



ICD-10 for Ophthalmology

UConn Health



Just himagine what we can accomplish together.

Introduction

Dr. Frank Turner

ICD-10 Implementation Physician Advisor

Agenda

- After attending this session, participants will be able to:
 - Describe the challenges associated with ICD-10 implementation
 - Identify documentation standards necessary for complete and accurate code assignment
 - Identify the importance of physician documentation and coding
 - Discuss the importance behind the query writing process and Physician response.

ICD-10 Resources: USA.GOV

ICD-10 Resources: CMS.GOV

<http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html>



- **About ICD-10**
- The transition to ICD-10 is required for everyone covered by the [Health Insurance Portability Accountability Act \(HIPAA\)](#). Please note, the change to ICD-10 does not affect CPT coding for outpatient procedures and physician services.
- **Road to 10: CMS Online Tool for Small Practices**
- **Jumpstart your ICD-10 transition with [Road to 10](#), an online resource built with input from providers in small practices.**
- **“Road to 10” includes specialty references and helps providers build ICD-10 action plans tailored for their practice needs.**
- **CMS Resources**
- Check out the updated [CMS ICD-10 Resources Flyer](#).
- Access three new **Medscape Education resources** that **provide guidance around the transition to ICD-10**. Continuing medical education (CME) and nursing continuing education (CE) credits are available to health care professionals who complete the learning modules. Anyone can earn a certificate of completion. If you are a first-time visitor to Medscape, you will need to create a free account to access these resources.
 - Video: [ICD-10: Getting From Here to There -- Navigating the Road Ahead](#)
 - Video: [ICD-10 and Clinical Documentation](#)
 - Expert Column: [Preparing for ICD-10: Now Is the Time](#)
- View the [ICD-10 Introduction](#) fact sheet.
- Find official resources designed to help [providers](#), [payers](#), [vendors](#), and [non-covered entities](#) with the transition to ICD-10.



Important ICD-10 Updates

- **Senator Bill Cassidy** recommended that ICD-10 penalty be delayed for two years. This essentially means that CMS will continue accepting, processing and paying claims filed in ICD-9 even post **October 1 for the next 2 years.**
- Citing estimates provided by CMS about the disruption to cash flows brought about by ICD-10, **200 % spike in denial rates and doubling of days in account receivables,** Senator Cassidy pointed out the woes of small practices who are already having a hard time deploying EHR technology and coping with recent healthcare regulations.
- **“Smaller providers are already struggling with EHRs** and will soon face those payment disruptions, not because they’re doing it wrong but because the system has changed” expressed Cassidy while encouraging HHS to show some flexibility.
- **Secretary HHS Sylvia Burwell** , **countered by saying that many large payers and providers are ready and waiting for ICD-10** and that HHS is working to provide technical assistance and training to those organizations that are not at this point prepared.
- The debate is not over yet.

Road to ICD-10

- ICD (International Classification of Diseases) System created by WHO in 1893 as worldwide standard for classifying deaths.
- Implemented worldwide with modifications by country to fit their needs.
- ICD-9 in use in the United States since 1979. ICD-10 published in 1992.
- Most recent country to implement ICD-10, Canada from 2001-2005.
- Difference in U.S., ICD used for multiple purposes besides classification.



Final Rule Issued

- ▶ On **July 31st, 2014**, The U.S. Department of Health and Human Services (HHS) issued a rule finalizing **October 1, 2015** as the new compliance date





Uses of Enhanced Specificity of ICD-10

- Data will be collected over the next **2 years** – as well as **2 years** following implementation to feed initiatives impacting:
 - Measurement of patient care outcomes
 - Quality of care initiatives
 - Healthcare policy development
 - **Research related to profiling providers of healthcare *******
 - **Pay for performance initiatives**
 - **Justification of medical necessity**



Consequences of Inadequate Documentation

Inappropriate
Payment for
Submitted
Claims

Claim Denials

Increased Risk
of Government
Audit,
Repayment
and Fines

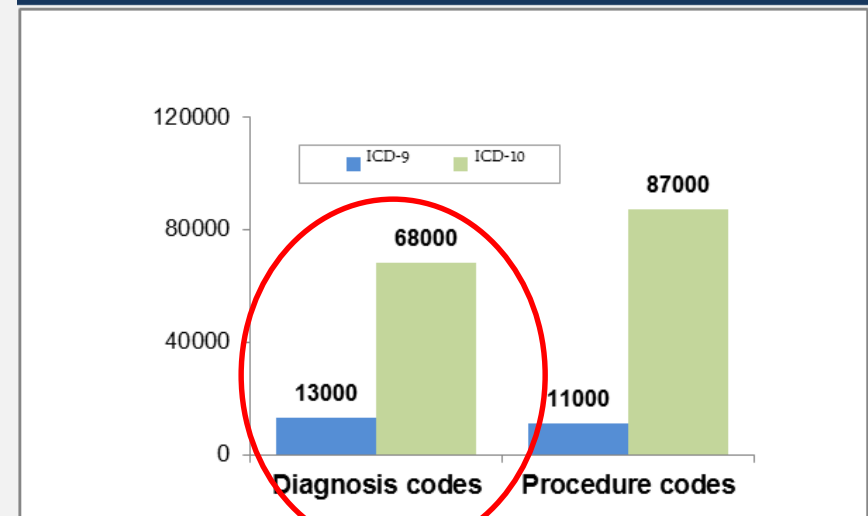
Changes to Diagnosis Codes

The most significant difference between ICD 9 and ICD 10 is the size and composition of the new codes

- ICD 9 is five digits where ICD 10 is 7 alphanumeric characters
- Re-structured classification
- Specificity and detail have been expanded

ICD 10 better describes acuity, complexity and laterality of the patients under your care

Number of ICD 9 and ICD 10 codes for diagnoses and procedures



(Source: ICD-10-CM and ICD-10-PCS Update, Thirteenth National HIPAA Summit, 9/26/2006; Rand Study, March 2004)



The ICD-10 and CPT Connection

- CPT codes **do not** change!
- ICD-10 diagnoses correlate with CPT procedures
- Potential reimbursement implications



Considerations

- **ICD-10 requires collaboration, collaboration and more collaboration between all members of the clinical and non-clinical healthcare team:**
 - Education of CDI/coder staff
 - Template revisions
 - Query revisions





Structure of ICD-10 codes



Category

Analogous to Problem List diagnoses, some with more specificity regarding etiology:

“Stroke”
Cerebral infarction = I63

“Head Injury”
Intracranial injury = S06

•

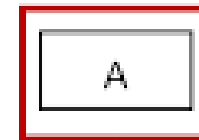


Etiology, Anatomic Site, Severity,
other vital clinical details

Adds detail as clinical picture becomes clearer.

Cerebral infarction due to embolism of right middle cerebral artery = I63.411

Diffuse traumatic brain injury with loss of consciousness for greater than 24 hours without return to pre-existing level with patient surviving = S06.2X6



Extension

For Injuries and Fractures:
- Initial, Subsequent, Sequela
- Open, Closed, Nonunion, etc. for fractures
- Only other use is in OB

Initial encounter = S06.2X6A

Also must describe how injury occurred.

Documentation for Diagnoses

Requirements for Detailed Documentation for Diagnoses

Acuity	Acute, chronic or both
Specific site	Aqueous humor, Outer ear canal
Laterality	Right, left, bilateral
Specific type of condition	Acute rhinosinusitis, Adenoid hypertrophy, Keratoconjunctivitis sicca
Etiology of diagnosis	Ear pain due to middle ear infection, Sleep apnea due to adenoiditis, Stromal keratitis due to Type 1 Herpes simplex
Link must be established between manifestations and underlying diseases	Glaucoma due to Hypertension,
Complications of care	Intraoperative, postoperative, mechanical malfunctions, infections
Degree of severity	Mild, moderate, severe

Documentation for Diagnoses

Requirements for Detailed Documentation for Diagnoses

Injury details	Place of occurrence, activity causing the injury
Episode of care	Initial treatment, subsequent treatment (for routine or delayed healing), sequela
Drug reactions/interactions/adverse reactions	Poisoning (accidental/intentional/assault/undetermined), adverse effect, underdosing (due to financial hardship, age-related)

Diagnosis Documentation Examples





Diseases of the Eye and Adnexa (H00-H59)

- **ICD-10 Chapter 7 (H00-H59) deals specifically with Disease of the Eye and Adnexa.** Anatomy knowledge will become more and more important. The eye has several structure and parts from the lens (H25-H28) to conjunctiva (H10-H11) to the cornea (H15-H22), etc.
- **Codes have been expanded to increase anatomic specificity and add the concept of laterality.**
- **Concept of laterality**
 - Right
 - Left
 - Bilateral
 - Unspecified
- **The term “senile” is not used in ICD-10 to describe a cataract. “Age-related” instead of senile cataract.**

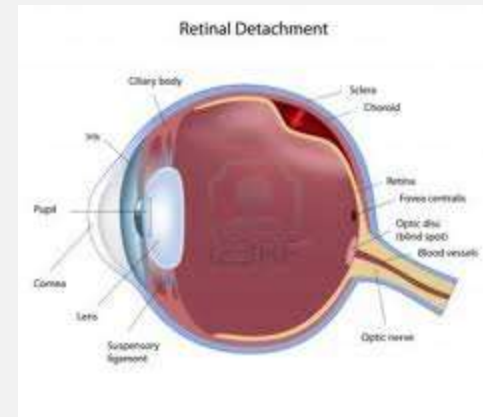
If bilateral is not available, assign code for right and left



Clinical Example: Documentation Improvement

Retinal Detachments

- Retinal detachments are described as **“Retinal detachments**
- **and breaks”** with further subdivisions for:
 - Unspecified
 - Single break
 - Multiple breaks
 - Giant retinal tear
 - Retinal dialysis
 - Total detachment
 - Retinal **breaks** without detachment
- **No code for included for “unspecified” retinal detachment**





Clinical Example: Documentation Improvement

Inflammation of eyelids

- Laterality not included in ICD9
- Upper/lower eyelid not specified in ICD-9-CM

ICD 10

– Laterality included

- Right
- Left
- Unspecified
- Bilateral



Further specified as
upper and lower eyelid

- **Over 5,000 diagnoses have a right and left distinction !**

ICD-9 Open-angle glaucoma, unspecified

- 2015 ICD-9-CM Diagnosis Code **365.10**
- ICD-9-CM 365.10 is a billable medical code that can be used to specify a diagnosis on a reimbursement claim.

ICD-9 Open-angle glaucoma, unspecified converts to H40.10X0 or:

- Convert to ICD-10-CM: 365.10 converts approximately to:2015 ICD-10-CM H40.10X0 Unspecified open-angle glaucoma, stage unspecified or:
- 2015 ICD-10-CM H40.10X1 Unspecified open-angle glaucoma, mild stage or:
- 2015 ICD-10-CM H40.10X2 Unspecified open-angle glaucoma, moderate stage or:
- 2015 ICD-10-CM H40.10X3 Unspecified open-angle glaucoma, severe stage or:
- 2015 ICD-10-CM H40.10X4 Unspecified open-angle glaucoma, indeterminate stage



ICD-10 H40.10X0 Unspecified open-angle glaucoma, stage unspecified

- Convert to ICD-10-CM: 365.10 converts approximately to:2015 ICD-10-CM H40.10X0 Unspecified open-angle glaucoma, stage unspecified
- Documentation Improvement
- Stages, Specific anatomical site, Laterality, Specific type of condition, Etiology of diagnosis, Link must be established between manifestations and underlying diseases, Degree of severity.

ICD-9 Senile nuclear sclerosis

- 2015 ICD-9-CM Diagnosis Code **366.16**
- ICD-9-CM 366.16 is a billable medical code that can be used to specify a diagnosis on a reimbursement claim.



ICD-9 Senile nuclear sclerosis converts approximately to: 2015 ICD-10-CM H25.10

- ICD-9-CM 366.16 converts approximately to:
- 2015 ICD-10-CM H25.10 Age-related nuclear cataract, unspecified eye.
- H25.10 is a billable ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.



ICD-10-CM H25.10 Age-related nuclear cataract, unspecified eye

- Documentation Improvement
- Acuity, Laterality, Specific type of condition, Etiology of diagnosis, Link must be established between manifestations and underlying diseases, Degree of severity.

ICD-9 Myopia

- 2015 ICD-9-CM Diagnosis Code **367.1**
- ICD-9-CM 367.1 is a billable medical code that can be used to specify a diagnosis on a reimbursement claim.



ICD-9 Myopia ICD-9-CM 367.1 converts approximately to: 2015 ICD-10-CM H52.13 Myopia, bilateral

- ICD-9-CM 367.1 converts approximately to:
- 2015 ICD-10-CM H52.13 Myopia, bilateral
- H52.13 is a billable ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.

ICD-10 ICD-10-CM H52.13 Myopia, bilateral

- ICD-10 ICD-10-CM H52.13 Myopia, bilateral
- **Documentation Improvement**
- Acuity, Laterality, Specific type of condition, Etiology of diagnosis, Link must be established between manifestations and underlying diseases, Degree of severity.

ICD-9 Exudative senile macular degeneration

- 2015 ICD-9-CM Diagnosis Code **362.52**
- ICD-9-CM 362.52 is a billable medical code that can be used to specify a diagnosis on a reimbursement claim.



ICD-9 Exudative senile macular degeneration ICD-9-CM 362.52 converts directly to:2015 ICD-10-CM H35.32 Exudative age-related macular degeneration

- ICD-10-CM H35.32 Exudative age-related macular degeneration
- H35.32 is a billable ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.

ICD-10-CM H35.32 Exudative age-related macular degeneration

- Documentation Improvement
- Acuity, Laterality, Specific type of condition, Etiology of diagnosis, Link must be established between manifestations and underlying diseases, Degree of severity.



ICD-10-CM Coding Guidelines

- **Chapter 7: Diseases of the Eye and Adnexa (H00-H59)**

- a. General Rules for Eye Cases**

- 1) Codes from chapter 7 and sequencing priority**

- Assigning as many codes from category H40, Glaucoma, as needed to identify the type of glaucoma, the affected eye, and the glaucoma stage

- 2) Bilateral glaucoma codes with same type and stage**

- When a patient has bilateral glaucoma and both eyes are documented as being the same type and stage, and there is a code for bilateral glaucoma, report only the code for the type of glaucoma, bilateral with the seventh character for the stage.
 - When a patient has bilateral glaucoma and both eyes are documented as being the same type and stage, and the classification does not provide a code for bilateral glaucoma (i.e. subcategories H40.10, H40.11 and H40.20) report only one code for the type of glaucoma with the appropriate seventh character for the stage.





Coding Book Changes for Eye

ICD-10 Code
Book Changes

Important

Diseases of the Eye

- Terms like "better eye" and "lesser eye" are removed, and replaced simply by descriptive like blindness one eye, low vision other eye with further breakdown of right eye, left eye, both eyes, or unspecified.
- **ICD-10-CM** introduces conditions not mentioned in ICD-9-CM such as day blindness, glare sensitivity, and impaired contrast sensitivity.
- Intraoperative and post procedural complications of the eye and adnexa are now covered within H59 instead of in the Complications of Surgical and Medical Care, NEC chapter, as in ICD-9-CM.



Glaucoma

ICD-9-CM

Stage of glaucoma is a separate code

No laterality included

Corticosteroid induced glaucoma

Congenital glaucoma classified in this chapter

ICD-10-CM

Stage of glaucoma is included in combination code

Laterality incorporated into the classification of this condition

Drug-induced glaucoma

Congenital glaucoma classified to Q15.0 in Chapter 17 – Congenital Malformations, Deformations and Chromosomal abnormalities

Example of Glaucoma

This is a 56-year-old female patient with primary open-angle glaucoma and age-related bilateral macular degeneration.

What diagnosis requires query? Why?

- Stage of Glaucoma is needed in order to select the most specific diagnosis code.
- Stage unspecified is available but only to be used if the provider is uncertain of the stage or is waiting further diagnostic results. Query should be made to provider for complete documentation purposes.

Retinal Detachment

ICD-10 CM

- Retinal Detachment is classified in ICD-10 as Retinal Detachments and breaks.
- In ICD-9: it is classified as Retinal Detachments and defects
- ICD-10: further breaks down retinal breaks as single, multiple and unspecified number of breaks. Education will need to be provided to Physicians so that these details are included in documentation for proper code selection.
- Giant and total tears of the retina as well as retinal dialysis are also specified in ICD-10.
- Laterality or bilateral is available for all retinal detachment codes

ICD-10 CM

- In ICD-10, the following codes include retinal detachment:
 - Code H33.0-Retinal detachment with retinal break
 - Code H33.01 - Retinal detachment with single break
 - Code H33.02 - Retinal detachment with multiple breaks
 - Code H33.03 - Retinal detachment with giant retinal tear
 - Code H33.04 - Retinal detachment with retinal dialysis
 - Code H33.05 - Total retinal detachment

NOTE: each of these categories are further classified to laterality

Example of Postprocedural or Intraoperative Complication

ICD-9 CM

- **Complications affecting other body system (997.99)**

ICD-10 CM

- **Disorders of the eye following cataract surgery**
 - **Keratopathy**
 - **Cataract fragments**
 - **Cystoid macular edema**
 - **Other disorders of eye**
- **Intraoperative hemorrhage/hematoma of eye**
 - **During ophthalmic procedure**
 - **During other procedure**
- **Accidental puncture or laceration**
 - **During ophthalmic procedure**
 - **During other procedure**

Visual Disturbance and Blindness

ICD-9 CM	ICD-10 CM
Laterality not included in the classification	Laterality included in classification
No classification for day blindness	Day blindness classified in category H53.11
No classification for Glare sensitivity or impaired contrast sensitivity	Glare sensitivity and impaired contrast sensitivity classified to H53.7X
Blindness classified to profound and moderate/severe as well as both or one eye	Blindness classified: blindness one eye, low vision other eye and laterality of the blindness vs. low vision; low vision and unqualified visual loss (with laterality)

Visual Disturbance

ICD-10 CM

- **Terms like "better eye" and "lesser eye" are removed in ICD-10, and replaced simply by descriptive like blindness one eye, low vision other eye with further breakdown of right eye, left eye, both eyes, or unspecified.**
- **ICD-10-CM introduces conditions not mentioned in ICD-9-CM such as day blindness, glare sensitivity, and impaired contrast sensitivity**
- **Education will need to be given to providers so proper code selection can occur.**



Clinical Example: Documentation Improvement

Underdosing – new concept in ICD-10

- Taking less of a medication than prescribed by physician or manufacturer's instruction
 - Noncompliance
 - Complication of care

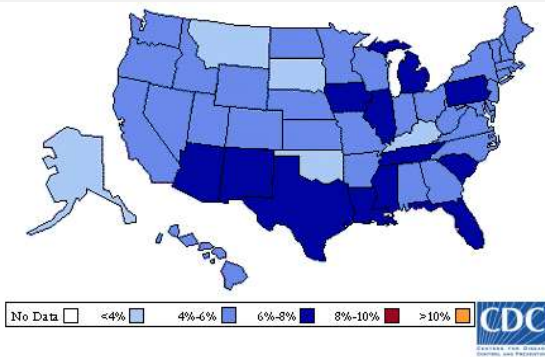


Underdosing – Documentation Needed:

- If a patient is purposely stopping or altering their medication regimen this needs to be documented to provided accurate coding



Diabetes Mellitus



- **New in ICD-10-CM**
- The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system.
- When documenting diabetes, include the following:
 - **Type:** e.g. Type 1 or Type 2 disease, drug or chemical induced, due to underlying condition, gestational
 - **Control:** out of control, inadequately controlled and controlled are no longer used in ICD-10-CM
 - **Complications:** What (if any) other body systems are affected by the diabetes condition? e.g. Foot ulcer related to diabetes mellitus
 - **Treatment:** Is the patient on insulin?

Hypertension ICD-9

- 401 Essential hypertension
 - 401.0 Malignant
 - 401.1 Benign
 - 401.9 Unspecified

Hypertension ICD-10

- **I10 Essential (primary) hypertension**
 - Includes high blood pressure, hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)
 - Excludes hypertension complicating pregnancy and associated with end organ disease

Hypertension

- There is only one code for hypertension without manifestations (benign, malignant, essential, etc...) in ICD-10.
 - The code is I10
- Documentation is required for any relationship between hypertension and other diseases.
 - Hypertensive heart disease- I11
 - Hypertensive chronic kidney disease- I12

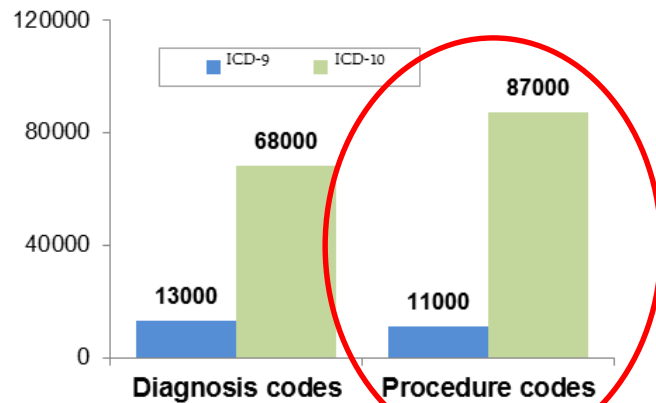
Procedure Documentation Examples





Changes to procedure codes

Number of ICD 9 and ICD 10 codes for diagnoses and procedures



(Source: ICD-10-CM and ICD-10-PCS Update, Thirteenth National HIPAA Summit, 9/26/2006; Rand Study, March 2004)

ICD 10 procedure codes will require additional and significant detail in surgical reporting

- Key ICD 10 characteristics
 - ICD 10 is a “dramatic departure” from current practice
 - Surgical codes lack decimals
 - The new code set will allow for incorporation of new procedures and technologies
 - Terminology is precisely defined and used consistently across all codes

Overview of ICD-10-PCS

- PCS stands for **Procedure Classification System**
- It is a multi-axial system with a 7 character alphanumeric code classification providing a **unique code** for all substantially different procedures and with **easy_expandability**, incorporating new procedures, technologies and devices utilized in medical/surgical procedures
- The classification for the general surgery procedures has undergone significant revision focusing primarily on section, body system, root operation, body part, approach, device and qualifier

Incision and Drainage

- Procedures require documentation of:
 - Specific anatomical area
 - Approach
 - Instrument used
 - Microscope
 - Open
 - Percutaneous
 - Percutaneous endoscopic
 - External
 - Type of device
 - Infusion
 - intraluminal



ICD-10-PCS Drainage

Patient presents for aspiration of right iris

ICD-10-PCS

089C30Z

- Drainage of Right Iris with Drainage Device, Percutaneous Approach



ICD-10-PCS Table

Section	0 Medical and Surgical		
Body System	8 Eye		
Operation	9 Drainage: Taking or letting out fluids and/or gases from a body part		
Body Part	Approach	Device	Qualifier
0 Eye, Right 1 Eye, Left 6 Sclera, Right 7 Sclera, Left 8 Cornea, Right 9 Cornea, Left S Conjunctiva, Right T Conjunctiva, Left	X External	0 Drainage Device	Z No Qualifier
0 Eye, Right 1 Eye, Left 6 Sclera, Right 7 Sclera, Left 8 Cornea, Right 9 Cornea, Left S Conjunctiva, Right T Conjunctiva, Left	X External	Z No Device	X Diagnostic Z No Qualifier
2 Anterior Chamber, Right 3 Anterior Chamber, Left 4 Vitreous, Right 5 Vitreous, Left C Iris, Right D Iris, Left E Retina, Right F Retina, Left G Retinal Vessel, Right H Retinal Vessel, Left J Lens, Right K Lens, Left	3 Percutaneous	0 Drainage Device	Z No Qualifier

ICD-10-PCS Drainage

1 st	2 nd	3 rd	4 th	5 th	6 th	7 th
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
0	8	9	C	3	0	Z

The ICD-10-PCS code structure tells a story

ICD-10-PCS Release cornea

Patient presents for Release of right Cornea

ICD-10-PCS

08N8XZZ

- Release Right Cornea, External Approach



ICD-10-PCS Table

Medical and Surgical			
Body System 8 Eye			
Operation N Release: Freeing a body part from an abnormal physical constraint by cutting or by the use of force			
Body Part	Approach	Device	Qualifier
0 Eye, Right 1 Eye, Left 6 Sclera, Right 7 Sclera, Left 8 Cornea, Right 9 Cornea, Left S Conjunctiva, Right T Conjunctiva, Left	X External	Z No Device	Z No Qualifier
2 Anterior Chamber, Right 3 Anterior Chamber, Left 4 Vitreous, Right 5 Vitreous, Left C Iris, Right D Iris, Left E Retina, Right F Retina, Left G Retinal Vessel, Right H Retinal Vessel, Left J Lens, Right K Lens, Left	3 Percutaneous	Z No Device	Z No Qualifier
A Choroid, Right B Choroid, Left L Extraocular Muscle, Right M Extraocular Muscle, Left V Lacrimal Gland, Right W Lacrimal Gland, Left	0 Open 3 Percutaneous	Z No Device	Z No Qualifier
N Upper Eyelid, Right P Upper Eyelid, Left Q Lower Eyelid, Right R Lower Eyelid, Left	0 Open 3 Percutaneous X External	Z No Device	Z No Qualifier
X Lacrimal Duct, Right Y Lacrimal Duct, Left	0 Open 3 Percutaneous 7 Via Natural or Artificial Opening 8 Via Natural or Artificial Opening Endoscopic	Z No Device	Z No Qualifier

ICD-10-PCS Release cornea

1 st	2 nd	3 rd	4 th	5 th	6 th	7 th
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
0	8	N	8	X	Z	Z

The ICD-10-PCS code structure tells a story

ICD-10-PCS Eye exam

Patient presents for examination of eye under

Anesthesia

ICD-10-PCS

08JLXZZ

- Inspection of Right Extraocular Muscle, External Approach

ICD-10-PCS Table

Section 0 Medical and Surgical Body System 8 Eye Operation J Inspection: Visually and/or manually exploring a body part			
Body Part	Approach	Device	Qualifier
0 Eye, Right 1 Eye, Left J Lens, Right K Lens, Left	X External	Z No Device	Z No Qualifier
L Extraocular Muscle, Right M Extraocular Muscle, Left	0 Open X External	Z No Device	Z No Qualifier

ICD-10-PCS Eye exam

1 st	2 nd	3 rd	4 th	5 th	6 th	7 th
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
0	8	J	L	X	Z	Z

The ICD-10-PCS code structure tells a story

Physician Queries



Query...why?

A query is a communication tool used to clarify documentation in the health record for accurate code assignment.



The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment.

Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

Query...when?

A query is written when the Health record Documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
 - Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
 - Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
 - Provides a diagnosis without underlying clinical validation
 - Is unclear for present on admission indicator assignment
- “A proper query process ensures that appropriate documentation appears in the health record”**

Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

Query...when?

“A proper query process ensures that appropriate documentation appears in the health record”



Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

Query... answer how?

Queries are generated to elicit more information from the Provider.

- A response is ***necessary*** from the provider to fulfill this process.



- ***A. signature alone on a generated query does not fulfill this requirement***

Query... answer how?

Queries are generated in various formats depending on the information being requested:

- *Written response* format
 - Requesting provider to freehand a response
- *Multiple Choice* format
 - Requesting provider select one of the offered responses



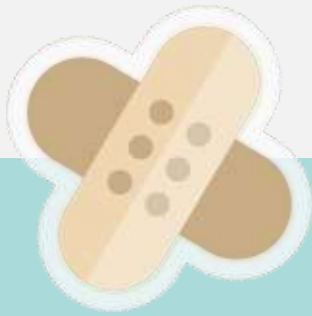
Please sign, date and time Queries!

Query... answer how?

A Physician response, 'see notes' does not fulfill the request generated by the query.

- The coder has already reviewed the notes and Medical Record Documentation
- ***Although the response may seem 'obvious' coders are only 'reporters' of the medical record and *cannot code a diagnosis* that is *not documented by the Provider.****





Questions?

