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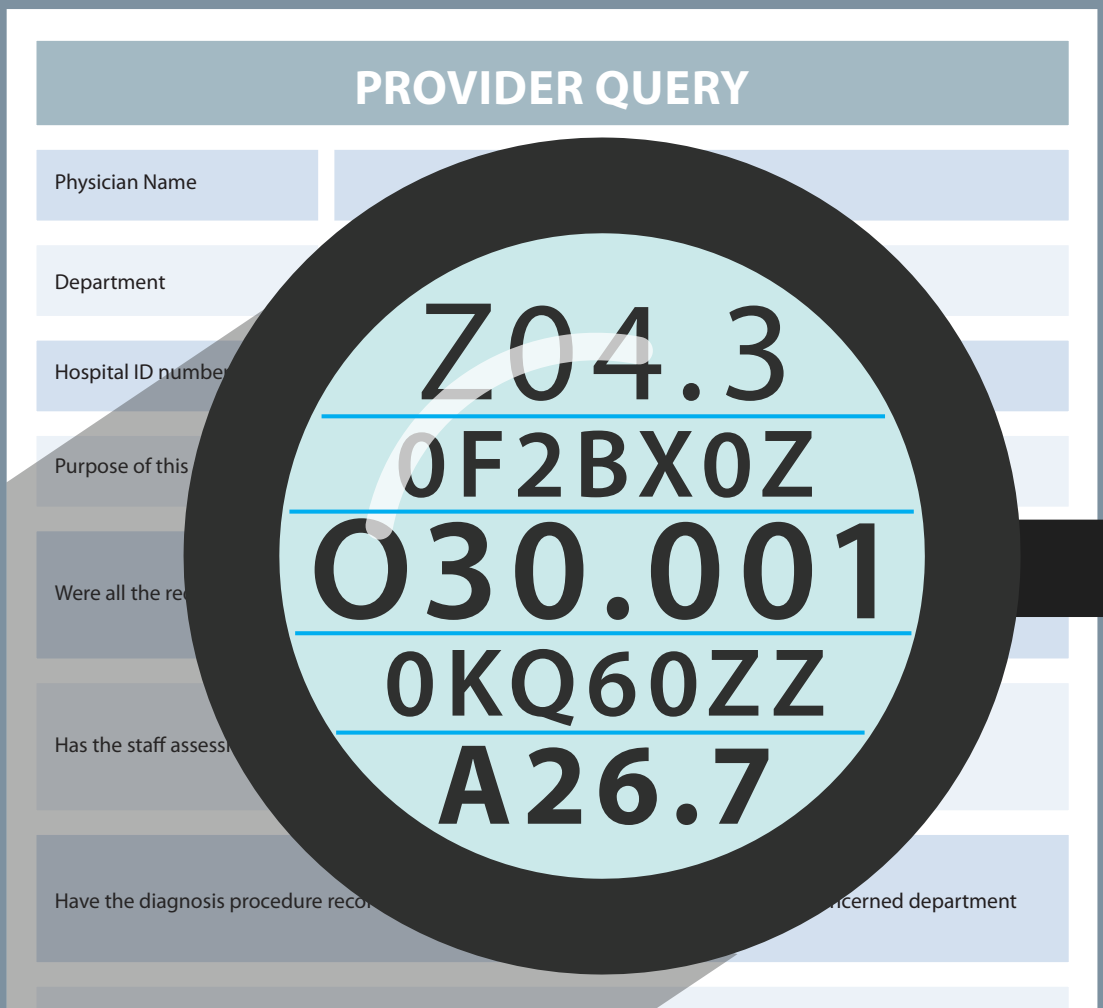
The Coder's Guide to Physician Queries

Adrienne Commeree, CPC, CPMA, CCS, CEMC, CPIP



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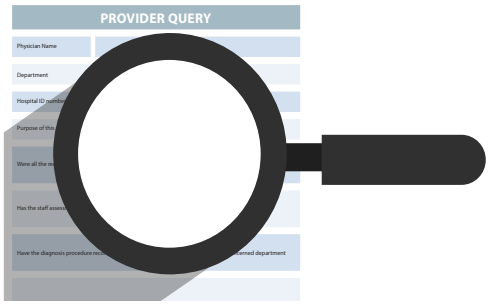

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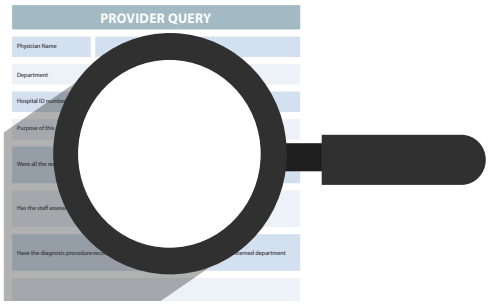


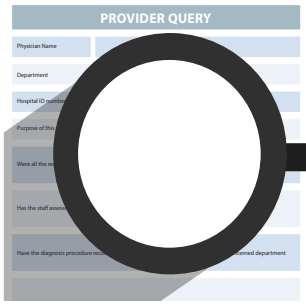
About the Author

Adrienne Commeree, CPC, CPMA, CCS, CEMC, CPIP

Adrienne Commeree, CPC, CPMA, CCS, CEMC, CPIP, serves as a regulatory specialist teaching the Certified Coder Boot Camp® programs. She is an instructor with extensive knowledge of inpatient coding guidelines as well as E/M and auditing guidelines. She has many years of experience in the healthcare industry, including coding, auditing, training, and compliance expertise.

Prior to joining HCPro, Commeree was a coding auditor/medical assistance program specialist with the Washington State Health Care Authority (HCA)'s Clinical Review Unit, working within the state's Medicaid program. She oversaw inpatient coding audits for the majority of Washington's hospitals, which included audits for inpatient claims, diagnosis-related group assignments, and coverage and payment policies. She also served as a coding consultant to other HCA departments by helping providers, policymakers, and data analysts to identify aberrant coding patterns and potential fraud, waste, and abuse.

Before working for Washington, she served as a coding specialist and trauma registrar with Trauma Trust, an organization that serves two major healthcare systems in the Tacoma area by providing level II trauma and acute care surgical services.



Introduction

The Coder's Guide to Physician Queries

As coders, we are tasked with reviewing volumes of medical records and translating the information into a type of shorthand, or codes. What may seem fairly straightforward is anything but, as disease processes and procedures performed to diagnose and treat these conditions can range from a simple excision of a benign mole to a quadruple coronary bypass on a patient with multiple comorbid conditions. CMS informs us that a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.

CMS developed guidelines to help us and our providers, but what happens when these guidelines aren't enough? How do we convey to the provider the documentation we need to accurately report the condition of the patient? According to CMS, the importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, accurate coding cannot be achieved. With the advent of ICD-10, the emphasis on accurate and complete coding ballooned, along with the volume of new codes. Hence, the physician query tool became essential to coders.

But what is a query, and why is such a device needed? The American Health Information Management Association (AHIMA) answers this question in the 2016 "Guidelines for Achieving a Compliant Query Practice" by stating:

> *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. The final coded diagnoses and procedures derived from the health record documentation should accurately reflect the patient's episode of care.*

The trouble is that physicians rarely learn about the intricacies of healthcare coding or the documentation requirements that coders must follow in order to assign a code. They know little, if anything, about how their documentation translates into various code sets for billing, research, and quality control and reporting efforts.

Such hand-in-hand relationships are essential to code assignment and reporting of diagnoses and procedures. In addition, the importance of consistent, complete documentation in the medical record is paramount—such sentiments are echoed in nearly every government statement regarding query practices. Without such documentation, accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

Initially, AHIMA's Code of Ethics offered a single set of rules, and its 2001 brief "Developing a Physician Query Process" provided additional direction. In 2008, AHIMA offered further clarification with briefs entitled "Standards of Ethical Coding" and "Managing an Effective Query Process." These directives aimed to simplify querying practices and to expand AHIMA's governance to include anyone involved in the process, regardless of their professional background.

Any discussion of coding should pay particular attention to the concept of "compliance." A variety of healthcare organizations have come under investigation for inappropriate query practices, including submitting leading queries, upcoding, and other concerns. Recovery Auditors target high-volume diagnosis areas and deny claims for which the medical record lacks supportive clinical evidence. Many auditors have even started to request query forms during their medical record reviews.

The question of what, exactly, constitutes a "leading" query has been the subject of much debate throughout the various query guidelines over the years. AHIMA's 2016 "Guidelines for Achieving a Compliant Query Practice" defines a leading query as follows:

> *One that is not supported by the clinical elements in the health record and/or directs a provider to a specific diagnosis or procedure.*

Throughout *The Coder's Guide to Physician Queries*, we will address the various government, coding, and industry developments that have shaped coding and query practices, offer examples of various query forms, and discuss how to craft effective and compliant query policies and procedures in an electronic world. Also, we will discuss the benefits of having coders and inpatient and outpatient clinical documentation improvement (CDI) specialists working together. If nothing else, those who purchase this edition should gain an awareness of the importance of creating specific policies and procedures governing

facility query efforts. Such policies should be consistent across departments and should address processes for query retention, reconciliation, and escalation, among other items.

For healthcare providers (e.g., physicians, nurse practitioners, physician assistants, nurses, respiratory therapists, and their extenders) and data quality specialists—as well as HIM and CDI specialists who compliantly interpret, abstract, and code documented clinical information into administrative coded data sets—success is about relationships. A few years back, the relationship between CDI professionals and coders and physicians was still relatively new. Many argued for different query rules depending on the professional submitting the query and the timing—either concurrent or retrospective—of the query. Discussions regarding the best type of query form to use for each diagnosis type also raised questions. Some professionals indicated that open-ended, formless queries were best, while others opined that only multiple-choice query forms should be used, and still others indicated that verbal encounters presented the best option. These concerns only grew as facilities introduced electronic health records, which brought additional challenges and questions regarding the electronic query.

Despite the volumes of query advice now available, definitive solutions remain elusive. As the adage goes, the solution is not black or white but is rather a shade of gray. Each query submitted must be used to best reflect the conditions and response sought. For example, the latest query guidance permits "yes/no" queries, which will be helpful as CDI specialists and coders work to clarify cause-and-effect relationships needed for accurate present-on-admission status and ICD-10-CM/PCS code assignment.

The heart and soul of successful query processes depend on crafting useful policies and effective relationships across departmental lines. Successful processes depend on the ability of the provider and the HIM professionals to be conscientiously and consistently aware of each other's backgrounds, biases, wants, and needs.

Failure to adequately foster these relationships frequently proves detrimental, not only to personal and professional relationships but also to the care of the patients themselves. In healthcare, lives really are at stake—even when it comes to appropriate documentation and application of transactional code sets.

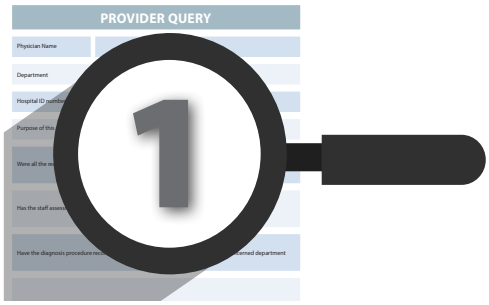
There are consequences for failing to understand this critical link between patient treatment and the documentation and coding for that treatment. ICD-10-CM/PCS and CPT® coding based on nonspecific physician documentation has led insurers to issue clinical denials and even raise patient copayments for certain "inefficient" providers, particularly those in tiered networks currently advocated by insurers and increasingly affecting Medicare payments via the hospital value-based purchasing program.

In the same light, coding from nonspecific physician documentation has led to negative publicity for hospitals and their physicians, conveyed via publicly reported mortality data posted on the CMS Hospital Compare website and other public websites. Here, some providers have high risk-adjusted readmission and death rates for community-acquired pneumonia, heart failure, myocardial infarction, or other conditions and procedures based on ICD-10-CM/PCS coded data. Communities have witnessed their local hospitals close in part due to providers' and coders' inability to negotiate the code-based reimbursement systems that are integral to establishing medical necessity, which is required for accurately assigning diagnosis-related groups for inpatient reimbursement and for assigning Hierarchical Condition Categories for outpatient services that are paid by accountable care organizations. Moving forward, physicians will be paid under a value-based purchasing system that depends on coded data for risk adjustment. As the government and the public continue to demand improvement quality of care, cost control, and transparency of data, the physician documentation and coder translation of the medical record becomes almost as vital as the care that the patient receives.

Although various stakeholders may not share the same interests or incentives, everyone involved—from physicians to administrators, from program directors to coders and CDI staff—must have familiarity with and empathy for each professional's contributions to the healthcare system. This will help bridge the communication gaps that exist and improve the quality of healthcare. Although reading literature and going to school helps, the best (and sometimes the only) way to learn about another person's world is to ask and listen. Every question deserves a respectful answer.

This book is dedicated to the coders, clinicians, midlevel providers, and physicians who diligently work every day to develop and support the professional relationships and processes that are essential to ensuring coded data quality.

As ever, we are grateful to the many colleagues, clients, and peers who continue to challenge us to achieve excellence. A special thank you to Amanda Norris for your feedback, insight, and support in the creation of this book.



The Evolution of Healthcare Reimbursement

In the past 30 years, as the government has attempted to rein in the unsustainable healthcare costs of an aging population, rules governing healthcare reimbursement in the United States have evolved dramatically. The question of the solvency of the government's healthcare programs has fallen victim to political ideology within the past decade. Total Medicare spending has been projected to increase from $703 billion in 2016 to $1.167 trillion by 2024. Enrollment in that time period is projected to increase from 56.1 million to 70.3 million (CMS, 2017a).

Over the years, the government has developed a number of initiatives to handle the dilemma, shifting the focus of payment away from episodic reimbursement to funding based on clinical outcomes and the quality of care provided across the healthcare continuum. In this chapter, we discuss two such payment shifts as representatives of this initiative—the implementation of diagnosis-related groups (DRG) and pay-for-performance strategies—to highlight the important roles of physician documentation and compliant coding queries in this landscape.

In the course of changing the way it pays for services, the government has kept its eye trained on inappropriate healthcare billing and outright fraud with the implementation of Recovery Auditors, Medicare Administrative Contractors, and other efforts. In this environment, clinical documentation improvement (CDI) programs have flourished, and this program works hand in hand with accurate coding. However, the reasons for such growth are not limited to the aforementioned trends. Some are more complex—from implementation of electronic health record systems and computer-assisted coding to the transition to the International Classification of Diseases, 10th Revision (ICD-10)—all of which require the capture of specific documentation to be effective.

Add to this the knowledge that data extrapolated from documentation is used in a variety of ways by a variety of organizations—everything from Medicare and Medicaid reimbursement, federal and private quality reporting systems, and even national publications that rank the quality of hospitals and physicians—and the need for accuracy becomes even more important. Yet the clinical language written

by physicians frequently does not match the nuanced language required by coders. Ongoing shifts in healthcare regulatory and reimbursement requirements only increase the challenges that coders face in translating physician documentation into applicable codes.

The goal of any facility is to address these complex issues by working across departments in order to obtain complete and accurate documentation of the severity of illness and care provided. The primary tool used to accomplish this task is the physician query.

Now, let's review how the historical changes in healthcare reimbursement led to the vital need for queries and how current changes in that arena are shifting the focus of coding efforts.

Advancement of Payment Methods

To understand how documentation influences hospital reimbursement, coders must first understand how the federal government, through CMS, pays for those services.

In 1965, Medicare reimbursed healthcare based on actual charges. The federal government introduced the inpatient prospective payment system (IPPS) in October 1983 as a way to influence hospital behavior through financial incentives and, in effect, encourage more cost-efficient management of medical care. Three years later, in 1986, CMS created the DRG system. This system summarizes the care provided during each patient's stay, grouping up to 24 secondary diagnoses that indicate comorbidities and complications (CC) and up to 25 procedures completed during the patient's stay into a DRG based on the principal diagnosis. The idea was to group diseases together based on comparative costs (CMS, 2017b).

In this system, instead of receiving a payment for each charge submitted, hospitals would receive one pre-dictated sum of money regardless of the number of tests performed or length of stay. By changing the reimbursement system, CMS felt that hospitals would be incentivized to control costs and length of stay so that they could remain profitable.

Almost 20 years later, in August 2007, CMS finalized its plans to implement the new MS-DRG system as detailed in the fiscal year (FY) 2008 IPPS final rule. More than 700 new MS-DRGs replaced the previous 538 DRGs. Additionally, the CC classification expanded to include major complications and comorbidities (MCC), conditions that require more resources than simple CCs (CMS, 2017b).

GETTING MORE SPECIFIC: AN MS-DRG EXAMPLE

A patient is hospitalized with a gastrointestinal hemorrhage. The physician documents that the patient also has congestive heart failure (CHF).

Under the MS-DRG system and ICD-10-CM, CHF unspecified is not a CC. However, if the physician further clarifies whether the CHF is chronic diastolic (I50.32) or chronic systolic (I50.22), it becomes a CC. Further, if a physician specifies CHF as acute diastolic (I50.31) or acute systolic (I50.21), it qualifies as an MCC.

The catch, as always, is that physicians must be precise with their documentation. For example, even documentation of "acute left heart failure" will not result in an MCC. The words "acute" along with the type, as well as "diastolic and systolic" or "combined systolic and diastolic" congestive heart failure, must be documented to code the MCC. This level of specificity makes an enormous difference in the MS-DRG assigned.

In a press release, CMS Acting Deputy Administrator Herb Kuhn stated that Medicare payments for inpatient services "will be more accurate and [will] better reflect the severity of the patient's condition" (CMS, 2007). CMS also said that the new system would support facilities caring for sicker patients and would help to prevent abuses:

> *Under the old DRG system (with payments based on broad averages) incentives could lead hospitals to cherry pick—the practice of treating only the healthiest and most profitable patients (CMS, 2007).*

One of the more controversial components of MS-DRG implementation was the assessment of a documentation and coding payment adjustment (DCA). The DCA decreased reimbursement based on the assumption that facilities would see an increase in their case-mix index not due to an actual increase in cases or care provided but simply due to the more explicit documentation and coding that the new system required.

Although some labeled this "DRG creep," many pointed to the improvements as the natural outcome of increased cooperation between the coder and provider to accurately define, document, and code patient conditions using appropriate terminology. In fact, given that hospitals faced a new DRG methodology and across-the-board reimbursement cuts by way of the DCA, many believed that hospitals were being incentivized (and were encouraged by the American Health Information Management Association

[AHIMA]) and other professional organizations) to partner with physicians to improve the definition and documentation of treated conditions.

In fact, the 2008 IPPS final rule included the following instruction:

> *We do not believe there is anything inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation in the medical record (CMS, 2008).*

Facilities began to find better ways to structure their query processes; to clarify imprecise, illegible, inconsistent, or otherwise incongruent physician documentation; and to refine or implement new concurrent record review and query processes to support the retrospective efforts already in place.

The good news with the new MS-DRG system was that coders would still follow the same principal/secondary diagnosis and procedure coding conventions as before. Furthermore, the MS-DRGs were expected to positively impact profiling and reimbursement for hospitals with a higher case-mix index (i.e., more severely ill patients) while requiring more complete and specific information regarding the patient's diagnoses and the care that physicians provided. The related Figure 1.1 illustrates the potential opportunity as well as the potential financial risk.

FIGURE 1.1

EXAMPLE OF A DRG CHART REVIEW

Deficiency	Volume	Revenue implication
None	34	0
DRG documentation opportunity	10	$65,867
SOI/ROM* documentation opportunity	7	N/A
Coding DRG opportunity	4	$23,452
Coding SOI/ROM* opportunity	4	N/A
Potential coding risk	2	$-10,422
Total		$78,897

*Additional documentation or coding would not change the DRG; however, it would change the APR-DRG severity of illness and/or risk of mortality for the case.

Source: The Essential CDI Guide to Provider Queries.

Although assigning a DRG based on the principal diagnosis and procedure remained essentially the same under the new MS-DRG system, considerable reorientation was needed to understand how the newly added and deleted CCs and MCCs affected secondary-diagnosis assignment and sequencing practices. Additionally, although the shift to MS-DRGs did not change the coding structure and process, it made various stakeholders along the healthcare chain of command more aware of the documentation specificity required to appropriately capture the CC/MCC. Just like in the old system, it still takes only one CC or one MCC to change the MS-DRG. In other words, a single element could dramatically alter the clinical picture and the payment related to a given case.

HCCs

Medicare Advantage health plans have been using risk adjustment and Hierarchical Condition Category (HCC) coding as a payment model mandated by CMS since 1997. If we look at the claim review activity with Medicare Advantage, we recognize that unspecified codes are fairly nonexistent in their 11,000 conditions that contribute to one or more valid HCCs. This means that the risk adjustment factor (RAF) associated with patients in the Medicare Advantage program will likely decrease based on the less specific ICD-10 coding during the grace year.

HCCs are similar to DRGs and ambulatory payment classifications (APC). HCCs set a reimbursement amount for a year for a patient based on the conditions that were coded and claimed the prior year. Chronic conditions drive most of the HCCs. Similar to a DRG, the HCCs are based on anticipated resource utilization. If those chronic conditions are being addressed by the physician and recorded on the claim, more resources are being utilized and the chronic conditions will trigger the HCCs. Unlike DRGs, but like APCs, a patient's multiple conditions may qualify for multiple HCCs.

Each HCC has a RAF (similar to the weight assigned to DRGs). More complex or higher resource utilization HCCs have a higher RAF; conversely, less complex or less resource utilization HCCs have a lower RAF. Additionally, HCCs have some unique documentation requirements, including legibility, signed documents, and face-to-face requirements.

At the time that this book is being written, there is some disconnect between providers and this risk adjustment reimbursement approach. Medicare Advantage health plans are approved by CMS. CMS pays the health plan based on the claims that have been submitted by providers. If the claims depict chronic conditions being addressed by the provider, the reimbursement to the health plan is higher. If the claims depict a patient with no comorbidities, the reimbursement to the health plan is lower. Not all Medicare Advantage health plans are reimbursing the providers based on HCCs yet. Therefore, providers do not realize that their diagnosis coding is important.

The unspecified situation may cause the health plans to lose reimbursement. The Medicare Advantage health plans will not appreciate this, because the lower the RAF, the less the health plans are paid under the CMS reimbursement model. In turn, the unspecified impact will trigger health plan inspection of the coding submitted by participating providers, and the outcome of that scrutiny is likely to result in penalties on providers.

Pay for performance

In 1999, the Institute of Medicine reported that medical errors caused more than 50,000 preventable deaths each year, with an associated cost of $20 billion (IOM, 1999). The 2006 Institute of Medicine report "Preventing Medication Errors" recommended the following:

> *... incentives ... so that the profitability of hospitals, clinics, pharmacies, insurance companies, and manufacturers (are) aligned with patient safety goals; ... (to) strengthen the business case for quality and safety (IOM, 2006).*

When healthcare providers receive incentives for performing better—that is, providing better care in a more cost-efficient manner and meeting preestablished targets for the delivery of healthcare—along with disincentives, such as eliminating payments for negative consequences of care (medical errors) or increased costs, the quality of care for Medicare beneficiaries will improve. This is a fundamental change from the traditional fee-for-service and DRG payment methods. The various approaches used to achieve this goal are discussed below.

Signed on February 8, 2006, the Deficit Reduction Act (DRA) required CMS to identify hospital-acquired conditions (HAC) that do the following:

- Are high cost, high volume, or both
- Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis
- Could reasonably have been prevented through the application of evidence-based guidelines and are a CC or MCC for the MS-DRG system (CMS, 2017c)

In addition, as of October 2007, CMS began requiring assignment of present-on-admission (POA) indicators. The goal of the POA indicator is to better define clinical conditions or consequences that arise during an inpatient admission. Reporting options include the following:

- Y = present at the time of inpatient admission
- N = not present at the time of inpatient admission

- U = documentation is insufficient to determine whether condition is POA
- W = provider is unable to clinically determine whether condition was POA
- Blank = unreported/not used (or "1" for Medicare billing) = exempt from POA reporting

Figure 1.2 illustrates one possible query template that may be used to clarify whether a particular diagnosis was POA. It also allows CMS to identify whether a HAC is POA. If it was not (or documentation is insufficient to determine), then the diagnosis does not qualify as a CC or MCC for the MS-DRG assigned. Moreover, if it is the only CC or MCC, the case is assigned to the lower-paying MS-DRG and hence penalizes hospitals with poor quality.

FIGURE 1.2

SAMPLE POA QUERY FORM

Clarification is needed for one (or more) of the following conditions in order to assign the "present on admission" indicator accurately. Please check the box that indicates whether the associated condition was present at the time of the order for inpatient admission.

Y Yes	N No	U Unknown	W Clinically unable to determine	
❑	❑	❑	❑	_____
❑	❑	❑	❑	_____
❑	❑	❑	❑	_____
❑	❑	❑	❑	_____
❑	❑	❑	❑	_____
❑	❑	❑	❑	_____
❑	❑	❑	❑	_____
❑	❑	❑	❑	_____

Please sign and date below:

_____ _____

Physician signature Date

Source: The Essential CDI Guide to Provider Queries.

In addition, on October 1, 2014, CMS launched the Hospital Acquired Condition Reduction Program (HACRP)—see Chapter 2 for more information—to incentivize hospitals to reduce HACs. This is part of the value-based purchasing program.

Value-based purchasing

In 2010, the Patient Protection and Affordable Care Act (ACA) required the U.S. Department of Health and Human Services to establish a value-based purchasing (VBP) program for inpatient hospitals and, on May 6, 2011, CMS published the VBP final rule. Whereas the CMS Hospital Inpatient Quality Reporting (IQR) program is a pay-to-report structure (i.e., hospitals receive payments for reporting data), the VBP program provides financial incentives based on adherence to processes and outcomes. It acts in tandem with the IQR.

Starting in FY 2013, CMS began withholding 1% of the base operating MS-DRG payments for each discharge, with plans to gradually increase the amount withheld. This allows CMS to create a pool of money that is then used to reward hospitals with higher quality (Quality Net, n.d.a).

The initial 2013 VBP program adopted performance measures under the following two "domains":

1. Clinical process, composed of 12 measures
2. Patient experience, composed of the Hospital Consumer Assessment of Healthcare Providers and Systems survey

Hospitals are evaluated based on whether they met the performance standards for the measures by comparing their performance during the performance period to their performance during a three-quarter baseline period. Each hospital is scored based on achievement and improvement ranges for each measure. Then, a total performance score is calculated by combining the greater of the hospital's achievement or improvement points for each measure to determine a score for each domain.

CMS then converts each hospital's total performance score into a value-based incentive payment.

RECENT PERFORMANCE SCORING PLANS

For the final score, each domain score is weighted as follows:

2016

- Outcome domain = 40%
- Clinical process of care domain = 10%
- Patient experience of care domain = 25%
- Efficiency domain = 25%

2017

- Clinical care = 30%
- Process of care = 5%
- Outcomes = 25%
- Efficiency domain = 25%
- Safety domain = 20%
- Patient experience of care domain = 25%

2018

- Clinical care = 25%
- Patient- and caregiver-centered experience of care/care coordination = 25%
- Safety = 25%
- Efficiency and cost reduction = 25%

2019

- Clinical care = 25%
- Person and community engagement = 25%
- Safety = 25%
- Efficiency and cost reduction = 25%

Sources:

Medicare, Hospital Compare. 2017. "The Total Performance Score information." Retrieved from *www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228772237147.*

Stratis Health. 2016. "FY 2017 Value-Based Purchasing Domain Weighting." Retrieved from *www.stratishealth.org/DOCUMENTS/VBP-FY2017.PDF.*

In 2014, CMS added two more domains to the hospital VBP scoring methodology. The first of these outcome domains encompasses 30-day mortality rates for acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PNA). It also includes Agency for Healthcare Research and Quality's (AHRQ) Patient Safety Indicator (PSI) 90, which is a composite of patient safety measures using coded data. Second, an efficiency domain was added that measures Medicare spending per beneficiary. This measure includes all Medicare

Part A and B payments from three days prior to admission through 30 days postdischarge. Both domains are risk-adjusted to account for the severity of the patient's illness (Quality Net, n.d.a).

Hospital Readmissions Reduction Program

Beginning in 2013, Section 302 of the ACA established the Hospital Readmissions Reduction Program. The program requires CMS to monitor hospitals with excessive readmissions for AMI, HF, and PNA, which are measured by dividing a hospital's number of predicted 30-day readmissions by the number that would be expected based on an average hospital with similar patients. A ratio greater than one indicates excess readmissions and is subject to a payment penalty.

In 2015, CMS expanded the measures to include monitoring of readmissions for chronic obstructive pulmonary disease (COPD) and elective primary total hip and/or total knee arthroplasty (THA/TKA). Then, in 2016, CMS updated the pneumonia readmission measure by expanding the measure cohort to include the following additional pneumonia diagnoses:

- Patients with aspiration pneumonia
- Sepsis patients coded with pneumonia present on admission (but not including severe sepsis) (CMS, n.d.a)

Although the program only monitors certain DRGs, a hospital's base rate for *all* DRGs during that fiscal year will be adjusted based on readmission rates. Figure 1.3 illustrates how these payment reductions have played out over time. Under such financial constraints, facilities must have a mechanism that both ensures accurate physician documentation and information collection and promotes collaborative effort among medical staff, coders, CDI, case management, and quality team members.

Additional pay-for-performance initiatives made headlines in early 2013 when New York City's Health and Hospitals Corporation, the nation's largest public health system, entered into negotiations with its physician unions to tie bonuses of nearly $60 million through 2016 to their quality measures (CMS, n.d.b).

Although the onset of MS-DRGs may have increased the need for accuracy in the medical record, the implementation of VBP is changing the focus of those programs dramatically. They are shifting away from CC/MCC capture rates ("one and done") and case-mix index ratios and toward capturing the complete specificity of the entire medical record and facilitating documentation improvement conversations across departmental lines.

FIGURE 1.3

VBP REDUCTIONS

Value-based purchasing, Hospital Readmissions Reduction Program, and hospital-associated conditions reimbursement incentives

FY 2013	VBP 1%	HRRP 1%		2%
FY 2014	VBP 1.25%	HRRP 2%		2.25%
FY 2015	VBP 1.5%	HRRP 3%	HAC 1%	5.5%
FY 2016	VBP 1.75%	HRRP 3%	HAC 1%	5.75%
FY 2017	VBP 2%	HRRP 3%	HAC 1%	6%

Source: The Essential CDI Guide to Provider Queries.

To make such a shift requires programmatic changes in a facility's health information management department. It may require additional staffing or changes to productivity requirements. It may require additional education for coders, CDI specialists, and physicians, or changes to institutional query forms to incorporate elements of the VBP initiative (Hartocollis, 2013).

Regardless, facilities with CDI programs and query efforts in place will undoubtedly fare better than those without any concurrent review and query program. Programs that continue to focus solely on CC/MCC capture will need to expand and recalibrate their query efforts to include documentation that supports POA, quality, and risk adjustment.

Meaningful use

Beginning in 2011, CMS and the Office of the National Coordinator for Health Information Technology (ONC) developed Electronic Health Records (EHR) Incentive Programs. The programs, commonly referred to as "meaningful use," established incentive payments to encourage eligible professionals and eligible

hospitals, critical access hospitals (CAH), and Medicare Advantage Organizations to adopt and demonstrate meaningful use of certified health information technology (HIT) and qualified EHR technology.

The goals of the meaningful use program include the following:

1. Improving quality, safety, and efficiency
2. Reducing health disparities
3. Engaging patients and families in their health
4. Improving care coordination
5. Improving population and public health
6. Ensuring adequate privacy and security protection for personal health information

To meet these goals, the program has been organized into three stages, which CMS updates each year:

Stage 1: Data capture and sharing

Stage 2: Advanced clinical processes

Stage 3: Improved outcomes

Failure to meet the criteria for each designated phase within a predefined period of time will result in a penalty. The penalties collected are then given to those facilities who have successfully implemented EHR technology and demonstrated meaningful use as set by the criteria at each stage.

Coders can have a significant role in each stage of the EHR implementation process and can also reap the benefits in the physician query process. Electronic patient records contribute to much clearer and more legible information, and the EHR is a central repository of information that allows caregivers timely access and input of all patient information. In that context, it is the coder's role to ensure that the record's quality and accuracy meets the needs of all who use the information. This role has never been more critical.

All of these changes speak to the importance of accurate and compliant documentation, including a need for a structured concurrent and retrospective physician query processes. In fact, one of the greatest challenges comes from helping physicians understand the reporting language of the clinical care they provide. The rest of this book explores how to accomplish concurrent and retrospective queries in a manner that is compliant and that promotes accuracy, quality, and VBP reimbursement.

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JustCoding

The Coder's Guide to Physician Queries

Adrienne Commeree, CPC, CPMA, CCS, CEMC, CPIP

Thanks to the frequent ICD-10-CM/PCS code updates, policy changes, and advancing electronic query systems, coders are being pushed in challenging new directions which require them to redefine where and how they generate queries. Meanwhile, coding managers need innovative solutions to improve their query process, target high-risk diagnoses, and educate delinquent providers, coders, or CDI professionals. This book provides a comprehensive analysis of query guidelines and easy-to-follow strategies to improve these processes and train coders effectively on how to develop and execute physician queries.

Using the guidance provided in this book, coding departments can update practices and train coders to meet the challenges of ICD-10-CM/PCS, government payer initiatives, auditor denials, and electronic initiatives.

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