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ICD-10 for Rheumatology

UConn Health

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Introduction

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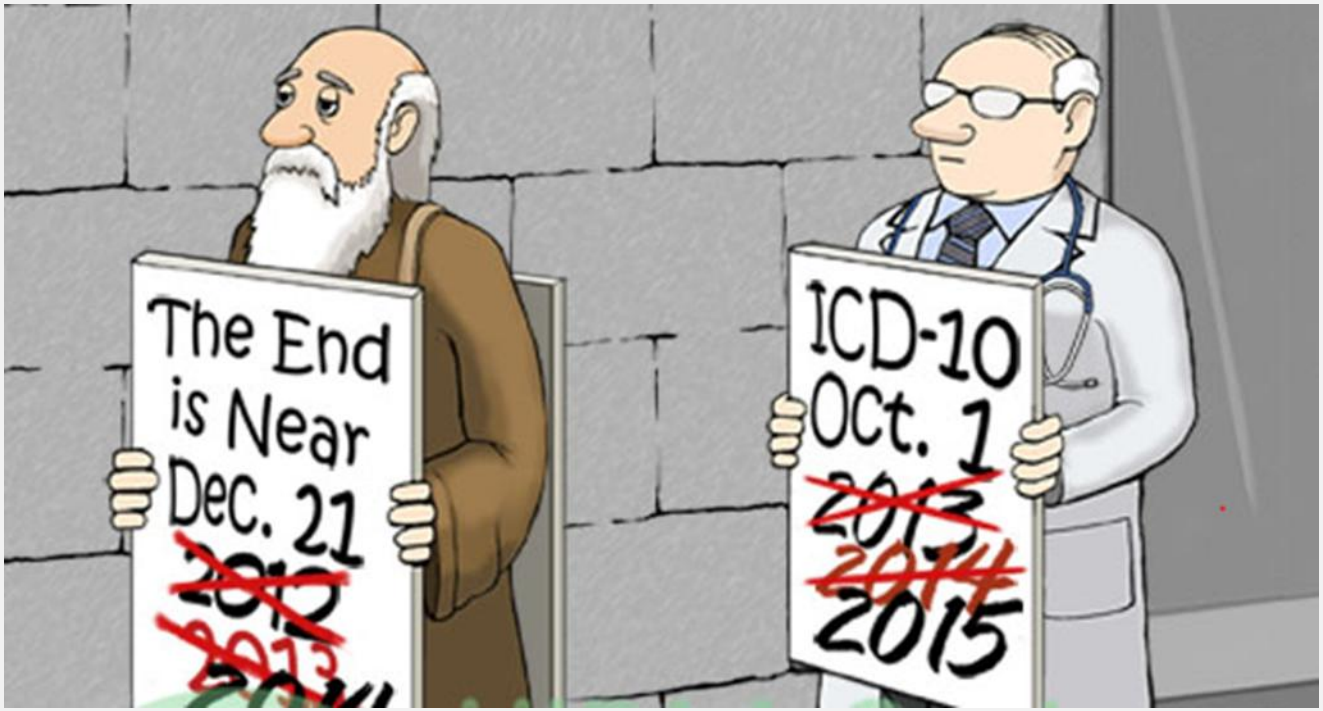
Agenda

- Describe the challenges associated with ICD-10 implementation
- Identify the importance of physician documentation and coding
- Review examples of the impact of the changes in ICD-10

Final Rule Issued

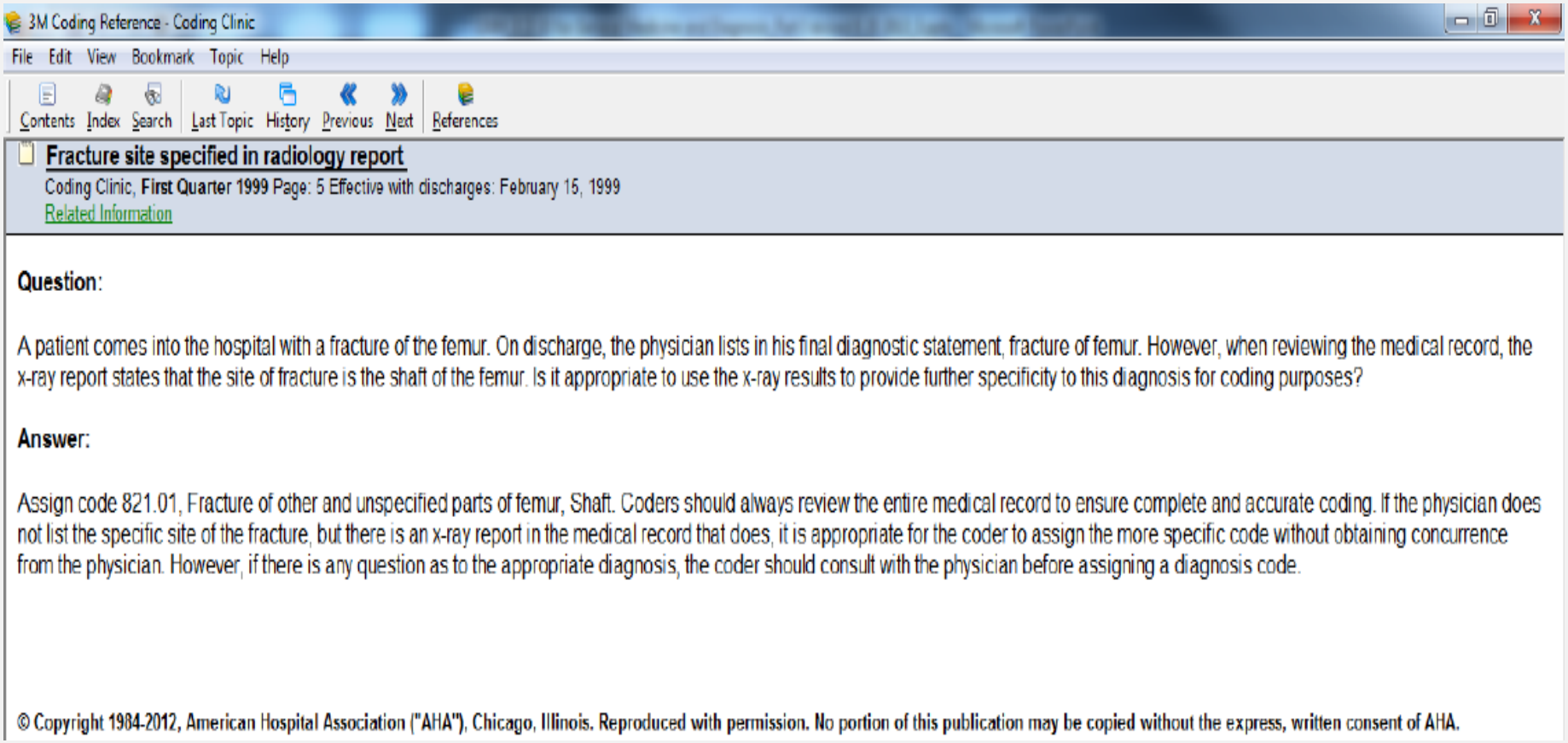
- On July 31st, 2014, The U.S. Department of Health and Human Services (HHS) issued a rule finalizing October 1, 2015 as the new compliance date



Challenges

- ICD-10 is a classification system, not a clinical language system:
  - Physician documentation - primarily directed for communication between clinicians
  - Bridging gaps between coder classification language and physician clinical documentation

Challenges: Coding Specificity



3M Coding Reference - Coding Clinic

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Fracture site specified in radiology report

Coding Clinic, **First Quarter 1999** Page: 5 Effective with discharges: February 15, 1999

Related Information

Question:

A patient comes into the hospital with a fracture of the femur. On discharge, the physician lists in his final diagnostic statement, fracture of femur. However, when reviewing the medical record, the x-ray report states that the site of fracture is the shaft of the femur. Is it appropriate to use the x-ray results to provide further specificity to this diagnosis for coding purposes?

Answer:

Assign code 821.01, Fracture of other and unspecified parts of femur, Shaft. Coders should always review the entire medical record to ensure complete and accurate coding. If the physician does not list the specific site of the fracture, but there is an x-ray report in the medical record that does, it is appropriate for the coder to assign the more specific code without obtaining concurrence from the physician. However, if there is any question as to the appropriate diagnosis, the coder should consult with the physician before assigning a diagnosis code.

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

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

The ICD-10 and CPT Connection

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

Differences in ICD-9 and ICD-10

- ICD 9 is five digits where ICD 10 is 7 alphanumeric characters
- ICD 10 better describes acuity, complexity and laterality of the medical conditions
- ICD-10-CM- Diagnoses
- ICD-10-PCS- Procedures (**Hospital only**)

It's Not As Bad As It Seems

- Almost 40,000 codes apply to Injury, Poisoning, and External Causes
- Over 6,300 codes apply to Musculoskeletal System and Connective Tissue
- 336 codes related to the Respiratory System

❖ **Remember**: Many of the new codes are based on laterality (over 5000 codes)and location

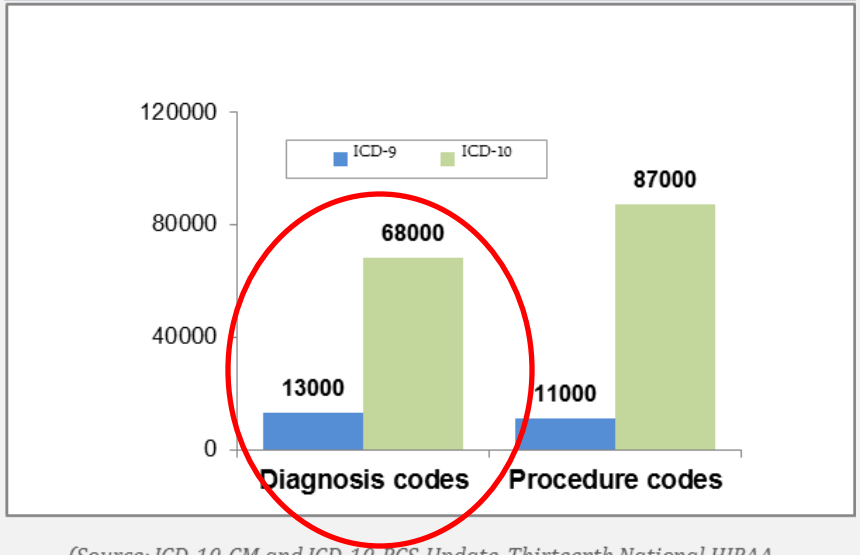
Changes to Diagnosis Codes

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)

Documentation for Diagnosis

Requirements for Detailed Documentation for Diagnoses	
Acuity	Acute, chronic or both
Specific site	Femur trochanteric – apophyseal, greater trochanter, intertrochanteric, lesser trochanter
Laterality	Right, left, bilateral
Specific type of fractures	Displaced/non-displaced fractures, transverse, oblique, spiral, comminuted, segmental
Etiology of diagnosis	Fracture/dislocation due to – pathological, recurrent, fatigue, age-related, osteoporosis
Link must be established between manifestations and underlying diseases	Osteomalacia – puerperal, senile, due to malabsorption or malnutrition, aluminum bone disease, drug induced
Non-pressure skin ulcers	Site, laterality and depth of tissue involvement

Documentation for Diagnosis (cont.)

Requirements for Detailed Documentation for Diagnoses	
Complications of care	Intraoperative, postoperative, mechanical malfunctions, Infections (device vs. wound)
Injury details	Place of occurrence, activity causing the injury; accident details
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)
Degree of severity	Mild, moderate, severe, e.g., Malnutrition: mild, moderate, severe

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Diagnosis Documentation Examples

Clinical Examples – Documentation Improvement

Laterality

- ICD-10-CM introduces laterality to the diagnosis classification system. Many providers already document which side of the body the disease or injury occurred, but it is now a required data element with ICD-10-CM.

- **Over 5,000 diagnoses have a right and left distinction, such as:**
  - Joint pain/effusion
  - Gout
  - Arthritis
  - Otitis Media

- The following are classification examples of when documentation of laterality is required:
  - M25.561 Pain in right knee
  - S52.521A Torus fracture of lower end of right radius
  - L89.011 Pressure ulcer of the right elbow, stage 1

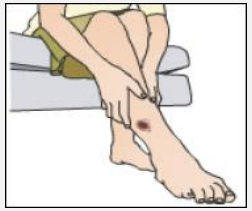
Routine General Medical Exam ICD-10

- Encounter for general exam w/o complaint, suspected or reported diagnosis
  - General adult medical exam
    - without abnormal findings
    - with abnormal findings
      - Use additional code to identify abnormal findings
  - Newborn, infant and child health exams
  - Period of rapid growth in childhood
  - Adolescent development state
  - Potential donor of organ and tissue
  - Normal comparison and control in clinical research program
  - Delayed growth in childhood
  - Other general examination

Non-Pressure Ulcers

A patient is admitted with a chronic non-pressure ulcer of the leg.

- In ICD-9-CM Diagnosis, seven (7) codes specify the site of the lower limb.
- In ICD-10-CM, more than 100 codes are used to delineate:
  - Site of the chronic non-pressure ulcer
  - Laterality
  - Depth of ulcer of the lower limb (e.g., limited to breakdown of skin, with fat layer exposed, with necrosis of muscle, with necrosis of bone and unspecified severity)



Non-Pressure Ulcers ICD-10 Code Examples

Pressure Ulcers

L97.10 – Non-pressure chronic ulcer of unspecified thigh

L97.101 - Non-pressure chronic ulcer of unspecific thigh, limited to skin breakdown

L97.102 - Non-pressure chronic ulcer of unspecified thigh, with fat layer exposed

L97.103 – Non-pressure chronic ulcer of unspecified thigh, with necrosis of muscle

L97.104 – Non-pressure chronic ulcer of unspecified thigh, with necrosis of bone

L97.109 – Non-pressure chronic ulcer of unspecified thigh, with unspecified severity

Right, left, unspecified lower limbs with all the above complications are specified in ICD-10-CM

Smoking ICD-9

- 305 Nondependent abuse of drugs

  Note: Includes cases where a person, for whom no other diagnosis is possible, has come under medical care because of the maladaptive effect of a drug on which he is not dependent and that he has taken on his own initiative to the detriment of his health or social functioning.
  - 305.0 Alcohol abuse
  - 305.1 Tobacco use disorder
  - 305.2 Cannabis abuse…..

Smoking ICD-10

- Z72 Problems related to lifestyle
  - Z72.0 Tobacco use
    - Excludes hx tobacco dependence, use in pregnancy
- F17.2 Nicotine dependence
  - F17.21 Nicotine dependence, cigarettes

Smoking ICD-10

- F17.2 Nicotine dependence
  - F17.20 Nicotine dependence, Unspecified
    - F17.200 – Uncomplicated
    - F17.201 – In remission
    - F17.203 – With withdrawal
    - F17.208 – With other nicotine-induced disorders
    - F17.209 – With unspecified nicotine-induced disorders
  - F17.21 Nicotine dependence, cigarettes
    - F17.210 – Uncomplicated
    - F17.211 – In remission
    - F17.213 – With withdrawal
    - F17.218 – With other nicotine-induced disorders
    - F17.219 – With unspecified nicotine-induced disorders
  - F17.29 Nicotine dependence, other tobacco products
    - F17.290 – Uncomplicated
    - F17.291 – In remission
    - F17.293 – With withdrawal
    - F17.298 – With other nicotine-induced disorders
    - F17.299 – With unspecified nicotine-induced disorders

Urinary Tract Infection ICD-9

- 599 Other disorders of urethra and urinary tract
  - 599.0 Urinary tract infection, site not specified
    - Use additional code to identify organism, such as E. coli

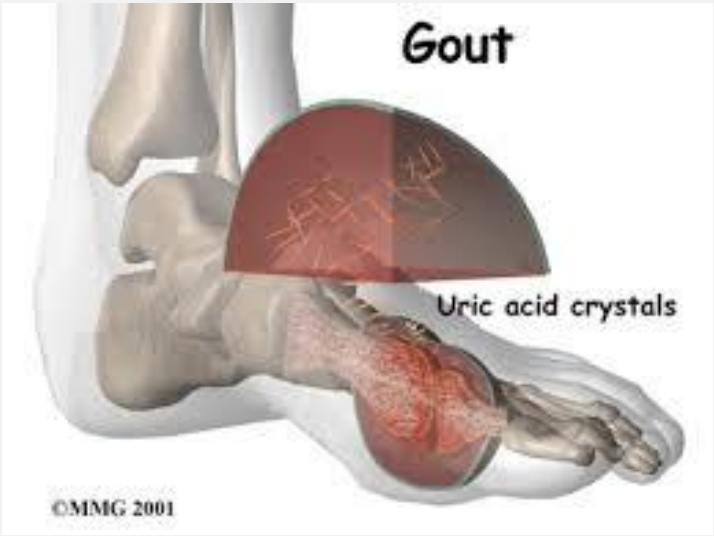
Urinary Tract Infection ICD-10

Other diseases of the urinary system (N30-N39)

- N30 Cystitis
  - N30.0 Acute cystitis
  - N30.1 Interstitial cystitis (chronic)
  - N30.2 Other chronic cystitis
  - N30.3 Trigonitis
  - N30.4 Irradiation cystitis
  - N30.8 Other cystitis
  - N30.9 Cystitis, unspecified
    - N30.90 without hematuria
    - N30.91 with hematuria
- N39 Other disorders of urinary system
  - N39.0 Urinary tract infection, site not specified
    - Use additional codes (B95-B97), to identify infectious agent

Gout – Documentation Improvement

- Document the type and site of the gout in order to get the most specific classification



Clinical Examples – Documentation Improvement

- Gout
  - Classifications include:
    - Acute
      - Idiopathic
      - Lead-induced
      - Drug-induced
      - Due to renal impairment
      - Other or unspecified
      - ***6th character for site***
    - Chronic
      - Idiopathic
      - Lead-induced
      - Drug-induced
      - Due to renal impairment
      - Other or unspecified- M10.9
      - ***6th character for site; 7th character for with or without tophus***

Gout ICD-10 Code Examples

Gout M10.0 – Idiopathic gout
- M10.00 – Idiopathic gout, unspecified site
- M10.01 – Idiopathic gout, shoulder
  - M10.011 – idiopathic gout, right shoulder
  - M10.012 – idiopathic gout, left shoulder
  - M10.019 – idiopathic gout, unspecified shoulder

M10.1 – Lead-induced gout
M10.2 – Drug-induced gout
M10.3 – Gout due to renal impairment
M10.4 – Other secondary gout
M10.9 – Gout, unspecified

Injuries and Fractures

- ICD-10-CM relies more heavily on categorizing the episodes of care for injuries and illnesses. Detailed documentation is required, for example, for fractures:
  - Fracture codes in ICD-10 include greater specificity:
    - Type of fracture
    - Anatomical site
    - Displaced or not
    - Laterality

Sprains and Strains– Documentation Improvement

- The ICD-10-CM classification of sprains includes specific ligaments as well as the laterality.
  - Ankle
    - Calcaneofibular
    - Deltoid
    - Tibiofibular
    - Other/unspecified
  - Toe
    - Interphalangeal joint
    - Metatarsophalangeal joint
    - Unspecified
  - Foot
    - Tarsal ligament
    - Tarsometatarsal ligament

Episodes of Care

Fractures in ICD-10-CM:

- Open Fracture of the Right Wrist, Initial Encounter - S62.101B

Character	
A	Initial Encounter/Closed Fracture
B	Initial Encounter/Open Fracture
D	Subsequent Encounter/Fracture Routine Healing
E	Subsequent Encounter for Open Fracture, Type I or II Routine Healing
G	Subsequent Encounter/Fracture Delayed Healing
K	Subsequent Encounter/Fracture Nonunion
P	Subsequent Encounter/Fracture Malunion
S	Sequela

Open Wounds/Lacerations

Below is an example of the classification differences between ICD-9-CM Diagnosis and ICD-10-CM for an open wound or laceration of the thumb with a foreign body.

ICD-9-CM Diagnosis

- 883.1 Complicated open wound of the finger.

ICD-10-CM

- S61.021A Laceration with foreign body of right thumb without damage to nail, initial encounter.
- **Much more descriptive of the injury allowing for reflection of patient acuity, outcome/prognosis, evaluation as well as follow up expectations.**

Overweight & Obesity and Hyeralimentation

- Overweight and obesity
  - Documentation requirement if applicable:
    - Drug induced,
    - Alveolar hypoventilation
- Hyperalimentation
  - Documentation requirement
    - Hypervitaminosis A
    - Hypercarotinemia
    - Hypervitaminosis D
    - Other specified hyperalimentation
- Sequela of hyperalimentation

Overweight and Obesity ICD-10 Code Examples

Overweight and Obesity

E66.0 – Obesity due to excess calories

- E66.01 – Morbid(severe) obesity due to excess calories
- E66.09 – Other obesity due to excess calories

E66.1 – Drug-induced obesity

E66.2 – Morbid (severe) obesity with alveolar hypoventilation

E66.3 – Overweight

E66.8 – Other obesity

E66.9 – Obesity, unspecified

BMI– Documentation Improvement

The BMI should also be documented and coded along with the obesity. These classifications are specific to adults or children.

- Z68.4 – Body mass index (BMI) 40 or greater, adult.
- Z68.41 – Body mass index (BMI) 40.0-44.9, adult.

Correct Use of "R" (symptom) Codes

- Chapter 18. Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, NEC (R00-R99)
  - Includes symptoms, signs, abnormal results of clinical or other investigative procedures, and ill-defined conditions.
  - Signs and symptoms pointing rather definitely to a given diagnosis have been assigned to a category in other chapters of the classification.
  - In general, categories in this chapter include the less well-defined conditions and symptoms that, without the necessary study of the case to establish a final diagnosis, point perhaps equally to two or more diseases or to two or more systems of the body.

Correct Use of "R" (symptom) Codes

- Chapter 18. Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, NEC (R00-R99)
  - Cases for which no more specific dx can be made even after all facts bearing on the case have been investigated
  - Signs and symptoms existing at the time of initial encounter that proved to be transient and whose causes could not be determined
  - Provisional diagnosis in a patient who failed to return for further investigation or care
  - Cases referred elsewhere for investigation or treatment before the diagnosis was made
  - Cases in which a more precise diagnosis was not available for any other reason
  - Certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right

Pain in Limb ICD-10

- Pain in limb, hand, foot, fingers and toes
  - Pain in limb, unspecified
  - Pain in upper arm
  - Pain in forearm
  - Pain in hand and fingers
  - Pain in thigh
  - Pain in lower leg
  - Pain in foot and toes

Pain in Limb ICD-10

- Pain in limb, hand, foot, fingers and toes
  - Pain in hand and fingers
    - right hand
    - left hand
    - unspecified hand
    - right finger(s)
    - left finger(s)
    - unspecified finger(s)

Abdominal Pain ICD-9

- 789.0 Abdominal pain
  - 789.00 unspecified site
  - 789.01 RUQ
  - 789.02 LUQ
  - 789.03 RLQ
  - 789.04 LLQ
  - 789.05 periumbilic
  - 789.06 epigastric
  - 789.07 generalized
  - 789.09 other specific site
    - includes multiple sites

Abdominal Pain ICD-10

- R10 Abdominal and pelvic pain
  - R10.0 Acute abdomen
  - R10.1 Pain localized to upper abdomen
  - R10.2 Pelvic and perineal pain
  - R10.3 Pain localized to other parts of lower abdomen
  - R10.8 Other abdominal pain
  - R10.9 Unspecified abdominal pain

Abdominal Pain ICD-10

- R10 Abdominal and pelvic pain
  - R10.8 Other abdominal pain
    - R10.81 Abdominal tenderness
      - R10.811 RUQ
      - R10.812 LUQ
      - R10.813 RLQ
      - R10.814 LLQ
      - R10.815 Periumbilic
      - R10.816 Epigastric
      - R10.817 Generalized
      - R10.819 Unspecified site
    - R10.81 Rebound abdominal tenderness
      - R10.821 RUQ
      - R10.822 LUQ
      - R10.823 RLQ
      - R10.824 LLQ
      - R10.825 Periumbilic
      - R10.826 Epigastric
      - R10.827 Generalized
      - R10.829 Unspecified site
    - R10.83 Colic
    - R10.84 Generalized abdominal pain
  - R10.9 Unspecified abdominal pain

Backache ICD-9

- 724 Other and unspecified disorders of back
  - 724.0 Spinal stenosis, other than cervical
  - 724.1 Pain in thoracic spine
  - 724.2 Lumbago
  - 724.3 Sciatica
  - 724.4 Thoracic or lumbosacral neuritis or radiculitis
  - 724.5 Backache unspecified
  - 724.6 Disorders of sacrum
  - 724.7 Disorders of coccyx
  - 724.8 Other symptoms referable to back
  - 724.9 Other unspecified back disorders

Backache ICD-10

- M54 Dorsalgia
  - M54.0 Panniculitis affecting regions of neck and back
  - M54.1 Radiculopathy
  - M54.2 Cervicalgia
  - M54.3 Sciatica
  - M54.4 Lumbago with sciatica
  - M54.5 Low back pain
    - Includes Loin pain, Lumbago NOS
  - M54.6 Pain in thoracic spine
  - M54.8 Other dorsalgia
  - M54.9 Dorsalgia, unspecified

Debility ICD-9

- 799 Other ill-defined and unknown causes of morbidity and mortality
  - 799.0 Asphyxia and hypoxemia
  - 799.1 Respiratory arrest
  - 799.2 Signs and symptoms involving emotional state
  - 799.3 Debility, unspecified
  - 799.4 Cachexia
  - 799.8 Other ill-defined conditions
  - 799.9 Other unknown and unspecified cause

Debility ICD-10

- R53 Malaise and fatigue
  - R53.0 Neoplastic (malignant) related fatigue
  - R53.1 Weakness
  - R53.2 Functional quadriplegia
  - R53.8 Other malaise and fatigue
    - R53.81 Other malaise
      - Includes debility NOS, chronic debility, general physical deterioration, malaise NOS, nervous debility
    - R53.82 Chronic fatigue, unspecified
    - R53.83 Other fatigue
- R54 Age-related physical debility
  - Includes frailty, old age, senescence, senile asthenia, senile debility

Fatigue ICD-9

- 780.7 Malaise and fatigue
  - 780.71 Chronic fatigue syndrome
  - 780.72 Functional quadriplegia
  - 780.79 Other malaise and fatigue

Fatigue ICD-10

- R53 Malaise and fatigue
  - R53.0 Neoplastic (malignant) related fatigue
  - R53.1 Weakness
  - R53.2 Functional quadriplegia
  - R53.8 Other malaise and fatigue
    - R53.81 Other malaise
    - R53.82 Chronic fatigue, unspecified
    - R53.83 Other fatigue
      - fatigue NOS, lack of energy, lethargy, tiredness

Dysuria ICD-9

- 788 Symptoms involving urinary system
  - 788.0 Renal colic
  - 788.1 Dysuria
  - 788.2 Retention of urine
  - 788.3 Urinary incontinence
  - 788.4 Frequency of urination and polyuria
  - 788.5 Oliguria and anuria
  - 788.6 Other abnormality of urination
  - 788.7 Urethral discharge
  - 788.8 Extravasation or urine
  - 788.9 Other symptoms involving urinary system

Dysuria ICD-10

- R30 Pain associated with micturition
  - R30.0 Dysuria
  - R30.1 Vesical tenesmus (feeling of incomplete emptying after unination)
  - R30.2 Painful micturition, unspecified

Nausea with Vomiting ICD-9

- 787.0 Nausea and vomiting
  - 787.01 Nausea with vomiting
  - 787.02 Nausea alone
  - 787.03 Vomiting alone
  - 787.04 Bilious emesis

Nausea with Vomiting ICD-10

- R11 Nausea and vomiting
  - R11.0 Nausea
  - R11.1 Vomiting
    - R11.10 Vomiting, unspecified
    - R11.11 Vomiting, without nausea
    - R11.12 Projectile vomiting
    - R11.13 Vomiting of fecal matter
    - R11.14 Bilious vomiting
  - R11.2 Nausea with vomiting, unspecified

Top 5 New Signs and Symptoms

- Projectile Vomiting
  - –Previously vomiting alone
- Anterior chest wall pain
  - –Previously chest pain, other
- Somnolence
  - –Previously other alteration of consciousness

Top 5 New Signs and Symptoms

- Repeated falls
  - –Previously other symptoms involving nervous and musculoskeletal systems
- Mouth breathing
  - –Previously other symptoms involving head and neck

Domestic Violence Coding

- ICD-10-CM has multiple codes each describing type of assault instrument as well as type of encounter such as:

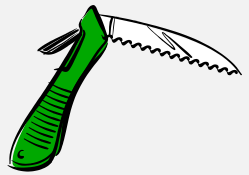
Example:

ICD-9-CM

– Assault by cutting and piercing instrument

ICD-10-CM

– Assault by sharp glass, initial encounter;
– Assault by sharp glass, subsequent encounter;
– Assault by knife, initial encounter;
– Assault by knife, subsequent encounter



Underdosing

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

Underdosing

Underdosing of drugs specifies documentation of intentional or unintentional underdosing:

- Intentional underdosing
  - Due to financial hardship
  - Other reasons
- Unintentional underdosing
  - Age-related debility
  - Other reasons

Separate "Z" code that is submitted alongside the code for underdosing.

Underdosing

- These codes also require a 7th character to identify whether this is:
  - **A**: Initial encounter – when the patient is receiving active treatment/first visit by that physician
  - **D**: Subsequent encounter – after the active phase of treatment and when the patient is receiving repeat or routine care for the injury.
  - **S**: Sequela is assigned for complication or condition that arises as a direct result of an injury (takes priority for code- if no sequelae, code initial or subsequent)

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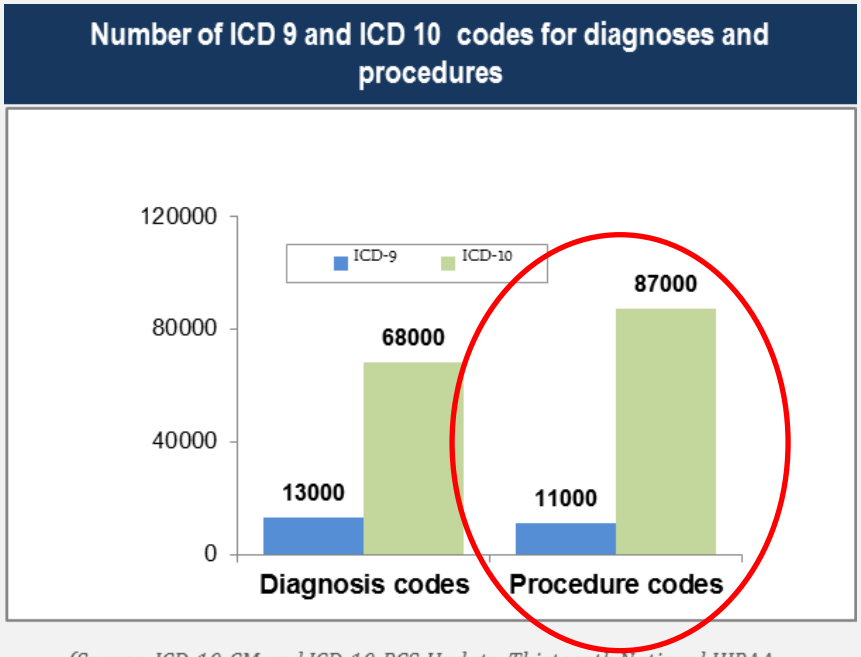
Procedure Documentation Examples

Overview of ICD-10-PCS

- Basic principles used when developing the system were that **no diagnostic information is included** in the procedure description (i.e., no codes for procedures exclusive to aneurysms, cleft lip, strictures or neoplasms, etc.).
- This procedure classification system is only utilized in the **inpatient hospital setting.**

ICD-10-PCS



(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

ICD-10-PCS Chest Tube with Drainage

Patient presents for chest tube placement

ICD-10-PCS

0W9930Z

- Drainage of Right Pleural Cavity with Drainage Device, Percutaneous Approach

ICD-10-PCS Table

Section	**0**	Medical and Surgical
Body System	**W**	Anatomical Regions, General
Operation	**9**	Drainage: Taking or letting out fluids and/or gases from a body part

Body Part	*Approach*	*Device*	*Qualifier*
0 Head **1** Cranial Cavity **2** Face **3** Oral Cavity and Throat **4** Upper Jaw **5** Lower Jaw **6** Neck **8** Chest Wall **9** Pleural Cavity, Right **B** Pleural Cavity, Left **C** Mediastinum **D** Pericardial Cavity **F** Abdominal Wall **G** Peritoneal Cavity **H** Retroperitoneum **J** Pelvic Cavity **K** Upper Back **L** Lower Back **M** Perineum, Male **N** Perineum, Female	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**0** Drainage Device	**Z** No Qualifier

Catheter Insertion into Vein

- Procedures require documentation of:
  - Specific vein where insertion performed
    - Right or left internal jugular vein
    - Right or left external jugular vein
  - Approach
    - Open
    - Percutaneous
    - Percutaneous endoscopic
  - Type of device
    - Infusion
    - Intraluminal
  - Code examples
    - ICD-9 – 38.93 – venous catheterization.
    - ICD-10-PCS – 05HM33Z – Insertion, internal jugular vein right, percutaneous, infusion device.

Catheter Insertion

Section	**0**	Medical and Surgical
Body System	**2**	Heart and Great Vessels
Operation	**H**	Insertion: Putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part

Body Part	*Approach*	*Device*	*Qualifier*
4 Coronary Vein **6** Atrium, Right **7** Atrium, Left **K** Ventricle, Right **L** Ventricle, Left	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**0** Monitoring Device, Pressure Sensor **2** Monitoring Device **3** Infusion Device **D** Intraluminal Device **J** Cardiac Lead, Pacemaker **K** Cardiac Lead, Defibrillator **M** Cardiac Lead	**Z** No Qualifier
P Pulmonary Trunk **Q** Pulmonary Artery, Right **R** Pulmonary Artery, Left **S** Pulmonary Vein, Right **T** Pulmonary Vein, Left **V** Superior Vena Cava **W** Thoracic Aorta	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**0** Monitoring Device, Pressure Sensor **2** Monitoring Device **3** Infusion Device **D** Intraluminal Device	**Z** No Qualifier

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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"

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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?