Is Your Query Process Ready for ICD-10-CM/PCS?

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Learning Objectives

- At the completion of this educational activity, learners will be able to:
  - Explain the importance of defining the mission of their CDI department (e.g., revenue enhancement, the mortality index, coding accuracy, etc.) by establishing how the success of the department will be measured
  - List potential vulnerabilities of their current query process in relation to ICD-10 documentation demands (e.g., increased combination codes, increased anatomic specificity, increased volume of complication codes, etc.)
  - Identify key areas that should be addressed within a query policy/process (e.g., the “what, who, when, where” of querying within their organization)

Coding

- Is the translation of the “clinical language” within the health record into a quantifiable language of alphanumeric codes representing diagnoses and procedures. These codes are used for a variety of purposes, including:
  - Reimbursement
  - Health statistics
  - Healthcare quality metrics
HIPAA: Transaction and Code Set Rule

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) adopted a standard code set for different types of transactions.
- This law requires any “covered entities”/any healthcare organization governed by HIPAA law to follow the standard set of coding.
- ICD-9-CM codes have been used for the purpose of hospital/inpatient reimbursement since 1983.

Coding

- HIPAA requires covered entities to report healthcare data using one or more of the following three code sets:
  - ICD-9-CM diagnosis codes
    - Used by all healthcare providers in all settings
  - ICD-9-CM procedure codes
    - Limited to inpatient medical interventions/procedures
    - Used to identify medical services and procedures furnished in the outpatient setting.
ICD-10-CM/PCS

- A Clinical Modified version of the International Classification of Diseases (ICD) in its 10th revision as developed by the World Health Organization (WHO) will be implemented **October 1, 2014** for general use by the U.S. healthcare industry for the purpose of reimbursement and the reporting of healthcare data as mandated under HIPAA
  - It is referred to as ICD-10-CM
- ICD-10-CM is only a disease classification system and doesn’t include classification of inpatient procedures

Modified Versions of ICD-10

- ICD-10-PCS (Procedure Coding System) replaces Volume III of ICD-9-CM
  - It is unique to the United States as other countries have also created a procedure coding system to accompany the ICD-10 code set
  - It has its own official coding guidelines
- CMS states that inpatient hospital claims with a discharge date of October 1, 2014 or later will **NOT** be processed unless submitted using ICD-10-CM/PCS
Coding After October 1, 2014

- ICD-10-CM/PCS
  - All settings will use ICD-10-CM
  - ICD-10-PCS will be used in the inpatient setting, which is billed to Medicare Part A
  - HCPCS/CPT is used in the outpatient setting, which is billed to Medicare Part B
- Providers will continue to document and bill in terms of HCPCS/CPT codes
  - Can impact Medicare inpatient-only procedure classification
  - Can impact CMS SCIP quality metrics

HIPAA: Transaction and Code Set Rule

- Adherence to ICD-10-CM/PCS coding guidelines is required under the Health Insurance Portability and Accountability Act (HIPAA)
  - Coding guidelines require a code be reported to the highest specificity, but specificity will not always translate into higher reimbursement
  - This may result in a dilemma for many organizations regarding the role of CDI and querying
Coding Productivity

- Initial estimates predicted a decrease of up to 40% in coder productivity, which now seems conservative as organizations begin implementing ICD-10-CM/PCS
- These estimates were based on implementation experiences in other countries more than 10 years ago where coded data is not used for the purpose of reimbursement
  - Other countries may not have the same level of oversight and scrutiny as occurs in the U.S. regarding coding accuracy, which can further decrease productivity

Coding Productivity

- A decrease in coder productivity can result in an increase in bill hold times
  - Bill hold times is a key organizational metric
- An increase in bill hold times can result in a decrease in “cash on hand,” which can negatively impact organizational cash flow
  - Cash on hand is a key organizational metric
- Organizations will be well served to anticipate how use of ICD-10-CM/PCS could negatively impact coding productivity in an effort to minimize the losses
Decreased Productivity

• If your organization’s bill hold is currently five (5) days and your organization experiences a conservative 40% decrease in coding productivity, that increases bill hold by at least two (2) days
  – Approximately seven (7) business days (coders don’t traditionally work weekends)
• Has your organization identified what factors or elements of coding can potentially impact productivity?

Possible Solutions?

• Computer assisted coding (CAC)
  – Don't overdo it with computer-assisted coding, study says
    • November 04, 2013 | Carl Natale, Editor, ICD10Watch
      “... The National Pilot program suggests that CAC doesn't do so much for medical coding accuracy and productivity ... Garbage in. Garbage out ... the problem with using CAC systems in ICD-10 implementation strategies. Those systems won't work when physicians don't enter the correct information to generate ICD-10 codes.”
The Big Unknown

- Organizational readiness vs. coding readiness
  - Coders may be trained and ready to use ICD-10-CM/PCS, but will providers be ready to document adequately for specificity?
  - How long have CDIs/coders been asking for CHF specificity? Querying for urosepsis?
  - Is your provider education plan realistic? Do you have the right resources and adequate staffing?
  - Will you be able to maintain your current CDI/coding performance metrics ...
    - Case-mix index (CMI)?
    - Query response rate?
    - Query agreement rate?

Query Issue #1: Assigning ICD-10-CM Codes

- The mechanics of code assignment (e.g., assignment of principal and secondary diagnoses) remains the same in ICD-10-CM; however, about 15%–20% of the official coding guidelines affecting when and how a code is assigned or sequenced were revised
  - Coding Clinic® is a resource used to augment the official coding guidelines to encourage consistent use of the code set
  - Many coders rely heavily upon Coding Clinic advice when assigning codes
Documentation Challenges

- Documentation issues in ICD-9-CM are likely to continue within the ICD-10-CM code set
  - An unspecified version of most codes is available, but many hypothesize that unspecified codes will be “downgraded” in the future, losing CC/MCC designation, to encourage full use of the code set
  - Most industry experts predict sweeping changes in CC/MCC designations and MS-DRG assignments come October 1, 2015 when Medicare will have a year of paid claims data using the ICD-10-CM/PCS code set to make adjustments
    - As a diagnosis becomes more common, it loses its value (e.g., acute renal failure)

Myths and Facts: ICN 902143 April 2013

MYTH

Unnecessarily detailed medical record documentation will be required when ICD-10-CM/PCS is implemented.

FACT

As with ICD-9-CM, ICD-10-CM/PCS codes should be based on medical record documentation. While documentation supporting accurate and specific codes will result in higher-quality data, nonspecific codes are still available for use when documentation doesn’t support a higher level of specificity. As demonstrated by the American Hospital Association/American Health Information Management Association field testing study, much of the detail contained in ICD-10-CM is already in medical record documentation, but is not currently needed for ICD-9-CM coding.

- What is the quality of your provider documentation? Yes, you can still assign codes in ICD-10-CM, but will there be an impact to your CC/MCC capture rate and/or case-mix index?
Coding Productivity

- Although the mechanics of coding will remain the same under ICD-10-CM/PCS, the nuances of coding under the new system have yet to be explored.
- *Coding Clinic* is a publication by the American Hospital Association (AHA), who is a cooperating party, for the purpose of promoting consistent code assignment through providing advice about use of the ICD-9-CM code set.
  - Various issues of *Coding Clinic* are used routinely by coders when applying codes and sequencing diagnoses.

Coding Clinic for ICD-10

- From *Coding Clinic*, Second Quarter 2010, AHA Coding Clinic for ICD-10 Briefing Series:
  - “There are no plans to translate all previous issues of Coding Clinic for ICD-9-CM® into ICD-10-CM/PCS since many of the questions published arose out of the need to provide clarification on the use of ICD-9-CM and would not be readily applicable to ICD-10-CM/PCS.”
Many are confused regarding what, if anything, is retained from ICD-9-CM Coding Clinic advice with ICD-10-CM as some recent advice allows the continuation of practices established through ICD-9-CM Coding Clinic but another source reverses previous advice

- Coding Clinic, 1st Quarter 2013 allows “additional information regarding the site for a condition that the provider has already diagnosed ... To assign a code to identify the specificity that is documented in the x-ray report”
- Coding Clinic, 2nd Quarter 2013 allows the word “decompensated” to be synonymous with “acute on chronic” with regard to heart failure

Coding Clinic, 1st Quarter 2004 indicated that “ICD-9-CM assumes a relationship between diabetes and osteomyelitis when both conditions are present ...” Is this same relationship between diabetes and osteomyelitis true for ICD-10-CM?
- The response from 4th Quarter 2013 is “No, ICD-10-CM does not presume a linkage between diabetes and osteomyelitis. The provider will need to document a linkage or relationship ... Before it can be coded as such.”
The uncertainty regarding application of ICD-9-CM Coding Clinic advice within ICD-10-CM can potentially increase query volume as many previous practices and “assumptions” may no longer apply, resulting in denials.

The provider will need to clearly document to support code assignment per coding guidelines until Coding Clinic addresses all the confusing nuances within the ICD-10-CM/PCS code set.

Query Issue #1: Assigning ICD-10-CM Codes

The ICD-10-CM code set captures more specificity through use of up to seven characters, compared to only five available in ICD-9-CM.

The increased volume of combination codes, which require the provider to “link” diagnoses by documenting “with” or similar terminology, can negatively impact CC/MCC capture rates and/or case-mix index if the organization is unable to assign these combination codes.
General Coding Guidelines

“With”
• Interpreted to mean “associated with” or “due to”
• Many diagnoses in ICD-10-CM are combination codes, requiring the provider to document a cause and effect relationship, which is often represented through use of the word “with”
• It is important to note that the word “with” does not support a cause and effect relationship as required by complication codes
  – Cause and effect linking words are: due to, from, secondary to, etc.

Combination Codes

• A combination code is a single code used to classify:
  – Two diagnoses
  – A diagnosis with an associated secondary process (manifestation)
  – A diagnosis with an associated complication
• The prevalence of combination codes removes the responsibility for sequencing those included diagnoses from the coder/CDI
• Documentation must support use of the combination code as a relationship between two conditions is rarely assumed in ICD-10-CM
Combination Code Guidelines

• Assign only the combination code when that code fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs
• Multiple codes should **not** be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis
• When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as a secondary code

Combination Code Guidelines

• Investigations into organizational coding and query practices by the OIG reveal that **when an organization queries** is just as important as **how the query is constructed**
• Organizations need to be querying whenever the most accurate code is a combination code for the relationship between/among diagnoses, according to coding guidelines
• Efforts should be made to hold providers, who often fail to respond to these types of queries, accountable
Query Guidance: Combination Codes

• Linking diagnoses
  – Alcohol abuse w/anxiety disorder is F10.180 = CC
• The relationship between conditions cannot be assumed by proximity in the documentation or based upon one’s clinical knowledge/experiences
  – A list of diagnoses as follows does not allow assignment of F10.180 (no CC is captured)
    • Alcohol abuse
      – (F10.10 = alcohol abuse, uncomplicated)
    • Anxiety disorder
      – (F41.9 = anxiety disorder, NOS)

Query Guidance

The diagnoses of alcohol abuse and anxiety disorder are both listed as discharge diagnosis. Can you please clarify in an addendum to the discharge summary if a relationship exists between these diagnoses as follows ...

- There is no relationship between the alcohol abuse and the anxiety disorder
- The anxiety disorder is associated with the alcohol abuse
- Unable to determine
- Other ___________________________
Combination Code Queries

• Constructing a query asking for the relationship between two conditions can at best be “clunky” and confusing to the provider; however, a recent update by AHIMA to its query practice statement in conjunction with ACDIS (the Association of Clinical Documentation Improvement Specialists) has expanded and clarified the list of possible query formats
  – Open ended
  – Multiple choice
  – Yes/no format

2013 Query Guidance

• In addition to present on admission (POA) determinations, yes/no queries may be utilized under the following circumstances:
  – Substantiating or further specifying a diagnosis that is already present in the health record (i.e., findings in pathology, radiology, and other diagnostic reports) with interpretation by a physician
  – Establishing a cause and effect relationship between documented conditions such as manifestation/etiology, complications, and conditions/diagnostic findings (i.e., hypertension and congestive heart failure, diabetes mellitus and chronic kidney disease)
  – Resolving conflicting documentation from multiple practitioners
Yes/No Query Format

- Expanded in the 2013 practice brief
  - The “yes/no” query format should be constructed to include the additional options associated with multiple choice queries (i.e., “other,” “clinically undetermined,” and “not clinically significant and integral to”)
  - Yes/no queries may not be used in circumstances where only clinical indicators of a condition are present and the condition/diagnosis has yet to be documented in the health record
  - Also, new diagnoses cannot be derived from a yes/no query

Query Guidance

The diagnoses of alcohol abuse and anxiety disorder are both listed as discharge diagnosis. Can you please clarify below within the next 24 hours if there is a relationship between these two conditions?

- No
- Yes
- Unable to determine
- Other _______________________

MD signature: _______________ Date/time: ________
New to ICD-10-CM

- Due to the prevalence of combination codes in ICD-10-CM, there are now single codes that capture both the principal diagnosis and the complicating condition (CC) or major complicating condition (MCC)
- These are referred to as:
  - Principal diagnosis with its own CC
  - Principal diagnosis with its own MCC
- Therefore, a claim can have one code on it that represents the principal diagnosis as well as the CC or MCC; however, all these codes cannot be first listed based on coding guidelines

Pdx w/Own CC Example

ICD-9-CM
- Pdx 250.71 Type 1 diabetes w/peripheral circulatory disorders
- Secondary dx 785.4 gangrene adds a CC
- The combination of these two codes on the claim maps to DRG 300, Peripheral vascular disorders w/CC

ICD-10-CM
- Pdx E10.52 Type 1 diabetes w/diabetic peripheral angiopathy w/gangrene
- One code results in assignment to DRG 300, Peripheral vascular disorders w/CC
- But the documentation has to link the diagnoses for use of the combination code
Pdx w/Own MCC Example

**ICD-9-CM**
- Pdx 570 Acute hepatic failure
- Secondary dx 572.2 hepatic coma adds a MCC
- The combination of these two codes on the claim maps to DRG 441, Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis w/MCC

**ICD-10-CM**
- Pdx K72.01 Acute and subacute hepatic failure with coma
- **One code** results in assignment to DRG 441, Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis w/MCC
- But the documentation has to link the diagnoses for use of the combination code

Procedure Coding

- CDI staff traditionally review records for clinical indicators of incomplete, vague, or missing diagnoses
  - Few medical interventions require clarification even though medical interventions can impact MS-DRG assignment
    - Excisional vs. non-excisional debridement focus
    - Number of hours on mechanical ventilation
- The goal of most organizations is to enhance CC/MCC capture rate (reimbursement) w/CDI
  - Procedures don’t add a CC or MCC to the MS-DRG assignment
The mechanics of coding in ICD-10-CM are very similar to ICD-9-CM with some guideline changes within body systems.

ICD-10-PCS is a new coding system with its own set of guidelines:
- ICD-9-CM Volume III does not have coding guidelines unique to assigning procedure codes.
  - Understanding and correctly using root operations.
- Documentation requirements are different to assign a code under ICD-10-PCS compared to ICD-9-CM due to the code specificity.

### Procedure Code Structure

**ICD-9-CM Volume III**

4224

**ICD-10-PCS**

0DB58ZX
PTCA With One Site and One Stent

**ICD-9-CM Volume III:**

- **36.06** (Insertion nondrug eluting coronary stent)
- **00.66** (Angioplasty (PTCA))
- **00.45** (Insertion one vascular stent)
- **00.40** (Procedure on single vessel)
- **00.44** (Procedure on vessel bifurcation)

**PCS: 02703D6**

- 0 Med/surg (procedure)
- 2 Heart and great vessels (body sys)
- 7 Dilation (root op)
- 0 coronary artery, one site (body part)
- 3 percutaneous (approach)
- D intraluminal device (for bare metal stent)
- 6 Bifurcation

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**PCS Coding Guidelines**

- A set of rules developed to accompany and complement the official conventions and instructions provided within ICD-10-PCS
  - Section A – Conventions
  - Section B – Medical and Surgical
  - Section C – Obstetrics
  - Section D – Selection of Principal Procedure (**NEW**)
- The instructions and conventions of the classification take precedence over guidelines
- These guidelines are based on the coding and sequencing instructions in the tables, index, and definitions of ICD-10-PCS, but provide additional instruction
ICD-10-PCS

- It is likely that PCS will result in more codes than were needed with ICD-9-CM
- A “Whipple” (Pancreaticoduodenectomy) was one code in ICD-9-CM (52.7)
- PCS will require several codes: one to capture the root operation associated with each body part
  - Pancreas, stomach, duodenum, common bile duct, gallbladder, etc.)
- Procedure sequencing guidelines were recently released to assist with identifying the principal procedure

ICD-10-PCS Guidelines: Procedure Sequencing

- ICD-10-CM coding guidelines encourage querying the provider when the principal diagnosis cannot be clearly identified
- The same advice is likely to be issued regarding assignment of the principal procedure as the principal procedure will drive the DRG assignment
- Coders need to be mindful of PCS coding guidelines of how many codes to assign under what circumstances, as this can affect principal diagnosis assignment
ICD-10-PCS Guidelines

• The following are examples of two PCS guidelines that will contribute to the increased volume of procedure codes compared to ICD-9-CM

• The same root operation is performed on different body parts as defined by distinct values of the body part character

➢ Diagnostic excision of liver and pancreas are coded separately
  ✓ One code to capture the body part “liver”
  ✓ One code to capture the body part “pancreas”

ICD-10-PCS Guidelines

• If a diagnostic excision, extraction, or drainage procedure (biopsy) is followed by a more definitive procedure, such as destruction, excision, or resection at the same procedure site, both the biopsy and the more definitive treatment are coded

  – Two codes are required

  – *Example*: Biopsy of breast followed by partial mastectomy at the same procedure site; both the biopsy and the partial mastectomy procedure are coded

    • One code for the **biopsy** of the breast
    • One code for the **excision** of the breast
PCS Increased Specificity

• Very few unspecified codes available
• Every character of the PCS code **must be** selected from the available characters defined in the applicable PCS table
• Need to know: body system and body part, underlying objective of procedure, specific approach (i.e., technique), any device that remains behind
• Increased specificity of non-OR procedures (e.g., route and substance administered, contrast media, etc.)
  – Does your organization require operative notes on these types of “simple” procedures?
  – What if they are completed at the bedside? How are they documented?

ICD-10-PCS Queries

• Organizations will need to determine who will query regarding the assignment of PCS codes
  – If CDIS will query for PCS specificity, then they will require the same PCS training as coding to ensure they can accurately assign PCS codes and, consequently, identify documentation issues prior to coding so they can query appropriately
    • Are they adequately staffed?
    • Do they have the correct skill set for procedure coding?
      – Do you need to hire nurses with surgical backgrounds?
Impact of ICD-10-PCS ... The Big Unknown

- Organizations may soon realize their coding staff will need the assistance of the CDI department to support ICD-10-PCS coding as coders may not have the documentation needed to assign a PCS code.
- Surgeons are notorious for their lack of responding to queries due to their payment under a “global” fee that doesn’t require daily documentation, so it may be difficult to get clarification to assign PCS codes.
- CDIS may need to know how to code under PCS to anticipate documentation requirements concurrently as well as to be able to continue to assign working DRGs.

Coding Clinic 1st Quarter 2013

Question:
- In an anastomosis between the deep branch of the cephalic vein and radial artery for hemodialysis access, how does the coder know which direction the blood is flowing to properly assign the body part and qualifier?

Response:
- This describes a bypass from the left radial artery to the lower arm vein, open approach 031C0ZF. The 4th character is the body part bypassed from and the 7th character qualifier is the body part bypassed to. Blood generally flows from artery to vein. Coders need to know which direction blood is flowing.
ICD-10-PCS Coding Guideline

- It is the coder’s responsibility to determine what the documentation in the medical record equates to in the PCS definitions.
- The physician is not expected to use the terms used in PCS code descriptions, nor is the coder required to query the physician when the correlation between the documentation and the defined PCS terms is clear.
  - Example: When the physician documents “partial resection,” the coder can independently correlate “partial resection” to the root operation **excision** without querying the physician for clarification.

Documentation for PCS

- What will be the response rate for surgeons:
  - Who haven’t traditionally been part of the query process?
  - Whose reimbursement is not impacted by their daily progress notes?
  - Who bill using CPT codes rather than ICD-10-PCS codes?
  - Who could have performed surgery several days or weeks prior to discharge?
  - Who are not required per official coding guidelines to use PCS terminology?
Query Issue #2
Who Queries for What and When

- If the coding department currently issues and follows post-discharge and/or retrospective queries, will they be able to continue to do so as coder productivity is expected to decrease with ICD-10-CM/PCS implementation?
- What will be the impact of retrospective querying when it is initiated 40% later than currently occurs on metrics?
  - Bill hold times?
  - Cash on hand?
  - Provider response rate?

Why Query the Physician?

- There are many instances within the official coding guidelines that state the provider should be queried when the documentation is unclear
- The Office of Inspector General (OIG) has initiated investigations due to lack of querying when the documentation was unclear and led to potential overpayment
- To ensure an accurate and cohesive medical record reflecting hospital resource consumption in the care of the particular patient during an episode of care
“Managing an Effective Query Process”

- Outlines a process for queries and how they may be made in situations such as the following:
  - Clinical indicators of a diagnosis but no documentation of the condition
  - Clinical evidence for a higher degree of specificity or severity
  - A cause-and-effect relationship between two conditions or organism
  - An underlying cause when admitted with symptoms
  - Only the treatment is documented (without a diagnosis documented)
  - Present on admission (POA) indicator status

CDI Department Mission

- Organizations need to clearly define the role of CDI compared to that of coding.
  - There should be a complementary and collaborative effort between these departments
- CDI usually reviews a subset of the patient population, while coders review the entire patient population.
  - Inpatient, adult, non-obstetric Medicare patients
- Is the role of CDI revenue enhancement or coding specificity? These are two different objectives.
Who Queries for What and When

• Once the mission of CDI is established, a query policy needs to clarify which department queries under what circumstances if both departments issue queries
• There will be many more specific codes that don’t impact MS-DRG assignment and may or may not impact APR-DRG assignment ... if there is no impact on the DRG assignment either by clarifying the principal diagnosis or adding a CC or MCC, should CDI be issuing the query?

Query Dilemma

• Under what circumstances will a provider be queried at your organization?
  – If the acuity of a diagnosis does not change the DRG assignment or add a CC or MCC, should a query be placed? Even if required by coding guidelines?
    • If the query is only for additional specificity for accurate code assignment, should the query be placed by CDI or coding?
    • If the query response does not impact DRG assignment, how long will the query be allowed to remain open without a response?
  – Does your query policy cover how to prioritize queries and include an escalation process to resolve open queries?
Query Fatigue

- The issuing of too many queries can result in decreased effectiveness of the query process.
- The 2001 practice brief states:
  - “Every discrepancy or issue not addressed in the physician documentation should not necessarily result in the physician being queried.”
  - “Each facility needs to develop policies and procedures regarding the clinical conditions and documentation situations warranting a request for physician clarification.”
    - “For example, insignificant or irrelevant findings may not warrant querying the physician regarding the assignment of an additional diagnosis code.”
    - “Facilities need to balance the value of marginal data being collected against the administrative burden of obtaining the additional documentation.”

AHIMA Recommended Policies

- Organizations should outline the following procedures for written queries:
  - A protocol to identify where queries are placed in the medical record
  - A process for notifying the medical staff of the presence of a query in the medical record
  - A protocol to address open (concurrent) queries, including:
    - How frequently open queries will be addressed
    - How long queries are allowed to remain unanswered or open
    - How queries opened under concurrent review are addressed when the patient is discharged without a response
AHIMA Recommended Policies

- A protocol for query maintenance
- A QA process for written queries, including:
  - Who will monitor the written queries
  - How many queries will be reviewed for compliance and how often
  - The feedback and corrective action needed, including who will take corrective action and when
  - Reporting documents for CDI QA processes

AHIMA. "Guidance for Clinical Documentation Improvement Programs." Journal of AHIMA 81, No. 5 (May 2010): expanded Web version

Who Queries for What and When

- Be sure your query policy also addresses:
  - How does your organization address open concurrent queries on discharge?
    - Does CDI follow the query to closure?
    - Does coding or another department assume responsibility for the query upon discharge?
    - Does coding “re-issue” the query?
  - How will CDIs and/or coders prioritize their query efforts if the goal is code specificity?
    - Coders typically review a record upon discharge, but how often will CDI need to complete follow-up reviews to achieve this goal?
Who Queries for What and When

- How many queries can be placed on a record at one time?
  - Is the process different with an electronic record?
  - What is the provider threshold?
- How are simultaneous queries achieved?
  - Which query is first and which is last? How will providers respond to multiple, simultaneous queries?
- How long does a provider have to respond?
  - What occurs if the provider fails to respond, which is NOT the same as failing to agree?

Don’t Wait

- The time is now to review your current query practices to see if they can be sustained during and following the transition to ICD-10-CM/PCS
- What is the mission of CDI?
  - Revenue enhancement? Code specificity?
  - Do you have adequate staff? The right skill mix?
- What is the role of coding in regard to querying?
  - How will querying impact productivity in ICD-10-CM/PCS?
- Do you have a query policy? Does it meet industry standards?
Thank you. Questions?

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