Don’t ‘grab and run’ with diagnoses
Become a clinically savvy documentation improvement specialist

If they don’t perform a thorough record review, CDI specialists may fail to catch many DRG-changing CCs and MCCs.

Or they may overlook clues that can lead to improved capture of severity of illness. For example, they may miss the opportunity to change a simple pneumonia to a gram-negative pneumonia through a physician query.

“There’s more to reviewing a record than just arriving at a DRG; that’s only half the battle,” says Glenn Krauss, RHIA, CCS, CCS-P, CPUR, FCS, PCS, an independent consultant in Maryville, TN. “A clinical documentation specialist has to use his or her clinical acumen and go through the record.”

Although finding the most salient DRG and quickly moving on to another case may sound tempting, a truly savvy CDI specialist will take his or her time to review the entire medical record.

Doing so can reveal much more about the patient’s condition, and it will often yield a higher-reimbursing MS-DRG.

Construct a clinical picture
When Deborah Mange, RN, BSN, the DRG-DOC specialist in the documentation improvement program for EMH Regional Medical Center in Elyria, OH, reviews a medical record, she begins with the admitting diagnosis as a basis for what she might expect to find and then builds a more complete clinical picture of the patient.

For example, if the patient presents with a documented gastrointestinal hemorrhage, she looks for related conditions, such as acute blood loss anemia.

If pneumonia is the diagnosis, she looks to see whether the physician has documented a clinically accurate type of pneumonia (given the patient’s clinical presentation and consideration of risk factors) and checks the patient’s respiratory status on arrival for evidence of respiratory failure or underlying chronic obstructive pulmonary disease.

“To me, it’s sort of a puzzle. You have an idea of what it looks like from the outside of the box, but then you look at each piece and try and put it together correctly,” says Mange.
Clinically savvy
continued from p. 1

Take note of the patient’s age, Mange says, as elderly patients can have a common set of secondary diagnoses that can affect the final MS-DRG. If the patient is 90 years old, for example, look for malnutrition or decubitus ulcers in the record. “Look at the nursing documentation for the skin status. Often, the doctors don’t pick up decubitus ulcers when the nurse is charting it,” she says. Although a coder cannot code from the nursing notes, the CDI specialists can use those notes to query the physician so that he or she will document the condition in the record.

Likewise, dietitian documentation can reveal valuable information about body mass index (BMI) and malnutrition/obesity. Note that a BMI under 19 or over 40 qualifies as a CC.

Look for problematic diagnoses

Physicians sometimes document diagnoses that, although clinically accurate, are not specific enough to allow a coder to assign an accurate ICD-9 code.

“If clinical evidence warrants it, the CDI specialist should clarify uncertain documentation,” Mange says. Some problematic diagnoses are:

» Acute renal insufficiency: Query for acute renal failure.

» Acute respiratory insufficiency: Query for acute respiratory failure.

» Failure to thrive: Query for malnutrition.

» History of cerebrovascular accident (CVA): Look for residual effects of the CVA (e.g., hemiparesis and dysphagia).

» Pneumonia: Query for specificity (e.g., aspiration pneumonia).

» Confusion: Query for delirium, delusion, or encephalopathy. “You want to ask the physician to clarify if the confusion has a root cause,” says Mange. “Or if the physician does document encephalopathy, and the patient has hypertension, is the hypertension causing the encephalopathy, such as hypertensive encephalopathy, which groups to a different DRG?”

» Severe dysphagia and pneumonia: Look for underlying causes of pneumonia (e.g., aspiration pneumonia).

Conduct a thorough record review

Krauss and Mange recommend the following plan of action to conduct a thorough record review:

1. Begin with the ambulance sheet. This allows you to formulate an initial picture of the patient’s problem.

2. Move to the emergency department (ED) nursing notes/dictation. In addition to presenting symptoms, you’ll often find documented services and medication administrations that can provide additional clinical clues and enable you to capture important diagnoses.

“Sometimes, events that happen in the ED are resolved by the time the patient gets to the floor,” Mange says. For example, a patient reports to the ED with low

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at www.copyright.com or 978/750-8400.
sodium (hyponatremia) and receives IV fluids. After admission, the patient’s sodium level is normal. “As a CDI specialist, you need to go to the ED staff and explain why you want to capture the hyponatremia as it’s happening, and later go back to the [treating] physician and ask him to document the hyponatremia,” she says.

3. Review the patient’s history and physical and consult notes.

4. Review the physician’s orders for clues and indications of clinical conditions that the physician is exploring or considering in the workup of the patient.

5. Scan the labs and radiology reports for possible clinical conditions that guide the physician’s medical decision-making. Look for abnormal results and evidence that the physician treated the problem but did not supply the accompanying documentation (e.g., documentation of a BUN of 53 and creatinine of 2, without writing “acute renal failure” or “acute renal insufficiency,” which is a noncodeable diagnosis). “What I find is that the physician often sees the abnormality and treats it, but they just don’t capture it with the diagnosis,” Mange says.

6. Finish with the progress notes. “This gives you an idea of what the physician is thinking, and what clinical path he’s going down,” Krauss says. “Use [progress notes] to formulate a query.”

If specialists don’t understand the clinical picture, they shouldn’t be afraid to use external resources, including medical journals or Web sites, says Krauss. “If you’re going to be a savvy documentation specialist, you have to continually expand your horizons,” he says. “If you don’t understand something, invest the time to look it up.”

CDI specialists should think of each record that they review as an opportunity to expand their clinical knowledge and acumen and should research unfamiliar conditions to learn more about those conditions, Krauss says. “The more clinically astute the documentation specialist becomes, the more valuable and effective he or she is in carrying out the duties and responsibilities of a CDI specialist,” he adds.

For an example of the results a thorough record review can produce, see “Consider this case example of a thorough record review” on p. 4.
Consider this case example of a thorough record review

While performing a concurrent chart review, a CDI specialist notes that an emergency department (ED) physician documents possible/probable congestive heart failure (CHF) with arrhythmia.

The specialist assigns MS-DRG 293 (Heart failure and shock without CC/MCC, relative weight 0.8765) as the working DRG and moves on to the next record.

Several problems ensue.

The patient ultimately stays in the hospital for nine days. The treating physician documents that the patient has dependent pedal edema, coronary heart disease with stable angina, hypertension, obesity, depression, anxiety, and malnutrition as the final diagnoses.

From this list, a coder reports dependent pedal edema as the principal diagnosis because the CHF was not codeable given the lack of documentation.

“The coder realized that the CHF wasn’t there, which the clinical documentation specialist didn’t realize, and coded a symptom instead,” says Glenn Krauss, RHIA, CCS, CCS-P, CPUR, FCS, PCS, an independent consultant in Maryville, TN.

The final DRG assignment is MS-DRG 948 (signs and symptoms without MCC), which has a relative weight of 0.6542. This is a very low reported acuity level and does not accurately capture the extent of resources that the hospital expended while managing and treating the patient during his or her nine-day stay.

Upon review, however, the CDI specialist finds clues in the record that lead to a completely different diagnosis. For example, the specialist determines the following:

» The physician’s orders state that the patient had clear lungs (i.e., no wheezing or rales), and a chest x-ray showed no indications of fluid in the chest. This casts the diagnosis of CHF in doubt.

» The ED nursing notes state that the patient received an IV of 80 mg of Lasix to treat three-plus pitting edema of the legs. Later during the stay, the patient received additional doses of Lasix and, finally, a step-down therapy of oral medication. The ED record is also the first place in which a physician reported CHF. However, the physician determined that the patient did not have CHF after performing a study and workup.

» Further review indicates that the patient had a BUN of 35 and a creatinine level of 2.1, which is well above normal and indicative of potential renal failure. Lab reports show that the patient’s creatinine level later spiked to 2.8, 3, and 3.6.

» The patient’s potassium rose to 5.2, 5.8, and 7.2, which is critically elevated, leaving the patient in danger of suffering cardiac arrest or ventricular tachycardia. The patient received Kayexalate and calcium gluconate for treatment.

» The patient also received insulin, which, according to Krauss, is administered for reasons other than diabetes, such as serious hyperkalemia. “It drives the potassium from the blood stream into the cells,” he says. “If the patient is not diabetic, the nurse specialist should ask why insulin was given.”

» The physician ordered a nutritional consult, and the nutritionist suggested that the patient take nutritional supplements and change his or her eating habits. Although not documented as such, this points toward malnutrition, Krauss says. “If dietitians aren’t including a diagnosis, you need to work on prompting the physician to write it down,” he adds.

At the end of the review, the CDI specialist confirms with the attending physician that the patient was suffering from a sudden worsening of the kidney, causing fluid overload, and which contributed to the pedal edema of the leg.

After the specialist’s query, he or she determines that there are two critical diagnoses—chronic stage IV renal failure and malnutrition.

When coded, this yields MS-DRG 683 (Renal failure with CC), which has a relative weight of 1.1942. This is almost twice the relative weight of the initial DRG assignment.

Overall, this case is representative of how poor physician documentation, missed diagnoses, and a cursory record review can affect reimbursement.

“What can happen sometimes is that a CDI specialist will look at what the physician wrote and convince themselves that’s what’s happening,” Krauss says. “They won’t go any further.”
Greene Memorial Hospital in Xenia, OH, is just starting its second year of a CDI program. And despite having only one CDI specialist to run the program, this small (199-bed) acute care facility has experienced considerable success.

Debbie Glenn, RN, BS, ACM, a longtime case manager, was hired in January 2007 to start the concurrent clinical documentation review program. Glenn had experience as a CDI specialist with her past employer, and Greene Memorial was confident that her expertise—and not that of a consulting firm or other expensive external resource—was enough to get its program off the ground.

“I guess you could say this program is homegrown,” says Glenn. “We don’t have access to outside resources that other institutions may have, so I use an Excel spreadsheet for tracking and reporting purposes.”

By mid-February 2007, Glenn had the program up and running. As part of her duties, she runs a monthly progress report that includes percentage of charts reviewed, percentage of queries, positive/negative responses to queries, changes to the case-mix index, and positive revenue changes that occur due to her queries.

Previously, Greene Memorial’s coding staff performed only postdischarge reviews and queries. “Although our coding staff does a great job, we found that we needed a real-time, concurrent documentation specialist to improve our process and reduce our postdischarge physician queries,” says Deb Fennell, CCS, coding/data quality coordinator at Greene Memorial.

Despite the fact that Greene Memorial’s overall CC capture rate dropped after the implementation of MS-DRGs—an expected trend—its overall case mix is up considerably.

“We’ve seen a steady increase in our case-mix index; a 20% improvement since the start of the program,” Glenn says. “But it wasn’t easy, and it took some considerable publicity, buy-in, and education to pull it off.”

Implementing the program

In order to make all of Greene Memorial’s physicians aware of and engaged in the program, Glenn organized a kick-off campaign that included:

» Mailing a letter to all physicians introducing herself and the program, and then following up with formal introductions at medical staff, quality, and hospitalist meetings.
» Conducting PowerPoint educational presentations.
» Hanging posters for physicians throughout the hospital.
» Attending daily case management meetings. Glenn also assists case managers with identifying transfer DRGs so they can identify any problems with physician documentation relating to length of stay.
» Attending monthly hospitalist meetings to keep them updated on the most recent documentation requirements.
» Providing documentation education and updates by way of an interview with the medical director on the hospital’s monthly physician CD. “Our medical director creates a monthly CD for physician education,” Glenn says. “The physicians can listen to the CD at their convenience.”

Glenn sold the program to physicians by demonstrating how improved documentation better reflects severity of illness. “You want them to know that improved documentation will reflect a higher severity of illness,” she says. “It also justifies length of stay and the consumption of resources.”

Glenn also demonstrated that better documentation had a positive effect on physicians’ individual profiles and justified hospital expenditures for new equipment and technology needed to care for more severely ill patients.

“We knew what we wanted to do; we wanted the program to get their attention in a big way,” says Fennell. “Debbie also pointed out via her PowerPoint the advantage for the medical staff to document with improved specificity so their case mix and acuity was accurate.”

“We also had the buy-in of senior management, which was so important,” Glenn says.

Reviewing charts concurrently

Glenn’s daily goal is to review all patient charts concurrently and generate pertinent physician queries while the patients are still in-house. Greene Memorial’s coding staff still performs postdischarge queries when necessary.

continued on p. 6
Greene Memorial Hospital
continued from p. 5

“Doctors want to talk to nurses, and by virtue of their clinical background, it pulls them into [the physicians’] ball game. Whereas in HIM, it’s on a different level,” Fennell says. “Our documentation specialist is the bridge; she bridges the coding staff with the medical staff, and it puts us all on the same team.”

Glenn assigns a working DRG one to two days after admission and places this information in the chart. In the case of a surgical patient, she waits two or three days before reviewing the case and assigning a DRG.

She also visits the medical records department daily. If a final DRG assignment conflicts with her working DRG, she and the coder discuss the discrepancy. “I review the chart with the coder, and most of the time, I’ll notice right away the reason for the discrepancy. Something either came up after my initial review of the chart, or the doctor documented additional information based on clinical results which were not available previously,” she says. “If there are any issues we need to talk about, I simply go straight to the coder, and we talk about it at that time. We can do that because we’re a smaller facility and can work one-on-one.”

In a previous role at a different hospital, Glenn witnessed some tension between the CDI specialists and the coders, and she was determined to avoid similar problems at Greene Memorial. Fortunately, Greene Memorial’s coding staff welcomed Glenn with open arms.

“We couldn’t wait to get a [clinical documentation specialist]. We saw it as a complement to HIM and coding,” Fennell says. “We respect Debbie’s clinical background, and in turn, I think Debbie respects our knowledge of the coding guidelines.”

A ‘sticky’ success story: Labels help to ensure documentation for morbid obesity, malnutrition

Under the new MS-DRG system, documentation of morbid obesity and malnutrition are more important than ever. But physicians don’t always document these diagnoses in the chart. “We found that although the dietitian was documenting [morbid obesity or malnutrition] in her nutritional assessment and these conditions were being treated, our physicians occasionally failed to document the diagnoses in their progress notes,” says Debbie Glenn, RN, BS, ACM, clinical documentation specialist at Greene Memorial Hospital in Xenia, OH.

To combat this problem, Glenn worked closely with the dietitian in July 2007 to develop a bright-green adhesive label, which the dietitian now places in the physician’s progress note. The stickers help physicians quickly identify these conditions (see the two sample labels above). The physician simply signs the label to confirm the diagnosis. Glenn has tracked the progress of the labels since they were put into use in mid-October 2007, and so far, the results have been quite positive. “Our dietitian’s label has made a significant impact, especially since the implementation of [MCCs]. We’ve had measurable success with this process and are planning for the development of future documentation tools,” Glenn says.
Overcoming the MS-DRGs challenge

When CMS implemented MS-DRGs on October 1, 2007, Glenn encountered some difficulties. Several nursing homes are located in close proximity to Greene Memorial, which made it necessary to make Medicare patients a priority for concurrent review.

But post-MS-DRG implementation, Glenn had to shift her focus to review specific diagnoses, such as congestive heart failure (CHF), sepsis, and pneumonia. She says that she typically reviews 15–18 records per day.

Glenn spent most of September 2007 educating physicians about new documentation requirements for MS-DRGs, including documenting for the present-on-admission (POA) indicator. She also sent physicians a letter to explain the changes.

“We did some educational sessions in the [ER] medical staff meetings, quality meetings, and the hospitalist meetings,” she says.

For example, because CHF specificity is much more important under MS-DRGs, Glenn developed a specific CHF query form. “I’ve noticed that I haven’t had to query as often because now [physicians] know that they have to document the type and severity of CHF,” Glenn says.

Fennell assisted with the implementation of POA requirements. She worked with the hospital’s transcription department to modify the template on the discharge summaries and history and physicals to include places for POA reporting. “We have found that our doctors have been very compliant; they’re documenting everything,” she says. “We expected it to be a lot more cumbersome with more questions, but we have been pleasantly surprised.”

Glenn says Greene Memorial’s physicians, as a whole, have been very accommodating. “Occasionally, there’s a physician who may not answer a query, but it could be because he or she doesn’t have an answer until discharge,” she says.

To combat this, Greene Memorial’s coders cannot code the chart until physicians have addressed all outstanding queries. “That’s an incentive for physicians; they don’t want to come to medical records to deal with these issues, so they attempt to answer my queries while their patient is still in-house,” Glenn says.

Collaborate with your ancillary departments to ensure success
Clinical documentation improvement specialists don’t have to do it all

by Lynne Spryszak, RN

Working collaboratively with other departments in your hospital is essential if you want your documentation improvement efforts to succeed. Do you really want to query for every detail in a medical record, or is it more beneficial to spend that time working with ancillary staff members so they can help provide the documentation for you?

Writing a compliant query involves asking the physician to substantiate a condition that you identified during the course of your chart review. It takes time and effort to craft the correct wording that will capture the diagnosis that you’re asking for, and it takes more time and effort when the physician doesn’t respond in the record prior to the patient’s discharge. Gaining the assistance of ancillary departments can help make this process more efficient.

Following are some examples of how a CDI specialist can work with other departments in his or her hospital, including nutrition, general nursing, wound care, the emergency department (ED), and HIM/coding.

Clinical nutrition department

Here’s an example of how you can collaborate with nutrition: A CDI specialist notes that the patient’s height and weight calculate to a body mass index (BMI) of > 40, netting a much-needed CC for the principal diagnosis. But the BMI is nowhere to be found in the chart.

The CDI specialist could formulate a query asking the physician to document the BMI, but chances are the physician won’t understand why it’s important, and he or she won’t provide the documentation that the specialist has requested. Therefore, the CDI specialist should work with
the clinical nutrition department and ask staff members to document the BMI in their dietary assessment form.

Coding Clinic, fourth quarter 2005, pp. 96–98 (effective for discharges that occur on or after October 1, 2005), allows a coder to code the BMI from the dietitian’s note. This means that the CDI specialist should take the time to talk with the director of clinical nutrition. A dietitian understands the implication of an elevated or decreased BMI and how this affects the patient’s care and prognosis. It shouldn’t be too difficult to request that he or she document this information in the initial assessment.

A CDI specialist should also consider asking the clinical dietitian for help formulating an evidence-based query for malnutrition. Clinical dietitians are familiar with the specific types of laboratory tests that a hospital uses and can provide a CDI specialist with the clinical parameters for the various levels of malnutrition (i.e., mild, moderate, or severe). Clinical dietitians will be more likely to include severity indicators in their assessments, thus providing a CDI specialist with the clinical information that he or she needs to generate a physician query.

Nursing department

Our clinical documentation management program at Alexian Brothers Medical Center provides periodic inservices to the nursing staff regarding documentation issues, particularly in light of the advent of present-on-admission (POA) indicators.

For example, we prepared a short presentation (less than 10 minutes) that covered the important elements of the POA initiative, which we gave during all of the nursing unit meetings. We emphasized that accurately documenting all indwelling lines, drains, catheters, and devices was essential to not only formulating a complete nursing care plan, but also providing valuable information if one of these devices is later identified as the source of a symptom at admission.

When nurses properly identify these devices, it helps to ensure that physicians will also identify and assess them. This measure prevents potential complications, improves patient care and safety, and reduces the institution’s liability.

Wound care department

Likewise, when nurses perform a complete and accurate admitting wound assessment, the result is improved patient outcomes. Our emphasis at Alexian Brothers Medical Center is on patient safety and compliance because most floor nurses have little interest or experience with hospital-based reimbursement concepts.

However, improved nursing documentation has other benefits for the CDI specialist. For example, it makes it easier to query a physician regarding a catheter-related urinary tract infection (UTI) or the presence of decubitus ulcers. A CDI specialist can attach copies of the nursing assessment to the query to substantiate the reason for that query and to justify the use of additional resources.

Appropriately documenting decubitus ulcers and other wounds leads to accurate treatment and compliant coding. For example, the documentation should clearly state whether an ulcer is a decubitus or a venous stasis. These are different conditions that require differing treatment modalities, and they each result in different ICD-9 code and MS-DRG assignments.

At our facility, we involve a representative of the wound care team in our POA chart abstracting meetings. By participating in this process, the representative quickly realized the implications of incomplete nursing documentation on the nursing admission assessment and daily nursing assessment forms, especially for those cases in which the wound care nurse had not been involved in the care of the patient.

Through the representative’s participation in these meetings, we were able to identify the need to provide additional information to the nursing staff regarding identification and staging of decubitus ulcers, venous/arterial ulcers, surgical wounds, and other skin impairments. We are currently revising an electronic assessment form based on observations and input from the nursing staff.

Emergency department

Involve your ED staff in the teaching process as well. Many inpatients are admitted through the ED, and the ED record provides important information about devices or conditions that may appear inconsequential at the time of admission but that can present documentation issues later.

For example, a patient arrives from the nursing home with an intact foley catheter. The patient is transferred for
an unrelated reason (e.g., pneumonia), but also presents with a fever that is linked to a UTI. To ensure accurate code assignment, the documentation should link the infection to the device.

From a POA standpoint, the documentation should also substantiate that the infection may have been present even though the physician may not have diagnosed it at the time of admission.

The ED record can also substantiate the current or past history of methicillin-resistant *Staphylococcus aureus*, *Clostridium difficile*, or other infections. If ED staff members include this information in the record, a coding professional can assign the proper POA indicator.

Recognize that because most ED encounters are outpatient visits, ED physicians are accustomed to providing documentation that is entirely appropriate in the outpatient/clinic setting (e.g., symptoms instead of diagnoses, and vague terminology). This means that when patients are admitted with symptom diagnoses, the CDI specialist must then generate queries to link presenting symptoms to later-diagnosed conditions.

By educating ED practitioners now, CDI specialists will save time later because they won’t have to generate as many queries for principal diagnoses or POA conditions.

**HIM/coding department**

If you haven’t already done so, it’s a good idea to invite a member of the coding and documentation improvement departments to serve on any committees that are involved in the development of hospital-based documentation forms. These could include:

- Standing order sets
- Risk assessment tools
- Admission assessments
- Wound care flow sheets
- Anesthesia assessments
- History and physical forms

If your facility plans to implement an electronic medical record, now is the time to get involved. Once the templates are built, it is much harder (and takes longer) to make changes to them.

In my experience, clinicians who serve on the forms committees usually have little, if any, knowledge of coding requirements or how coding affects hospital reporting measures—both of which are becoming increasingly important. Developing a well-written tool ensures that clinicians are provided with prompts that promote greater documentation specificity. In addition to providing these forms, encourage periodic education or refreshers to keep everyone updated on their proper use.

By educating all members of the healthcare team about the importance of accurate and complete documentation, and by gaining their support and input, you will reduce the amount of time spent on writing and following up with queries.

The additional benefits are what we’re all working toward: improved patient outcomes, excellent quality profiles, and continued growth. 

*Editor’s note: Spryszak is coordinator of the clinical documentation management program at Alexian Brothers Medical Center in Elk Grove Village, IL. You can reach her via e-mail at spryszal@alexian.net.*

Would you like to contribute an article to *CDI Journal*?
E-mail ACDIS director Brian Murphy at bmurphy@hcpro.com.
ACDIS submits comments to AHIMA on physician queries

Editor’s note: On February 20, members of the Association of Clinical Documentation Improvement Specialists submitted the following comments to the American Health Information Management Association regarding its 2001 document, “Practice Brief on Developing a Physician Query Process.” AHIMA is currently in the process of revising this document, and ACDIS members have asked AHIMA to consider the input of CDI specialists.

To: The American Health Information Management Association (AHIMA)
From: The Association of Clinical Documentation Improvement Specialists (ACDIS)
Date: February 20, 2008
Subject: Comments to AHIMA regarding AHIMA’s “Practice Brief on Developing a Physician Query Process”

In recognition that AHIMA is currently undertaking the process of reviewing/revising its 2001 document, “Practice Brief on Developing a Physician Query Process,” and that, in the intervening years since 2001, Clinical Documentation Improvement (CDI) specialists have moved to the frontline of the physician query process, we, the members of the Association of Clinical Documentation Improvement Specialists (ACDIS), have drafted the following set of comments and considerations for AHIMA to use in their decision-making process. Note that some of these comments are taken from a representative of FMQAI, the Florida Quality Improvement Organization.

ACDIS members affirm that the AHIMA Practice Brief is a great foundation, but does not allow enough flexibility when posing queries to physicians in a concurrent, real-time basis. In particular, we would like to see the following inclusions/revisions to the following sections of the Practice Brief:

» The current AHIMA Practice Brief states, “Each facility should develop a standard format for the query form . . . ‘Open-ended’ questions that allow the physician to document the specific diagnosis are preferable to multiple-choice questions or questions only requiring a ‘yes’ or ‘no’ response . . .”

ACDIS members believe that any question that seeks clarification for a diagnosis supported clinically in the medical record, but not specifically documented by the physician, is appropriate. Open-ended questions are preferable; however, multiple-choice questions and questions requiring a “yes” or “no” response are acceptable, as long as there is a clinical explanation documented on the query to support the reason for the question. The clinical explanation should be based on the treatment, evaluation, monitoring, and/or services provided during that admission. ACDIS does not accept any query that is not supported clinically in the medical record and ultimately “leads” a physician to a response that is not supported in the medical record.

» The current AHIMA Practice Brief states, “Physicians should be queried whenever there is conflicting, ambiguous, or incomplete information in the medical record regarding any significant reportable condition or procedure . . .”

ACDIS encourages the use of queries to clarify conflicting, ambiguous, or incomplete information in medical records. The definition of conflicting includes, but is not limited to the following:

1. A diagnosis is present, but not clinically substantiated in the medical record, and there is no evidence of the treatment, evaluation, monitoring, and/or services provided.
2. Clinical evidence of the evaluation, treatment, monitoring, and/or other services provided appears to substantiate a diagnosis or condition that is not documented in the medical record.
3. There are contradictory entries and/or documentation in the medical record from consultants, a radiologist, a pathologist, or an anesthesiologist, and/or diagnostic test results do not agree with each other.
4. There is a contradiction between the documentation in the discharge summary and the body of the medical record.
5. There is an indication in the clinical evidence of a more specific diagnosis if the physician would provide an etiology or precise information regarding the condition. For example, if the physician documents congestive heart failure, documentation of the mechanical failure (e.g., systolic heart failure) is a more accurate description of CHF.
6. The current AHIMA Practice Brief states, “Queries are not necessary if a physician involved in the care and treatment of the patient, including consulting physicians, has documented a diagnosis and there is no conflicting documentation from
another physician . . . Queries are also not necessary when a physician has documented a final diagnosis and a clinical indicator—such as test results—do not appear to support this diagnosis . . . ”

ACDIS believes that a query is not necessary when there is no conflicting information in the medical record. However, when a physician has documented a final diagnosis, but clinical indicators such as test results or other forms of documentation do not appear to support the diagnosis, ACDIS believes that a query can be beneficial in providing clarification. For example, if a physician documents hyponatremia, and the record does not support that diagnosis, a CDI specialist should clarify with the physician why he or she documented the hyponatremia. ACDIS recommends that facilities should develop a policy that addresses the process for querying the physician in these instances.

continued on p. 12
The current AHIMA Practice Brief states, “Queries that appear to lead the physician to prove a particular response could lead to allegations of inappropriate upcoding . . . .”

ACDIS believes that this statement should be phrased such that the physician is allowed to specify the correct diagnosis. For example, if clinical circumstances and laboratory results indicate respiratory failure, but the physician has not documented the term “acute” in the medical record, a CDI specialist should be permitted to give the physician the option to specify the diagnosis (i.e., “When you say respiratory failure, it can be acute, chronic, or acute on chronic—which term best specifies the patient’s respiratory failure?”)

We at ACDIS strongly believe that the goal of queries is not to use blanket questions, but to tailor each query to the individual patient and situation, pointing out the clinical indicators for the query and including the necessary verbiage, if appropriate, as determined by the provider. Under the section of the Query Brief entitled “Query Format,” we encourage AHIMA to include the following statement: “The query form should include the clinical information that prompts the query.”

The current AHIMA Practice Brief states that, “Complete and accurate diagnostic and procedural coded data must be available, in a timely manner, in order to facilitate tracking of fraud and abuse.”

We at ACDIS suggest a change to “Complete and accurate diagnostic and procedural coded data must be available, in a timely manner, in order to assure an accurate clinical picture as well as facilitate the tracking of compliance.”

To sum up the above points, ACDIS believes that compliant queries are not a matter of how a coder or CDI specialist asks a question, it’s why he or she asks the question. If one has a reason to ask a direct yes/no or multiple-choice question (i.e., to help discern the clinical elements in the record), and the question results in a more specific and accurate ICD-9-CM diagnosis code assignment, then the query should be considered appropriate and compliant. Conversely, if one asks a non-specific query to a physician, he or she will likely receive a non-specific answer in return.

We have provided three examples of what we believe to be compliant query practices (see “ACDIS query examples” on p. 11).

In addition to the above changes to the general query process, we hope that the AHIMA Practice Brief can be updated to reflect the current environment of CDI specialists querying physicians on a concurrent basis, using verbal, “real-time” queries in addition to the traditional model of post-discharge, written queries by HIM/coding staff. Open and free dialogue between CDI specialists (be they from nursing, case management, or HIM/coding backgrounds) and the treating physician to clarify the clinical elements in the medical record is a reality of this new environment and should be encouraged in the Practice Brief.

To better reflect the role of the CDI specialist, many of whom are former/current nurses, case managers, and other caregivers, we would like to see the line in the section entitled “Principles of Medical Record Documentation” to read as follows:

» Providing clinical data for research, education, and quality of care measures

In conclusion, the drastic changes brought about by MS-DRGs, and the added emphasis on capturing the severity of each patient’s illness, has added new and ever-changing requirements for CDI specialists and HIM/coding staff. ACDIS believes that, because the physician query process is constantly evolving, AHIMA should consider re-examining its revised Practice Brief again in two years’ time.

Thank you very much for your time and consideration,

Cindy Basham, MA, RN, CPC, CCS
Gloryanne Bryant, BS, RHIA, RHIT, CCS
Jean S. Clark, RHIA
Wendy De Vreugd, RN, FNP
Colleen Garry, RN, BS
Robert S. Gold, MD
William E. Haik, MD
Tamara Hicks, RN, BSN, CCS
Pam Lovell, MBA, RN
Shannon McCall, RHIA, CCS, CPC
Brian Murphy, CPC
Lynne Spriyak, RN
Heather Taillon, RHIA

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at www.copyright.com or 978/750-8400.
Unspecified or aspiration pneumonia? Clinical clues in the record can provide the answer

by William E. Haik, MD

When it comes to problematic diagnoses and proper ICD-9-CM coding, aspiration pneumonia is at or near the top of the list. The big question is: When should a CDI specialist suspect aspiration pneumonia in a medical record in which the physician merely documents “pneumonia”?

The reimbursement implications of obtaining a more specific aspiration pneumonia diagnosis are great. For example, the highest-weighted simple pneumonia DRG (MS-DRG 193, Simple pneumonia & pleurisy with MCC) has a relative weight of roughly 1.2, whereas the highest-weighted complex pneumonia (MS-DRG 177, Respiratory infections & inflammations with MCC) has a relative weight of 1.8 (see “Charting pneumonia payment” below).

Therefore, when a physician merely documents “pneumonia,” it falls on the CDI specialist’s shoulders to look for clinical evidence that might lead to a more specific type of pneumonia (e.g., aspiration pneumonia). Look for clinical clues in the record in order to query the physician and obtain the right diagnosis.

Identify conditions of aspiration pneumonia

To diagnose aspiration pneumonia, a patient must have two conditions:

1. A neurological condition that causes aspiration into the vocal chords. Patients do not aspirate easily. The larynx (the trapdoor that opens to the lungs) is extremely sensitive to acid. When acid reaches the vocal chords, the patient will cough in reflex.

   Conditions that impair the brain (e.g., stroke, seizure, Alzheimer’s disease, or a drug overdose) can impair this defense mechanism, causing the brain to fail to sense reflexes from the vocal chords. Additionally, some neurological diseases (e.g., Parkinson’s disease) and some types of strokes can cause the vocal chords to not close properly when they are doused with acid.

2. Gastrointestinal conditions that cause regurgitation. Patients have protective mechanisms that keep the stomach’s contents from regurgitating into their esophagus and up into the vocal chords. But conditions can develop that overwhelm

---

Charting pneumonia payment

- MS-DRG 177: Respiratory infections & inflammations with MCC, relative weight (RW) 1.8444
- MS-DRG 178: Respiratory infections & inflammations with CC, RW 1.5636
- MS-DRG 179: Respiratory infections & inflammations without CC/MCC, RW 1.2754
- MS-DRG 193: Simple pneumonia & pleurisy with MCC, RW 1.2505
- MS-DRG 194: Simple pneumonia & pleurisy with CC, RW 1.0235
- MS-DRG 195: Simple pneumonia & pleurisy without CC/MCC, RW 0.8398

continued on p. 14
Pneumonia
continued from p. 13

these defense mechanisms. For example, hiatal hernia reflux esophagitis is a condition in which the stomach prolapses into the chest or nasal/percutaneous feeding tubes.

If these two conditions are present in the record, a CDI specialist can begin to suspect the presence of aspiration pneumonia and develop an appropriate physician query.

Don’t overlook the subtle clues

Additional clues that may lead to a query for aspiration pneumonia include:

» Right lower lobe pneumonia. This type of pneumonia is not uncommon in patients who suffer from aspiration pneumonia. This area of the lung is predisposed to aspiration.

» A documented swallowing disorder that occurs during the patient’s hospital stay. If a speech therapist performs a swallowing test to determine that a patient has a swallowing disorder, this may be an indication that the patient has aspiration pneumonia. Note that the absence of a swallowing disorder at the time of a test does not rule out aspiration pneumonia.

» Documented antibiotics. When the patient’s medical record contains documentation that a physician is providing antibiotics commonly used to treat aspiration pneumonia, this may be grounds for a query. For more information about formulating an effective, compliant query, see “Cut to the chase when querying physicians” below.

Editor’s note: Haik is director of DRG Review, Inc., in Fort Walton Beach, FL, where he has practiced medicine since 1980. He has received board certification in internal, pulmonary, and critical care medicine. Haik served on the editorial advisory board of AHA Coding Clinic for ICD-9-CM from 1988–1992 and subsequently on the expert advisory panel. Presently, he serves on the Hospital Payment Monitoring Program with the Florida Quality Improvement Organization.

Cut to the chase when querying physicians

Some state quality improvement organizations (QIO) are debating about what formulates a compliant query, particularly one that does not “lead” the physician into documenting an inappropriate diagnosis.

However, William E. Haik, MD, director of DRG Review, Inc., in Fort Walton Beach, FL, says that it is appropriate to ask a direct question to the physician regarding the presence of a diagnosis, provided that clinical evidence in the medical record supports the question.

CDI specialists should keep in mind that it’s not how you ask the query, but why you ask the query, Haik says. “We can argue about what is and isn’t a leading question, but it really comes down to why you are asking it,” says Haik. “Are you asking it because there’s clinical information in the record that makes you think that a more complete or specified diagnosis is present? Or are you asking it because you just want more money?”

The battle over leading vs. nonleading queries in terms of how they are phrased is missing the point, Haik says, adding that the 2000 American Health Information Management Association practice brief on querying is inadequate. “Leading is asking a question when there’s no evidence in the medical record that makes you think that the condition is there,” he says. “But if you think that condition exists due to information in the medical record, if you don’t ask specifically for that diagnosis, you won’t arrive at the right answer.”

For example, consider this example of a direct, effective, and compliant query for aspiration pneumonia:

Dear Dr. Smith,

For this nursing home patient who was admitted with a prior cerebrovascular accident, a decrease in sensorium, and a history of vomiting, can the patient’s pneumonia be further specified as a suspected aspiration pneumonia?

Each QIO has a different stance on what constitutes a leading query. Therefore, Haik recommends that CDI specialists consult their state QIO before changing their query process.
Clinical guidelines for reporting aspiration pneumonia

Introduction
The final diagnostic impression, documented by the responsible physician, must be clinically supported in the current medical record. When the documentation is unclear, the responsible physician must be queried prior to final reporting. Additionally, code assignment and sequencing must conform to official coding guidelines and conventions.

Clinical guidelines of aspiration pneumonia
In order for a patient to have a pneumonia diagnosis, a patient must currently be or have been treated with at least one item from each of the following three categories:

1. Signs and symptoms of pneumonia: Fever > 100.4° or hypothermia < 96.8°, chills, difficulty breathing, worsening cough, malaise/lethargy, acute onset of confusion or obtundation, pleuritic chest pain, purulent sputum production, tachypnea > 20, rales/crackles, decreased or coarse breath sounds, or evidence of consolidation.
   Note: The above signs and symptoms may be subtle or absent in the elderly.

Pulmonary infiltrate: An acute pulmonary infiltrate may not be evident on the initial chest x-ray in the presence of dehydration, leukopenia, with aspiration of a small volume, or normal pH, especially in the presence of structural lung disease, such as chronic obstructive pulmonary disease, pulmonary fibrosis, etc.

AND

2. Treatment with IV antibiotics

AND

3. Neurological and gastrointestinal risk factors for aspiration pneumonia: Impaired gag reflux (as from a cerebrovascular accident, Parkinson’s disease, decreased sensorium, etc.) and impaired swallowing (as from a gastroesophageal reflux disease, esophageal obstruction, PEG/feeding tube, etc.).

OR

Abnormal swallowing study revealing evidence of aspiration

OR

Specific treatment for aspiration pneumonia, including aspiration precautions, speech or physical therapy, PEG tube insertion, etc.

Source: William E. Haik, MD, director of DRG Review, Inc., in Fort Walton Beach, FL.