ICD10monitor

July 10, 2017

Coding and Clinical Criteria: The Value of an Escalation Policy

By Linda Schwab-Messmer, RHIT, CCS, AHIMA-Approved ICD-10-CM/PCS Trainer, and Dotsy Baxter, RHIA, CCS, AHIMA-Approved ICD-10-CM/PCS Trainer

As coders, we often face dilemmas without benefit of clear guidance, creating the feeling of being pulled in different directions. In today's audit environment, coders need practical solutions to succeed in a setting of conflicting expectations. This article focuses on coding and clinical criteria dilemmas, and the value of having a facility policy for coding in these situations.

Codes should tell the story of a patient's encounter. Yet how do we make sure we're telling the true story – striking a balance between overstating and understating? In a recent training session, several polling questions were presented to illustrate various dilemmas, including the following:

Here is one example of a common scenario:

> Documentation includes a laboratory finding of serum sodium value of 120 mmol/L. Normal range is 135-145 mmol/L. The attending physician documents hypernatremia in the final diagnostic statement, but there is no mention of the word "hyponatremia" in the record. What should be done?

A. Code hypernatremia
B. Code hyponatremia
C. Send a query to the attending physician regarding hypernatremia
D. Code either hypernatremia or hyponatremia and report the case to designated person at your facility
E. Other_____

Most respondents chose C: send a query, including the lab values. For answer D, you would need an escalation process in place for reporting, and many organizations lack a strategy for doing so.

Here are three other dilemmas to consider:

- Diagnosis is stated only on a query response. Is the query part of the legal medical record? Clinical documentation improvement specialist (CDIS) or coder query? For some facilities, coder queries are a part of the legal medical record, but CDI queries are not. Policies vary by facility.
- Diagnosis is stated only in the ED record. Is there a facility policy for coding? Would this hold up under audit scrutiny? Is the decision left to coder discretion? Recommended policy: If documented only in the ED record and not mentioned again, then send a query. Without clear direction, CDI and coding may handle the situation differently from one case to another.
- Though CDI and coding are complementary, the boundaries are not entirely clear. The two professions often approach cases from different perspectives based on department priorities. Joint training would be beneficial to promote understanding of both perspectives and knowledge of coding rules.

Of all the numerous challenges involved with coding, one of the most common dilemmas occurs when clinical criteria do not appear to match a provider's documented diagnosis. When the provider documents a condition and there are weak or missing clinical indicators, this will likely raise a red flag to external auditors. Coders need an internal escalation process to provide proper guidance.

Evolution of Coding Responsibilities and Guidance

When it comes to establishing policy, historical perspective lends insight. Since the 1980s, we've gone through

multiple iterations of federal auditing bodies along with expectations to properly assign codes that impact reimbursement – and now, quality indicators. With that evolution came the need for coders to understand how to interpret and query regarding diagnoses and clinical indicators. Fast forward to 2017, and we're now reestablishing the boundaries to define coder responsibilities.

As ICD-10 matures, coding guidelines will continue to evolve accordingly. For example, three sentences were added to the ICD-10-CM guidelines in October 2016, formally alleviating the coder's burden of validating diagnoses against clinical criteria and questioning physicians' diagnostic statements:

> 2017 ICD-10-CM Guideline I.A.19—Code assignment and Clinical Criteria:
>
> The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

On the heels of that update, Page 147 of the Coding Clinic published during the fourth quarter of 2016 expanded the guidance to further explain implications. A question was posed asking if the new guideline means that CDISs should no longer query on diagnostic statements that don't meet clinical criteria. Coding Clinic's response included these points:

- Coding and clinical validation are separate functions. Clinical validation may be performed by a clinician, including RNs.
- Clinical definitions change rapidly, and applying them is subjective, based on an unknown baseline of the patient and changes to that baseline. Physicians use their knowledge of the patient and judgment to arrive at a diagnosis.
- The final statement points out that if the physician documents sepsis, the coder assigns a sepsis code, and later a reviewer disagrees with the physician's diagnosis because of lack of clinical criteria, that is a clinical issue, not a coding error.

The question applies to coding as well as CDI professionals. Though coding and clinical validation are separate functions, we all work for "the facility" and share responsibility to ensure that documentation is complete, accurate, and appropriately reflective of patient conditions. Coders are not directly responsible for validating the clinical criteria to support the provider's diagnostic statements, but they do need to have an avenue in which to forward concerns to the appropriate clinical staff when documentation does not seem to match the clinical picture.

Establishing an Escalation Policy

Coders and CDI professionals see documentation firsthand every day and are experts at identifying discrepancies, conflicting statements, and documentation that is not aligned with the patient's clinical picture. When repeated querying and provider education have not worked to improve the quality of your facility's documentation, a policy must be in place for front-line users of information to report their observations.

An escalation process may involve a physician advisor, chief medical officer, or other administrative personnel who can help address unanswered queries and unsatisfactory responses. Or, you may choose to create a multidisciplinary team, involving health information management (HIM), CDI, compliance, quality, auditors, legal staff, and physicians. Coders and CDI staff can forward cases to the designated person or team for guidance when clinical support for a documented diagnosis is questionable.

With the shift to value-based care, clinical guidance is necessary to mitigate risks as they pertain to audits, compliance, quality of care, and reimbursement. Expressing your concerns through a defined escalation process can make a difference in your facility's reimbursement and quality report cards in the long run. In doing so, you can play a pivotal role in preventing risk while ensuring compliance, proper payment, and accurate reflection of high-quality care.

Best Practices

Here are seven best practices to help ensure appropriate documentation supported by clinical indicators:

- Implement an effective escalation policy.
- Identify common and risky targets, looking for patterns of denials, U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) targets, Recovery Audit Contractor (RAC) scope of work, and audit tricks.
- Advance pre-bill efforts to identify and correct problems.
- Create or expand a CDI program to ensure concurrent intervention.

- Establish a well-defined query process.
- Solicit feedback from providers, CDISs, and coders.
- Offer provider education, keeping in mind the importance of quality data:
  - Response to queries, part of legal medical record
  - Awareness of clinical validation billing denials
  - Documentation: complete, accurate, timely

Resources

The American Health Information Management Association (AHIMA) provides a variety of resources to help design, develop, and support the process of ensuring quality documentation for patient care, coded data quality, and reimbursement.

AHIMA Toolkits are available online here: https://my.ahima.org/search/toolkits

- Clinical Documentation Improvement (CDI) Toolkit
- Government Audit
- Query

AHIMA Standards of Ethical Coding:

http://www.ahima.org/about/aboutahima?tabid=ethics

An addendum* to the “Guidelines for Achieving a Compliant Query Practice” (February 2013) with helpful examples of escalation policies:

http://journal.ahima.org/2013/05/01/guidance-on-a-compliant-query-internal-escalation-policy/

*Updated in 2016, available to AHIMA members only: http://bok.ahima.org/PB/QueryCompliance#.WVWA-YTythE

Linda Schwab-Messmer, RHIT, CCS, AHIMA-Approved ICD-10-CM/PCS Trainer, and Dotsy Baxter, RHIA, CCS, AHIMA-Approved ICD-10-CM/PCS Trainer

Linda Schwab-Messmer is the senior coding consultant at Haugen Consulting Group. Linda is a well-known expert on ICD-10-CM and CPT® coding, MS-DRG, APR-DRG and APC methodologies, and hospital reimbursement systems. She is an AHIMA-approved ICD-10-CM and ICD-10-PCS trainer, and is currently an active member of AHIMA, AHIMA ACE Volunteers, the Colorado Health Information Management Association (CHIMA), and the Northern Colorado Health Information Management Association (NCHIMA). Linda is the recipient of various awards from CHIMA and NCHIMA, including the CHIMA Professional Lifetime Achievement Award received in May 2016.

Dotsy Baxter is a senior consultant at Haugen Consulting Group. With more than 30 years of health information management leadership experience, she is also a skilled coder and educator. Dotsy has held leadership and coding positions in various healthcare settings including acute care, long-term care, public health, and her local community college. An AHIMA-approved ICD-10-CM and ICD-10-PCS trainer and active member of AHIMA, she has served in leadership roles with AHIMA, the Colorado Health Information Management (CHIMA), and the Southern Colorado Health Information Management Association (SCHIMA).
editor@icd10monitor.com