, Massachusetts, answered this question. Contact her at lprescott@hcpro.com. For information regarding CDI Boot Camps, click here.
By Stephen Houlahan, RN, MSN, MBA, CCDS

The future of aortic valve replacement (AVR) is here, and it is called trans AVR (TAVR). Also known as trans-aortic valve implantation (TAVI), TAVR has been commercially available in Europe since 2007 and in the United States since 2011. It is recommended in patients with prohibitive surgical risk: estimated risk of death or irreversible morbidity, or other factors, including frailty (Holmes et al., 2012). Per CMS, healthcare providers must adhere to strict criteria for TAVR patient selection.

TAVR is an interventional cardiology procedure and is much less invasive than traditional open heart surgery. The first TAVR implantation in a human being was on April 16, 2002 (Cribier et al., 2004); since then, it has proven to be an important life-saving cardiac intervention. TAVR can be performed via four approaches:

- Transfemoral
- Subclavian
- Transapical
- Transaortic

Transfemoral AVR is the most common approach, utilizing an incision in the groin to access the femoral artery, as opposed to the open sternotomy approach utilized in surgical AVR (SAVR). In the transfemoral AVR approach, a percutaneous catheter is passed from the femoral artery through the aorta to the aortic valve.

A specialized angioplasty balloon is used to fully dilate the patient’s native aortic valve, making it completely insufficient. This is followed by the near-simultaneous deployment of a specialized, fully collapsed, prosthetic aortic valve into position over the insufficient native aortic valve, completely taking over the native valve’s function.

Once the prosthetic device has been implanted and the patient’s hospital stay has run its course, HIM/coding professionals analyze the medical record to report the correct DRG for reimbursement. TAVR has only two ICD-10 MS-DRGs that are submitted to CMS for reimbursement:

- MS DRG 266, Endovascular cardiac valve replacement with MCC
- MS DRG 267, Endovascular cardiac valve replacement without MCC

Getting the documentation correct will result in correct DRG assignment and proper payment. Currently, TAVR implantation requires supervision from both an interventional cardiologist and a cardiothoracic surgeon. These attending physicians provide the documentation that ensure proper reimbursement for a TAVR patient’s care.

The principal diagnosis ICD-10-CM code for most patients suffering from aortic stenosis is:

- I35.0, Nonrheumatic aortic (valve) stenosis

The principal procedure ICD-10-PCS code for the majority of transfemoral AVR implantations is:

- 02RF3JZ, Replacement aortic valve with synthetic substitute, percutaneous approach

However, the clinical presence, and correct documentation, of an MCC affecting the TAVR patient is the difference between an organization submitting MS-DRG 266 or MS-DRG 267 for reimbursement (Optum360, 2019).

The reality of the U.S. healthcare system is that hospital service lines must provide a positive contribution margin to their respective organizations lest they be discontinued. In fiscal year (FY) 2019, the relative weight (RW) of both MS-DRG 266 and MS-DRG 267 was decreased (see chart on the next page).
Year-over-year RW changes

<table>
<thead>
<tr>
<th>FY 2018</th>
<th>FY 2019</th>
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<tbody>
<tr>
<td>MS DRG 266:</td>
<td></td>
</tr>
<tr>
<td>■ RW: 7.7516</td>
<td></td>
</tr>
<tr>
<td>■ National payment average: $42,632.71</td>
<td></td>
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<tr>
<td>MS DRG 267:</td>
<td></td>
</tr>
<tr>
<td>■ RW: 6.539</td>
<td></td>
</tr>
<tr>
<td>■ National payment average: $33,578.30</td>
<td></td>
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<tr>
<td>MS DRG 266:</td>
<td></td>
</tr>
<tr>
<td>■ RW: 7.1915</td>
<td></td>
</tr>
<tr>
<td>■ National payment average: $40,047.23</td>
<td></td>
</tr>
<tr>
<td>MS DRG 267:</td>
<td></td>
</tr>
<tr>
<td>■ RW: 5.8481</td>
<td></td>
</tr>
<tr>
<td>■ National payment average: $32,566.26</td>
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</tbody>
</table>

This lowered RW will result in, on average, a decrease of $2,585.48 for MS-DRG 266 and a decrease of $1,012.04 for MS-DRG 267 in FY 2019. With the TAVR prosthetic aortic valve implant costing approximately $25,000, margins will remain tight for this life-changing service.

Patients with severe symptomatic aortic stenosis typically have comorbidities that include congestive heart failure (CHF). CDI staff constantly query providers for the type and acuity of CHF patients. When TAVR patients are diagnosed with acute-on-chronic diastolic CHF (code I50.33), CMS reimburses for MS-DRG 266, since the patient had an MCC (Optum360, 2019).

If the TAVR patient was diagnosed with chronic diastolic CHF (code I50.32), however, CMS reimburses for MS-DRG 267 unless the patient has an alternative MCC (Optum360, 2019). Therefore, the proper, clinically valid documentation of the TAVR patient’s CHF type and acuity will result in optimized payment for the TAVR procedure.

CDI staff are taught to review the patient’s medical record for a recent cardiac ECHO to discern the ejection fraction and distinguish the type of CHF; they are also taught to review laboratory data, including the patient’s serum pro-BNP level, for the CHF’s acuity.

Administration of an IV diuretic (e.g., Lasix, Bumex) is a good clinical indicator that the patient’s CHF is acutely exacerbated. TAVR patients, however, typically do not present with elevated serum pro-BNP levels and do not require IV diuretics prior to TAVR to clinically validate an acute CHF exacerbation. This leads to the question all interventional cardiologists and cardiothoracic surgeons must ask: What specifically constitutes acute exacerbation of CHF?

To answer this question, every healthcare organization that performs TAVR implantations and receives reimbursement from CMS must establish an organizational definition of what constitutes acute exacerbation of CHF. For example, the Framingham CHF criteria state that two major criteria, or one major and two minor criteria, must be present for the patient to be considered in “acutely decompensated CHF” (McKee, Castelli, McNamara, & Kannel, 1971). See the chart below.

### Framingham’s CHR Criteria

<table>
<thead>
<tr>
<th>Major criteria</th>
<th>Minor criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paroxysmal nocturnal dyspnea</td>
<td>Bilateral ankle edema</td>
</tr>
<tr>
<td>Neck vein distention</td>
<td>Nocturnal cough</td>
</tr>
<tr>
<td>Rales</td>
<td>Dyspnea on exertion</td>
</tr>
<tr>
<td>CXR Cardiomegaly</td>
<td>Hepatomegaly</td>
</tr>
<tr>
<td>Acute pulmonary edema</td>
<td>Pleural effusion</td>
</tr>
<tr>
<td>S3 gallop</td>
<td>Decrease in Vital Capacity by 1/3 from maximum recorded</td>
</tr>
<tr>
<td>Increased Central Venous Pressure</td>
<td>Tachycardia (HR &gt; 120)</td>
</tr>
<tr>
<td>Hepatojugular Reflex</td>
<td></td>
</tr>
<tr>
<td>Weight loss &gt;4.5 kg in 5 days in response to treatment</td>
<td></td>
</tr>
</tbody>
</table>

Providers must document these important clinical manifestations in their notes to support the acuity of the CHF. Supporting medical record documentation with established clinical criteria, like Framingham, will help organizations quantify clinical diagnosis of CHF.
specificity, resulting in proper payment, audit avoidance, and denial prevention.

TAVR is a breakthrough and a marvel of modern medical science. Although patient selection criteria are currently very strict per CMS guidelines, TAVR has the potential to completely displace SAVR in the coming decades. CMS decreased the RW of the two TAVR MS-DRGs in 2019, decreasing reimbursement for the procedure. Organizations should adopt Framingham’s congestive HF criteria, or some other evidence-based CHF criteria, to support clinical diagnosis of CHF type and acuity. Providers, meanwhile, must follow CMS’ TAVR selection criteria, perform the TAVR intervention efficiently and cost-effectively, and document all clinically valid diagnoses to ensure optimal reimbursement and maintain a positive contribution margin for their TAVR program.

References


Editor’s note: Houlanah is a senior CDI specialist at Sharp Health Care in San Diego, California. Fun fact: He is also the vice mayor of his hometown of Santee, California! Contact him at Stephen.houlahan@sharp.com. Opinions expressed are that of the author and do not necessarily represent HCPro, ACDIS, or any of its subsidiaries.
Recovery Auditor (RA) denials raise my blood pressure more than anything else (except maybe the postal service and the IRS). The constantly increasing number of clinical validation denials are repeated attacks against my hospital and my colleagues. I recently received a denial that assaulted a previously untouched target: the clinical validation of acute congestive heart failure (CHF) exacerbation. Unfortunately, that denial has proven not to be an isolated incident. Hopefully, sharing my experience and our hospital’s strategy will help in your appeal battles.

CHF clinical criteria

The criteria invariably quoted in acute heart failure (HF) clinical validation denials come from the Framingham classification system. This is a simple and straightforward clinical tool designed to help clinicians make the diagnosis and decide if treatment is warranted. This system should be incorporated into your CDI education process, and knowing these parameters will help your medical staff bolster your charts against future attacks.

Under this system, a patient should be diagnosed and treated for an acute HF exacerbation if he or she has two major or one major and two minor criteria:

- **Major criteria:**
  - Acute pulmonary edema
  - Cardiomegaly
  - Hepatojugular reflux
  - Neck vein distention
  - Paroxysmal nocturnal dyspnea or orthopnea
  - Pulmonary rales
  - Third heart sound (S3 gallop rhythm)
  - Weight loss greater than 4.5 kg in five days in response to treatment

- **Minor criteria:**
  - Bilateral ankle edema
  - Dyspnea on exertion
  - Hepatomegaly
  - Nocturnal cough
  - Pleural effusion
  - Tachycardia (heart rate greater than 120 beats/minute)

Some patients, however, don’t fit neatly into this system, yet they’re in florid exacerbation that needs aggressive treatment. If your patient doesn’t meet the criteria, how do you successfully appeal the denial?

First, understand that the Framingham classification system is only one tool. It should not be taken as the final word in the diagnosis of acute CHF. For example, the 2013 ACCF/AHA “Guideline for the Management of Heart Failure,” (Journal of the American College of Cardiology; volume 62, number 16) defines HF as:

>a complex clinical syndrome that results from any structural or functional impairment of ventricular filling or ejection of blood. The cardinal manifestations of [HF] are dyspnea and fatigue, which may limit exercise tolerance, and fluid retention, which may lead to pulmonary and/or splanchnic congestion and/or peripheral edema. Some patients have exercise intolerance but little evidence of fluid retention, whereas others complain primarily of edema, dyspnea, or fatigue. Because some patients present without signs or symptoms of volume overload, the term ‘[HF]’ is preferred over ‘[CHF].’ There is no single diagnostic test for [HF] because it is largely a clinical diagnosis based on a careful history and physical examination.

This same language is reiterated in the article “Evaluation of the Patient With Suspected Heart Failure” (Up to Date, last updated January 2018). This definition is less stringent than the Framingham criteria. It indicates that patients with increased dyspnea and known
problems with reduced diastolic filling or systolic ejection are likely having an acute HF exacerbation. To restate, not all acutely decompensated HF patients will demonstrate “classic” clinical indicators. If patients with chronic HF are acutely functionally decompensated and no other obvious cause can be discerned, they’re probably having an acute exacerbation.

**BNP levels**

Do not ignore a patient’s admission beta natriuretic peptide (BNP) level when formulating your defense. Per the 2017 ACCF/AHA/HFSA “Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure” (*Circulation*, April 2017), “in patients presenting with dyspnea, measurement of natriuretic peptide biomarkers is useful to support a diagnosis or exclusion of heart failure.” This source further states that “higher values have reasonably high positive predictive value to diagnose heart failure.”

You should also compare your patient’s BNP level with levels obtained from previous admissions (or office appointments). Even if previous BNP levels were elevated but stable, the current value may be suddenly and significantly higher. If that’s the case, chances are your patient’s having an acute HF exacerbation.

Some clinicians discount BNP levels because they may be elevated due to many other medical issues. Don’t allow that practice to dissuade the formulation of an appeal argument; use every piece of evidence at your disposal to persuade whomever reads the appeal. If the RA is in the habit of blaming elevated BNP levels on something else, address those concerns and concentrate on the acute rise in levels in comparison to previous test results.

**Elevated left ventricular end diastolic pressure**

In discussing this diagnosis with my cardiology colleagues, they concur that an elevated left ventricular end diastolic pressure (LVEDP) indicates active systolic HF. Physicians who are not cardiologists may be unaware of this definition, but to cardiologists, this is a clinically accepted fact. (For example, see these notes.)

Additionally, my cardiologists diagnose patients as having CHF based solely on this value, even if the ECHO is read as being without any obvious abnormalities. Normal LVEDP is considered to be 6–12 mmHg. In my facility, anything above this range detected during a cardiac catheterization will likely result in some form of diuresis once the procedure is over. Furthermore, the higher the value, the more diuresis the patient appears to receive. Therefore, an elevated LVEDP should certainly be used as evidence to support your defense.

**Patient’s clinical response**

A final useful piece of information is to review the patient’s demonstrated excellent clinical response to aggressive treatment for an acute HF exacerbation. If the disease process that was diagnosed at admission and the treatment for that disease process brought about a favorable outcome, the involved clinician was probably correct regarding the initial diagnosis.

Many patients, however, present with different disease processes, all of which appear to acutely decompensate simultaneously. It’s difficult to determine the order, the causation, and, for the sake of the appeal, the principal diagnosis under the United Healthcare Discharge Data Set definition. Since clinical validation denials target cases where the acute HF exacerbation is the only MCC reported, it can be difficult to isolate the treatment that most affected the patient’s recovery.

Sadly, clinical validation denials are here to stay, and I predict they will grow in volume and scope. In my facility, we have witnessed a yearly doubling of these denials. Medicare and commercial payers are constantly pressured to maintain viability and profits. When a denial sounds credible upon first reading, remember that the auditor probably isn’t telling you the whole story. Review every entry in the record before conceding. You never know what evidence was overlooked or ignored in the RA’s attempt to discredit your physicians. Regardless of how ludicrous the reason for the denial, if an appeal’s not attempted, you automatically lose.

**Editor’s note:** La Charité is a hospitalist with the University of Tennessee Hospitalists at the University of Tennessee Medical Center at Knoxville, a clinical assistant professor, and the medical director for UTMC’s CDI program. La Charité’s comments and opinions do not reflect necessarily those of UTMC, HCPro, ACDIS, or any of its subsidiaries. Contact him at Clachari@UTMCK.EDU.
CODING CORNER

How an ICD-10 code is born

by Kay Piper, RHIA, CDIP, CCS

Have you ever thought to yourself, “I wish there was a code for that?” Good news! You can make your dreams come true by submitting a code proposal to the ICD-10 Coordination and Maintenance Committee (C&M). In this article, I’m going to walk you through the process by sharing the experience of a medical coding educator and a CDI physician advisor.

“There’s no good way to code it,” Janice Noller, RHIA, CDIP, CCS, CICA, told Holly Ledyard, MD. “We can’t capture ‘traumatic brain herniation’ with the current ICD-10-CM codes.”

Noller and Ledyard work at University of Utah (U of U), a Level I trauma care center and a tertiary referral center that receives patients transferred from surrounding states. ICD-10-CM code G93.5, compression of brain, looked like a good option. It reports brain herniation resulting from strokes, tumors, and other medical etiologies. However, traumatic etiologies are assigned to category S06, traumatic brain injury, which doesn’t identify the specific injury. Capturing data specific to brain herniation is vital information for a research hospital like U of U. Once the brain herniates, there’s a high risk of mortality. A code for traumatic herniation would help with retrospective studies that could advance the care of these incredibly ill patients.

How to create an ICD-10 code

Anyone may propose a new ICD-10 code to the C&M, which meets twice a year to consider proposals. The meetings are free and open to the public and are held at the CMS headquarters in Baltimore. If you attend in person, you must pre-register, a process which opens approximately one month in advance of the event. You may view the meeting in real time, even without registering, via live streaming. Simply navigate to the webpage and the audio transmits through computer speakers. A call-in phone number is available for those wanting to ask questions or comment during the meeting.

Attendees, both in-person and remote, are encouraged to ask questions or make comments. Everyone must send their comments in writing even if they speak up at the meeting. Comments must be submitted by the deadline, which is approximately one month following the meeting. Please be aware that no decisions are made at the meeting itself. Recommendations and comments are carefully reviewed and evaluated once the comment period has closed, before final decisions are made.

CEU credits for both AAPC and AHIMA are approved for those attending in person or viewing online. The meetings are recorded and posted on YouTube immediately after adjournment. Several prior meetings are still available for viewing, which is extremely helpful for anyone seeking information on recently created codes.

Writing the proposal

Noller researched previous proposals at the National Center for Health Statistics (NCHS) website. She viewed YouTube recordings of prior C&M meetings to understand how the information was presented.

Proposals must include:

- Description of the code(s)/change(s) being requested
- Rationale for why the new code/change is needed (including clinical relevancy)
- Supporting clinical references and literature

One must submit the coding proposal in advance to nchsicd10CM@cdc.gov. Submission deadlines are posted on the NCHS website under “Upcoming Meetings.” Once proposals are reviewed, requestors are contacted as to whether the proposal has been approved for presentation. Once selected, many requestors create PowerPoint presentations that help attendees understand the clinical concepts more easily.
Determine detail needs

In presenting their case, Ledyard noted that traumatic brain herniation care differs from care required for herniation due to medical causes. And within traumatic herniations, treatment and survival rates differ depending on what part of the brain herniates. For instance, an open skull fracture brain herniation is different from a tentorial herniation through the cerebellum, each causing different clinical syndromes. Treatments differ, as do survival rates. Detail about types and locations of brain herniation is needed for research on treatment and prevention.

Noller and Ledyard worked together to identify which details were significant to capture. Together, they fine-tuned the code proposal based on clinical terminology that neurologists most commonly use. Then, Ledyard provided the clinical rationale and the supporting references to include in the proposal.

Consider code set structure

Noller reviewed the ICD-10-CM code book to determine which code category to place the proposed codes in. Because it’s traumatic, it fit best in ICD-10-CM Chapter 19, Injuries, Poisoning, and Other Consequences of External Causes (S00–T88), and in category S06, intracranial injury. She proposed the new subcategory S06.7-, traumatic intracranial compression, because the other categories didn’t reflect clinically what was happening with patients.

Next, Noller considered the best way to set up the code in keeping with the code category structure. For instance, what are the Includes and Excludes notes for other codes? Are there any sequencing directions such as “Code first” or “Code also”? Noller considered that brain herniation happens later as the brain swells, and not immediately at time of trauma; she created a “Code first the underlying traumatic brain injury” note.

**S06 Intracranial injury**

<table>
<thead>
<tr>
<th>New Code</th>
<th>S06.7- Traumatic intracranial compression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add</td>
<td>Includes: Unicidal herniation</td>
</tr>
<tr>
<td></td>
<td>Subfalcine herniation (cingulate)</td>
</tr>
<tr>
<td></td>
<td>Transtentorial herniation (central) (upward cerebellar)</td>
</tr>
<tr>
<td></td>
<td>Tonsillar herniation</td>
</tr>
<tr>
<td>Add</td>
<td>Code first the underlying traumatic brain injury, such as:</td>
</tr>
<tr>
<td></td>
<td>Traumatic hemorrhage of right cerebrum (S06.34-)</td>
</tr>
<tr>
<td></td>
<td>Traumatic hemorrhage of left cerebrum (S06.35-)</td>
</tr>
<tr>
<td></td>
<td>Contusion, laceration, and hemorrhage of cerebellum (S06.37-)</td>
</tr>
<tr>
<td></td>
<td>Traumatic subdural hemorrhage (S06.5-)</td>
</tr>
<tr>
<td></td>
<td>Traumatic Subarachnoid hemorrhage (S06.6-)</td>
</tr>
</tbody>
</table>
This makes a difference because patients may be transferred to U of U due to the herniation, but the “Code first” instruction provides accurate sequencing direction.

Noller’s proposal included parts of the brain: tonsillar, subfalcine, transtentorial, and uncal based on Ledyard’s input. Less common parts were included in S06.718-, other cerebral herniation.

Finally, Noller proposed an Excludes1 statement be added under G93.5 that directs the coder to assign S06.-, traumatic brain compression.

**Presenting the proposal**

Once approved, submitters present the proposal at the C&M meeting in Baltimore. Often, clinicians from clinical societies or specialties present the proposals, but speaking is open to anyone. Unfortunately, Noller and Ledyard found out too late that their proposal made the list and was on the agenda, so David Berglund, MD, of Classifications and Public Health Data Standards with the Centers for Disease Control & Prevention, presented the clinical background and the coding modifications for their proposal. Noller worked closely with Berglund prior to the meeting, so he was familiar with the details.

Noller viewed the meeting remotely and was excited when no one objected to her proposal. However, there were two comments, including one questioning why the location of the brain herniation was needed and citing concern that this information wouldn’t be documented. The commenter suggested there be just two codes, brain herniation with compression and one without compression. (See the box below for details)

**Post meeting: Public comment period and beyond**

Noller responded to the comment in writing. As the proposal submitters, she and Ledyard felt strongly that the specific site of the herniation is important to study treatment and mortality. Ledyard responded that herniation means there is compression, so a code stating “without compression” isn’t clinically credible. Noller requested that the clinical detail remain.

It’s been a year since that March 7, 2018, C&M meeting. Berglund’s team will review the comments they’ve received, and notes that once approved, CMS must consider payment and other implications for the new codes. Berglund also sent all the responses to Noller, so she will have a chance to respond to them. Noller suggested grouping most of the sites together in one code, but keeping a couple of them separated out. She also proposed that the locations be allowed to be coded from imaging reports, as this is allowed for other cerebrovascular diseases per Coding Clinic.

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**Proposed codes**

<table>
<thead>
<tr>
<th>New Code</th>
<th>Proposed Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>S06.71-</td>
<td>Traumatic cerebral compression</td>
</tr>
<tr>
<td>S06.710-</td>
<td>Traumatic cerebral compression with no herniation</td>
</tr>
<tr>
<td>S06.711-</td>
<td>Traumatic cerebral compression with tonsillar herniation</td>
</tr>
<tr>
<td>S06.712-</td>
<td>Traumatic Cerebral Compression with subfalcine herniation</td>
</tr>
<tr>
<td>S06.713-</td>
<td>Traumatic Cerebral Compression with central transtentorial herniation</td>
</tr>
<tr>
<td>S06.714-</td>
<td>Traumatic Cerebral Compression with uncal (lateral transtentorial) herniation</td>
</tr>
<tr>
<td>S06.718-</td>
<td>Traumatic Cerebral Compression with other cerebral herniation</td>
</tr>
<tr>
<td>S06.719-</td>
<td>Traumatic Cerebral Compression with unspecified cerebral herniation</td>
</tr>
</tbody>
</table>
Summary

Noller said that the process for submitting a code proposal is not as long and involved as one might think. It took just two people—her and Ledyard—and about 8–12 hours of work on Noller’s part, plus some of Ledyard’s time dealing with emails. Noller’s biggest task was going through the code book, determining what category their proposed code would fit into, and how to design codes to best represent what clinicians feel is useful. Noller says her team is thinking about submitting more proposals because the experience went so well.

For those interested, you can read Noller’s written proposal by clicking here, and you can listen to Dr. Berglund’s presentation by clicking here (it starts at 2:24:00 and runs through 2:37:00).

ABOUT THE AUTHOR AND FEATURED PROFESSIONALS

When Piper served on Coding Clinic’s Editorial Advisory Board (EAB), she learned that the EAB refers ICD-10’s code structure issues to the Coordination and Management Committee. EAB members explained that they need and want real-life feedback based on coding and CDI expertise. She also learned that when more people write in, it illustrates the importance of the topic.

Piper presented on this topic at Utah’s annual HIMA event where her long-time friend and former former boss discussed submitting her own proposal. “It was a lot of fun learning about how she did it,” Piper says. “I hope this article encourages everyone to give their input. Please don’t feel you are not knowledgeable or important enough—you are!”

Get to know the author and sources

Kay Piper, RHIA, CDIP, CCS, has a passion for helping others improve their coding knowledge and skills. Piper is the inpatient coding educator for SSM Health based in St. Louis, Missouri. She provides education for coders from 19 hospitals in four states. Piper is committed to others through volunteerism for local, state, and national HIM associations, and previously served on the American Hospital Association (AHA)’s ICD-10-CM/PCS Coding Clinic Editorial Advisory Board.

Janice Noller, RHIA, CDIP, CCS, CICA, has been in health information for more than 40 years and has had a wide range of experience from working in different capacities around the country. She has volunteered for multiple state HIM associations and has always enjoyed educating coders. She is currently the inpatient coding educator for University Hospital in Salt Lake City, Utah. She serves on the AHA’s ICD-10-CM/PCS Coding Clinic Editorial Advisory Board.

Holly Ledyard, MD, MS, is assistant clinical professor in neurology and surgery in the University of Utah (U of U) School of Medicine. She is board-certified in neurocritical care and emergency medicine and works actively as a clinician in the ED and neurological critical care unit of University Hospital. She has been a physician advisor for the documentation improvement committee for several years.
Lourdes Albino Cacanindin, MD, CCDS, is a CDI specialist at Sutter Health–Sutter Delta Medical Center in Antioch, California, and is a member of the California chapter of ACDIS.

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

Cacanindin: It’s been the most rewarding eight and a half years since 2010, when I was hired by Sutter Delta Medical Center as their CDI reviewer. Before that, I was a Philippine board-certified doctor and practiced pediatrics in Manila. I graduated in 1987, magna cum laude, in pre-med from the University of Santo Tomas College of Science, went on to medical school at UST Faculty of Medicine and Surgery, and graduated in 1991, passing the medical board exam that same year.

I was a pediatric clinical practitioner affiliated in six major hospitals in the Greater Manila area until 2005. Then I became the head of the department of pediatric and health coordinator at Martinez Memorial Hospital, before eventually moving here and getting into CDI.

ACDIS: Why did you get into this line of work?

Cacanindin: Through God’s grace! We finally decided to stay in my mother-in-law’s home in San Francisco for good in May 2005 to take care of my husband’s aging parents. I passed the four steps of the United States Medical Licensing Exam but didn’t want to do the residency training outside California. I did a year of clinical observation in a pediatric clinic, then struggled to get into the matching program here.

Then, we got tired of the city, and my husband suggested it was time to buy a new house in the East Bay in 2010 when the housing market was really great. When my father-in-law died in November 2010, we went back to Chattanooga to stay in the city on weekends. Then, I was referred to Sutter Delta Medical Center’s CEO at the time, by my new home and car insurance agent who happened to be one of the members of the board of trustees of Sutter Delta and the president of the Delta Memorial Hospital foundation. He invited me to come offered me the job as a CDI reviewer. The rest is history!

ACDIS: What has been your biggest challenge?

Cacanindin: My biggest challenge, when I started, was getting hold of the chart. We did not have Epic in 2010, so I suggested staying on the floors while I read the charts in the doctor’s quarters. I was able to chat with the providers and do verbal queries at the same time. I used neon orange–colored paper for my written queries so that our doctors could locate them among the piles of paper in the patient’s chart. The funny part was, when I went up to the floors, I could see some doctors going to the opposite direction to avoid me. It was like a mouse seeing a cat. But, I got some help from the telemetry nurses. They called my extension or my cell when they saw the doctors in my “most wanted list.”

Once a particularly rude provider asked, “Where do you get those differentials? Google?” So, I said, “Yes! I can get more precise diagnoses from Google than from your chart.” And said it with a big smile.
ACDIS: What has been your biggest reward?

Cacanindin: My biggest reward was to be respected as a medical colleague doing another line of work and be recognized for my CDI efforts by our CFO. When I was hired to do this job, I didn’t introduce myself as a Philippine board-certified medical doctor to the rest of the medical staff, but as a CDI reviewer. Then, after three months at work, the CEO introduced me as a doctor who had practiced pediatrics in the Philippines for more than 10 years. After that meeting, I received some more respect and more acceptance for my queries.

And the best comment I got was from our CFO at the time, Julie Peterson, who told my husband during our hospital Christmas party, “I’m glad to see you, and I would like you to know that we want to clone your wife.” Being a witty Navy veteran and a financial expert, my husband replied, “Great, I’ll give you the clone, I’ll bring my wife home, then you give me two checks.”

Whenever I saw Julie in the hallways, she always recognized my good work and updated me about our case-mix index. Recently, I was invited to our inpatient council to collaborate with them on physician education with our chief medical officer and my manager, the director of CDI. I already did some presentations with one of our surgical providers last October and he shared it with his group. Then, last November, I did a presentation with one of our hospitalists, who also shared it with his hospitalist group. Since then, I’ve seen significant improvement in the documentation. We are now preparing one for our larger hospitalist group.

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

Cacanindin: There has been great progress in the CDI field. I was already familiar with ICD-10 from when I was the insurance coordinator and head of our pediatric department in Martinez Hospital. I used ICD-10 diagnosis codes in my practice, which is why I was so surprised to know that clinicians here still used ICD-9 codes. Before I was hired, I took an ACDIS Boot Camp in Fremont, California, with Shannon McCall and immediately became an ACDIS member. When I was hired in April, Sutter Delta wanted to send me to the Boot Camp, so when they found out I’d already done that, they reimbursed everything I incurred for that training.

I passed the CCDS exam on April 9, 2012, after two years at Delta. CDI has changed a lot since back then in terms of getting a hold of charts, paper queries, and waiting for the replies to those queries, which were sometimes misplaced. When the EHR was introduced to Delta, it was like a heaven-sent application for a CDI specialist with a flair for computers like me. Reviewing the charts was a breeze and sending queries became a lot easier with templates we could pull out in seconds. Then, the introduction of ICD-10 was the best thing for me since I was familiar already with those codes.

What I love the most in CDI is the constant change and updates. It keeps my brain’s neurons constantly synapsing. I love to read and learn continuously.

ACDIS: Can you mention a few of the “gold nuggets” you’ve received through ACDIS?

Cacanindin: My “one thing” from ACDIS isn’t just one thing. I learned tons of great information about the healthcare industry through ACDIS. I received a lot of medical knowledge about health information management that I shared with my alma mater, through our conferences with the University of Santo Tomas Medical Alumni Association in America, where I am a current member of the board of directors. I also encouraged our alumni to try out CDI, and I introduced my medical sorority sisters from Theta Lambda Phi to ACDIS and encouraged them to become members. I’ve met a lot of important and knowledgeable people and kept a few as close friends. I learn a lot from doctors when I attend the forum for clinicians during the annual conference. I intend to grow in this field and share its impact.

ACDIS: How many ACDIS conferences have you been to? What are your favorite memories?

Cacanindin: I’ve been to every ACDIS conference since 2011. We were asked to submit a comment about the impact of the conference during my first year of attendance, then to my surprise, it was published in the 2012 ACDIS Conference brochure and then again in the 2013 brochure. The brochure says on the last page what previous attendees said about the event. I’m quoted as saying, “I am more confident to educate our
ACDIS: If you could have any other job, what would it be?

Cacanindin: Probably a college professor. I’d love to teach and learn, but I hate lesson planning like what my mom used to do. She was an elementary school teacher when we were growing up and taught me a lot about being academically strong. She’s enjoying her life with my dad and two sisters in the Philippines.

ACDIS: What was your first job?

Cacanindin: I helped my mom manage our own mini grocery store in Malinta, Valenzuela City. I was the cashier after school hours. Everybody calls my mom Nonie “Mrs. Love” because the name of our store was LOVE—L for Lourdes, O for Orchids, and VE for Venus—her three precious daughters’ names.

ACDIS: Can you tell us about a few of your favorite things?

■ Vacation spots: Kauai. It’s the best island in Hawaii for me.
■ Hobby: Reading or watching movie marathons with my husband on Saturday nights.
■ Non-alcoholic beverage: Jasmine tea.
■ Foods: Adobo, Lumpia, and Pancit and any Sinigang or Nilaga. And, warm soup when I’m not feeling well.
■ Activity: Travelling with SHIRE (our RV), our home away from home.

ACDIS: Tell us about your family and how you like to spend your time away from CDI.

Cacanindin: We have a very busy social life. As one of our dear friends always says, “I can’t catch up with you guys. You’re hardly home!” Well, my husband just retired, and we want to enjoy life while we can. We always spend time with family and friends, and we love to invite people over whenever we’re home. We love to celebrate life, and it keeps us feeling young. You have to tell us in advance if you want to invite us somewhere because our calendar fills up fast. We’re moving around with Shire all the time when we have time.
2019 UPDATE
Guidelines for Achieving a Compliant Query Practice

This American Health Information Management Association – Association of Clinical Documentation Improvement Specialists (AHIMA-ACDIS) Practice Brief should serve as an essential resource for coding and clinical documentation improvement (CDI) professionals in all healthcare settings who participate in query processes and/or functions. It should also be shared and discussed with other healthcare professionals, such as quality, compliance, revenue cycle, patient financial services, physician groups, facility leaders, and any others who work with health record documentation, clinical coding, and/or coded data.

This Practice Brief’s purpose is to establish and support industry-wide best practices for the function of clinical documentation querying. Its intent is to integrate best practices into the healthcare industry’s business and workflow processes and the overall function of querying. This Practice Brief should be used to guide organizational policy and process development for a compliant query practice that implements the directives of the ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting and official advice in the American Hospital Association (AHA) Coding Clinic® for ICD-10-CM/PCS promoting the legible, consistent, complete, precise, nonconflicting, and clinically valid documentation essential to the integrity of the ICD-10-CM/PCS code sets. It is also intended to provide a resource for external reviewers (e.g., the Office of Inspector General (OIG), government contractors, payer review agencies, etc.) in their evaluation of provider queries and the documentation they provide.

Some specific use examples include:

- Orient new employees and educate current staff
- Assist with query audits
- Review of query policies and procedures annually
- Utilize during coding and CDI education and training
Examples of non-compliant queries include: directing a provider to document a diagnosis that is not clinically supported but serves as an exclusion for a patient safety indicator, adding a non-reportable diagnosis, or encouraging a provider to neutralize documentation suggestive of a post-surgical complication. Although open communication between members of the healthcare team and providers is necessary and important, when it can impact claims data these discussions should be memorialized as queries. Organizations should educate all relevant professionals in compliant query practices through collaboration with health information management, coding, and CDI professionals before engaging in these interactions. Regardless of the credential, role, title, or use of technology, all healthcare professionals (whether or not they are AHIMA or ACDIS members) seeking to clarify provider documentation must follow compliant query guidelines.

What is a query?

A query is a communication tool or process used to clarify documentation in the health record for documentation integrity and accurate code assignment for an individual encounter in any healthcare setting. Synonymous terms for “query” include: clarification, clinical clarification, and documentation clarification. Documentation queries (referred to as “queries” in this Practice Brief) are used by coding professionals, CDI professionals, and all professionals responsible for documentation clarification or who have oversight and/or involvement in the query process. As healthcare reimbursement methodologies evolve and reliance on claims data as a risk-adjustment and quality of care tool increases, so does the importance and complexity of the query process. Queries continue to be a mechanism that increases the precision of clinical documentation, which translates into accurate clinical data, reflecting a provider’s intent and clinical thought process in a manner that results in an accurate depiction of patient complexity within each episode of care.

All queries, including verbal queries, should be memorialized to demonstrate compliance with all query requirements to validate the essence of the query (see below). Regardless of how the query is communicated, it needs to meet all of the following criteria:

- Be clear and concise
- Contain clinical indicators from the health record
- Present only the facts identifying why the clarification is required
- Be compliant with the practices outlined in this brief
- Never include impact on reimbursement or quality measures

As query templates are now increasingly embedded in the electronic health record (EHR) or workflow software, query professionals must ensure relevant clinical indicator(s) specific to the particular
patient as cited within the health record are applied and referenced appropriately. Additionally, the choices provided as part of the query must reflect reasonable conclusions specific to the clinical scenario of the individual patient.

**Why query?**

Queries are utilized to support the ability to accurately assign a code and can be initiated by either coding or CDI professionals. Queries may be necessary in (but are not limited to) the following instances:

- To support documentation of medical diagnoses or conditions that are clinically evident and meet Uniform Hospital Discharge Data Set (UHDDS) requirements but without the corresponding diagnoses or conditions stated
- To resolve conflicting documentation between the attending provider and other treating providers (whether diagnostic or procedural)
- To clarify the reason for inpatient admission
- To seek clarification when it appears a documented diagnosis is not clinically supported
- To establish a diagnostic cause-and-effect relationship between medical conditions
- To establish the acuity or specificity of a documented diagnosis to avoid reporting a default or unspecified code
- To establish the relevance of a condition documented as a “history of” to determine if the condition is active and not resolved
- To support appropriate Present on Admission (POA) indicator assignment
- To clarify if a diagnosis is ruled in or out
- To clarify the objective and extent of a procedure

Although specific query formats will be discussed later in this Practice Brief, issuing clinical validation queries can be more challenging than other query types. These challenges have initiated the development of a separate Practice Brief to address these concerns. Please refer to the AHIMA Practice Brief titled “Clinical Validation: The Next Level of CDI” to learn more about the process of clinical validation, available in the AHIMA HIM Body of Knowledge at http://bok.ahima.org.

**What to query?**

A health record contains documentation authored by a variety of healthcare professionals. Increasingly, the electronic health record also contains information whose origin and accuracy cannot always be easily verified. While it is important to note the overall accuracy of the health record and how well it meets industry and regulatory standards, it is outside the scope of querying professionals to manage provider documentation practices. When coding and CDI professionals identify that the health record fails to meet one of the following seven criteria identified below, and after education and query efforts have been exhausted, it should be reported to the appropriate facility and/or organizational authority:

- Legibility
- Completeness
- Clarity
- Consistency
- Precision
- Reliability
- Timeliness

Facilities and organizations are encouraged to have robust guidelines in place that define the contents of the health record and outline documentation expectations, including the use of copy and paste functionality, automatically populated fields (e.g., problem lists, diagnostic results, etc.), and document templates that are included within the health record.

The focus of CDI professionals is to review the health record to ensure clear, high-quality clinical documentation. Ambiguous documentation fails to reflect the provider’s intent, impacts the clinical scenario (e.g., complications, quality of care issues), the accuracy of code assignment, and the ability to assign a code. It is important to note that code accuracy is not the same as code specificity. The ICD-10-CM Official Guidelines for Coding and Reporting’s General Guidelines B.2 only requires diagnosis codes be reported to the highest number of characters available, not to the most specific code available.
within the code set. Although there has been discussion from payers and others regarding the reporting of unspecified diagnoses, there are situations where an unspecified code is accurate based on the clinical scenario, such as the reporting of A41.9, Sepsis, unspecified organism.

Queries are not necessary for every discrepancy or unaddressed documentation issue. When determining the need to query, the query professional must consider if the provider can offer clarification based on the present health record documentation or resolve/seek clarification on conflicting documentation.

Organizational query policies and procedures should provide direction to guide staff when multiple opportunities exist. Specifically, organizations need to determine if there is a limit to how many questions may be issued at one time and how many queries may be communicated during the same encounter.

In a situation when multiple queries are required regarding the same set of clinical indicators or ambiguous documentation, querying professionals may need to utilize verbal queries to discuss these complex circumstances. For example, if both a diagnosis and additional specificity must be established for accurate code assignment (e.g., the presence of CHF and its type), a verbal query may be necessary or two separate written queries. Trying to obtain too much information in one query may result in a non-compliant query.

There may be times when a second query is needed to obtain further clarification of a previously answered query as additional information becomes available or as the clinical picture evolves. However, it is considered non-compliant to continue asking the same query to the same or multiple providers until a desired response is received.

The objective of a query is to ensure the reported diagnoses and procedures derived from the health record documentation accurately reflect the patient’s episode of care. Compliant query practice should follow these tenets:

- Queries must be accompanied by clinical indicator(s) that:
  - Are specific to the patient and episode of care
  - Support why a more complete or accurate diagnosis or procedure is sought
  - Support why a diagnosis requires additional clinical support to be reportable

- Avoid using terms that indicate an uncertain diagnosis as defined by ICD-10-CM Official Guidelines for Coding and Reporting and Coding Clinic® (e.g., “likely,” “probable,” etc.) as a query response choice unless the query is either provided at the time of discharge or after discharge; then it is the responsibility of the provider to continue to document any additional information until discharge, unless the query response is definitely ruled in or out

- Avoid the qualifier “possible” in the formation of the query question

- Avoid queries that:
  - Fail to include clinical indicators that justify the query or justify the choices provided within a multiple-choice format
  - Encourage the provider to a specific diagnosis or procedure
  - Indicate the impact on reimbursement, payment methodology, or quality metrics

**Role of prior encounters**

There has been much discussion and confusion regarding the use of information from prior encounters in a current clinical documentation query. Some major developments require taking another look at this:

- The field of Clinical Documentation Improvement continues to mature and develop beyond clarifying for reimbursement purposes and is striving for health record integrity

- Implementation of the EHR brings information that was
once buried in storage and hard to access to the fingertips of physicians and querying professionals, leading to a more detailed reference and a richer picture of a patient’s medical history.

Recent Centers for Medicare and Medicaid Services (CMS) initiatives such as bundled payments and value-based measures expand the “episode of care” across settings, transitioning to a patient or disease focus instead of a setting of care focus.

CMS and many commercial payers regularly aggregate healthcare data across settings on an annual basis.

AHA ICD-10-CM/PCS Coding Clinic’s Third Quarter 2013 section “Assigning codes using prior encounters” states “[When] reporting recurring conditions and the recurring condition is still valid for the outpatient encounter or inpatient admission, the recurring condition should be documented in the medical record with each encounter/admission. However, if the condition is not documented in the current health record it would be inappropriate to go back to previous encounters to retrieve a diagnosis without physician confirmation.”

This statement speaks to code assignment, not construction of a documentation query. A query may be initiated to clinically validate a diagnosis that a prior health record provided evidence to support particularly when clarifying specificity or the presence of a condition which is clinically pertinent to the present encounter supporting accuracy of care provided across the healthcare continuum. Prior encounter information may be referenced in queries for clinical clarification and/or validation if it is clinically pertinent to the present encounter. However, it is inappropriate to “mine” a previous encounter’s documentation to generate queries not related to the current encounter.

Queries using information from prior encounters may be utilized when relevant in the following situations (but not limited to):

- Diagnostic criteria allowing for the presence and/or further specificity of a currently documented diagnosis (e.g., to ascertain the type of CHF, specific type of arrhythmia)
- Treatment/clinical criteria or diagnosis relevant to the current encounter that may have been documented in a prior encounter
- Determine the prior patient baseline allowing for comparison to the current presentation
- Establish a cause-and-effect relationship
- Determine the etiology, when only signs, symptoms, or treatment are documented
- Verify POA indicator status
- Clarify a prior history of a disease that is no longer present (e.g., history of a neoplasm)

When considering whether a query could be issued using information in the prior record, carefully consider the “General Rules for Other (Additional) Diagnoses” that states: “For reporting purposes the definition for ‘other diagnoses’ is interpreted as additional conditions that affect patient care in terms of requiring: clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring,” according to ICD-10-CM Official Guidelines for Coding and Reporting, Section III. It would be inappropriate to query for a diagnosis that, if documented, would not satisfy this criteria. A query cannot be based solely on the information from a prior encounter, there must be relevant information within the current encounter to substantiate the query.

**Clinical indicators**

“Clinical indicators” is a broad term encompassing documentation that supports a diagnosis as reportable and/or establishes the presence of a condition. Examples of clinical indicators include: provider observations (physical exam and assessment), diagnostic findings, treatments, etc. provided by providers and ancillary professionals. There is not a required number of clinical indicators that must accompany a query because what is a “relevant” clinical indicator will
vary by diagnosis, patient, and clinical scenario.

While organizations, payers, and other entities may establish guidelines for clinical indicators for a diagnosis, providers make the final determination as to what clinical indicators define a diagnosis. AHA’s Coding Clinic® similarly affirms that in its first quarter 2014 issue, stating “Clinical information previously published in Coding Clinic® whether for ICD-9-CM or ICD-10-CM/PCS does not constitute clinical criteria for establishing a diagnosis, substitute for the provider’s clinical judgment, or eliminate the need for provider documentation regarding the clinical significance of a patient’s medical condition. It may still be useful to understand clinical clues regarding signs or symptoms that may be integral (or not) to a condition. However, care should be exercised as ICD-10-CM has new combination codes as well as instructional notes that may or may not be consistent with ICD-9-CM.”

The purpose or type of query will also impact how much clinical support is necessary to justify the query and, when applicable, reasonable option(s). When the purpose of the query is to add a diagnosis, clinical indicators should clearly support the condition, allowing the provider to identify the most appropriate medical condition or procedure. The quality of clinical indicators—how well they relate to the condition being clarified—is more important than the quantity of clinical indicators.

Clinical indicators can be identified from sources within the entirety of the patient’s health record including emergency services, diagnostic findings, and provider impressions as well as relevant prior visits, if the documentation is clinically pertinent to the present encounter. For example, there is care being provided in the current encounter that necessitated the review of a previous encounter to identify the undocumented condition. Compliant query practice always requires the individualization of each query to reflect the specifics of the current circumstance.

Who is queried?

Healthcare data is obtained primarily from diagnosis and procedure codes. In particular, diagnosis codes are only assigned based on the documentation of those licensed, independent providers who render direct patient care. The 2019 ICD-10-CM Official Guidelines for Coding and Reporting define the term providers as, “physician or any qualified healthcare practitioner who is legally accountable for establishing the patient’s diagnosis.” Independent providers include physicians, consulting physicians, nurse practitioners, physician assistants, and medical residents. Code assignment may be based on other physicians’ (i.e., consultants, residents, anesthesiologist, etc.) documentation if there is no conflicting information from the attending physician. Refer to ICD-10-CM Official Guidelines for Coding and Reporting’s I.B.14. “Documentation by Clinicians Other than the Patient’s Provider” section for additional guidance. When conflicting documentation is present, it is the attending physician who should be queried to resolve the discrepancy.

There are occurrences for which queries are applied to individuals who are not classified as a provider. AHA Coding Clinic® first quarter 2014 states that, “It is appropriate to assign a procedure code based on documentation by a non-physician professional when that professional provides the service.” For example, infusions may be carried out by a nurse, wound care provided by a nurse or physical therapist, mechanical ventilation may be provided by a respiratory therapist, or a medication may be ordered by the physician and administered by a nurse. In these instances, clarification may be needed from a non-physician professional and queries should be assigned as appropriate. All individuals who are likely to receive a query should be educated about the reason(s) for the query, the process, and the expectations for completion and documentation.

How to query

Verbal, written paper, and electronic queries serve the purpose of supporting clear and consistent documentation of diagnoses being monitored and treated during a patient’s healthcare encounter. Regardless of the method, a query must adhere to compliant, non-leading standards, permitting
the provider of record to unbiasedly respond with a specific diagnosis or procedure. References to reimbursement must not occur. All relevant diagnoses, lab findings, diagnostic studies, procedures, etc. which illuminate the need for a query should be noted.

Regardless of the format and technology used, a query should not direct the provider to document a specific response. Best practice dictates that, whenever possible, query responses be consistently documented within the health record as part of the progress notes and discharge summary or as an addendum as appropriate. If a compliant query has been properly answered and authenticated by a responsible provider and is part of the permanent health record, absence of the documented answer in a progress note, discharge summary, or addendum should not prohibit code assignment.

**Written queries**

Written paper and electronic queries are to be constructed in a clear and concise manner citing relevant clinical indicators and identify applicable diagnoses that are fundamental for the provider to accurately respond. Queries should be legible and grammatically correct. All clinically supported options should be included as well as additional options that permit the provider to craft their own alternate response. Options may include other, unknown, unable to determine, not clinically significant, integral to, or other similar wording.

Written queries can have the following format (see sample queries in Appendix B)

- **Open-ended:** The provider free texts a response which may or may not align with documentation needed to support code assignment

- **Multiple choice:** Multiple choice query formats should include clinically significant and reasonable option(s) as supported by clinical indicator(s) in the health record, recognizing that occasionally there may be only one reasonable option. 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. There is no mandatory or minimum number of choices necessary to constitute a compliant multiple choice query.

- **Yes/no:** Yes/No queries should only be employed to clarify documented diagnoses that need further specification. Yes/No queries may not be used in circumstances where only clinical indicators of a condition are present, and the condition/diagnosis has not yet been documented in the health record. The query should include the documentation in question with relevant clinical indicators and be constructed so that it can be answered with a “yes” or “no” response. Below are some examples for when a yes/no query may be applicable:

  - Determining POA status
  - Substantiating a diagnosis that is already present in the current health record (i.e., findings in pathology, radiology, and other diagnostic reports) with interpretation by a physician
  - Establishing or negating a cause and effect relationship between documented conditions such as manifestation/
etiology, complications, and conditions/diagnostic findings

- Resolving conflicting documentation from multiple providers

A provider’s response to a query should be documented in the health record even if the patient has been discharged. If the record has been completed, then an addendum should be created and authenticated according to organizational policy. 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.”

While organizations are free to determine the specifics of their query process, compliant practice requires that all queries either be a permanent part of the record or be retrievable in the business record.

**Query policies and procedures**

Query practice should be managed and monitored for compliance to organizational policy. Organizations should develop pertinent query policies, including a query retention policy and escalation policy (see additional details below). Examples of policies may be found on the AHIMA and/or ACDIS websites.

**Query retention policy**

It is recommended that the policy specify the completed query be a permanent part of the health record and the location. If it is not considered a permanent part of the health record, it should be considered as part of the business record and retained for auditing, monitoring, and compliance. If the query is deemed to be part of the health record, it will be subject to health record retention guidelines which vary from state to state.

**EXAMPLE:**

Query Retention: Queries will be maintained in a business folder (section) of the health record for a period of seven years or as stated by medical bylaws.

Provider response should not impact decisions regarding retention of the query.

**Escalation policy**

Facilities must develop an escalation policy for unanswered queries and address any medical staff concerns regarding queries. If a query does not receive an appropriate professional response, the case should be referred for further review in accordance with the facility’s written escalation policy. Escalation may begin with a supervisor or manager and should efficiently move up until resolved. The escalation process may include, but is not limited to, referral to a physician advisor, the chief medical officer, or other administrative personnel. The escalation process is not meant to direct or intimidate the recipient for a specific or particular response. This policy should clearly outline expectations of each individual involved in the process, including the expected time frames in which resolution or further escalation is expected.

**Follow best practices**

Healthcare professionals who work alongside practitioners to ensure accuracy in health record documentation should follow established facility and organization processes, policies, and procedures that are congruent with recognized professional guidelines. This Practice Brief represents the joint efforts of both AHIMA and ACDIS to provide ongoing guidance related to compliant querying. As healthcare delivery continues to evolve, it is expected that future revisions to this Practice Brief will be required.

**Editor’s Note:** This Practice Brief supersedes the January 2016 Practice Brief titled “Guidelines for Achieving a Compliant Query Practice (2016 Update).” For a complete list of references, contributing authors/reviewers, and further information, please visit the ACDIS Resource Library and download the PDF of this updated practice brief. 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. “Guidelines for Achieving a Compliant Query Practice” was produced through the joint effort of the Association of Clinical Documentation Improvement Specialists (ACDIS) and the American Health Information Management Association (AHIMA). Both associations collaborated on the creation of this Practice Brief and approved its contents, and as such it represents the recommended industry standard for provider queries.