CODING TIPS & TRAINING

To Query or Not to Query... That Is the Question: Partnering on Clinical Validation to Prevent Denials

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Coding guidelines are forever changing, and this certainly keeps coders on their toes. It is the responsibility of the coder to assign codes based on documentation in the chart and as guided by the code-set and the official coding guidelines. But what happens when documentation in the chart is not clear cut? When this occurs, it creates an opportunity for coders and CDI to work together in educating physicians in understanding the required elements of documentation and why, at times, their documentation is insufficient for proper code assignment. The team approach between the coder, CDS and physician is essential for accurate documentation and code assignment to appropriately reflect the severity of illness of the patient and to assure proper reimbursement. A query is an excellent tool and has proven to be successful in clarifying documentation and assisting in accurate data collection.

In October, 2016, a new coding guideline was released which further clarified the use of the query in the coding process.[1] It states: "Code assignment and Clinical Criteria: The assignment of a diagnosis code is based on the provider's diagnosis statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinic criteria used by the provider to establish the diagnosis."

Based on the new guideline, if a diagnosis is explicitly documented by the physician it is to be coded, period. With that being said, third party payers will at times deny claims that have diagnoses documented that are not supported by the clinical indicators. Therefore, it is essential that the documentation in the record supports the true clinical picture of the patient. This new coding guideline has placed greater emphasis on the CDS' role in clinical validation to ensure physician's documentation of the patient's conditions and interventions is consistent with diagnoses.

It is essential that documentation issues be resolved concurrently to ensure that clinical criteria meets the stated diagnosis. It also ensures that the physician understands the required elements of documentation to prevent the denial of claims. Coders will need to continue to use their critical thinking skills to recognize the need to discuss a case with CDI if a diagnosis is not supported in the documentation.

Once again, there's never a dull day in the world of HIM. Teamwork is the key to success!

Partner with UASI and allow our experienced teams of experts to assist you in managing and preventing claim denials.

[1] Changes to the ICD-10-CM Official Guidelines for Coding and Reporting, Coding Clinic, Fourth Quarter 2016: Page 118

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