Querying:
Getting it right the first time

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September 2013
Today’s presenter:

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Disclaimer

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Objectives: What will we cover today?

- How will ICD-10 affect querying?
- When should I query?
- Punctuation and formatting
- Don’t lead me on – how to avoid creating leading queries
- Three query formats: open-ended, multiple choice, yes/no
  - Appropriate uses
  - Recommended uses
- Hands-on practice
Introduction

Physician queries are questions sent to a physician or other qualified provider**, to clarify the content of a medical record.

Queries should become a part of the official medical record (ex. some facilities log query information into a separate database, and the query form is discarded). If it doesn’t, 3rd party reviewers (payers, quality, legal, etc.) may not receive the query information, leading to disagreements in coding and medical necessity.

(**the provider being queried must be actively participating in the care of the patient for the admission/encounter)**
Background: What are CCs/MCCs?

CCs (Complications and Comorbidities)

MCCs (Major Complications and Comorbidities)

Complication: disease or condition that occurs in the same patient at the same time as another disease. (Usually occurs after admission.)

Comorbidity: a disease or other pathological process that occurs simultaneously with another disease or pathological process. (Usually is present on admission.)

Both increase medical complexity, and significantly influence/increase the management or treatment of the patient.
Background: What are CCs/MCCs?

How do CCs and MCCs affect DRG?

Ex. DRG 377-379
377 GI hemorrhage with MCC Weight: 1.7817
378 GI hemorrhage with CC Weight: 1.0168
379 GI hemorrhage without CC/MCC Weight: 0.7015

Ex. DRG 537-538
537 Sprains, strains, and dislocations of hip, pelvis, and thigh with CC/MCC Weight: 0.8638
538 Sprains, strains, and dislocations of hip, pelvis, and thigh without CC/MCC Weight: 0.6405

(DRG weights change every year; these numbers are examples only)
How will ICD-10 affect querying?

Coding questions/issues that occur in ICD-9 will continue and even be magnified in ICD-10.

ICD-10 will likely require more querying because we will need more specificity in documentation, including:

- laterality
- relationships between diagnoses and manifestations
- relationships between diagnoses and complications
- acuity
- Initial, subsequent, or sequela encounter

This is information that physicians may not be accustomed to providing.
How will ICD-10 affect querying?

Lack of documentation specificity results in using unspecified codes.

May not be a problem initially, but over time, unspecified codes will likely be:

- Downgraded (MCCs become CCs, or even become non-MCC/CCs altogether) → lower payment and case mix index
- No longer accepted by payers for establishing medical necessity of procedures → payment denials.
How will ICD-10 affect querying?

Many more combination codes in ICD-10-CM:

- Requires more documentation (can’t use these codes unless all pieces are documented, and causally linked)
  - Proximity of documented conditions doesn’t prove a relationship. There must be some linking verbiage (ex. due to, in the setting of, secondary to, with), or linking adjective (ex. diabetic neuropathy)

Ex. Diabetes, peripheral neuropathy → No relationship
Ex. 1. Diabetes. 2. Neuropathy → No relationship
Ex. Diabetic neuropathy → Related
Ex. Neuropathy due to DM II. → Related
How will ICD-10 affect querying?

ICD-10-PCS codes: All information must be documented in order to be coded.

Ex. Hip joint replacement  0SR902A
Medical & surgical; Lower joints; Replacement; Hip joint, right; Open; Synthetic substitute, metal on polyethylene; Uncemented

Ex. CT of coronary arteries  B22310Z
Imaging; Heart; CT; Coronary artery bypass grafts, multiple; Low osmolar; Unenhanced and Enhanced; No qualifier.
How will ICD-10 affect querying?

Coding Clinics: which ones from ICD-9 can be applied to ICD-10?

No clear answer on this yet. There are ICD-10 specific Coding Clinics coming out already, but reviewing and translating each ICD-9 CC into ICD-10 guidance will take a long time.
"This guy is going to be a coding nightmare."
When should I query?

Per AHIMA Guidelines for Achieving a Compliant Query Practice, generation of a query should be considered 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.

AHIMA Guidelines for Achieving a Compliant Query Practice, Journal of AHIMA February 2013
When should I query?

(continued):

- Provides a diagnosis without underlying clinical validation
- Is unclear for present-on-admission (POA) indicator assignment.
When should I query?

- Not every discrepancy should necessarily result in a physician query.
- Guard against query fatigue (both for the writer and for the physicians).
- Use your judgment on what is important and what isn’t important.
- Organizations should create internal policies for when to query, and who should query in what situations.
When should I query?

A query is recommended when the following are affected:

Inpatient:
- Principal diagnosis (affects DRG)
- Procedures that affect reimbursement (affects DRG)
- Discharge disposition (can affect DRG)
- MCCs and CCs (can affect DRG; also important on their own as severity measures)
- HACs (Hospital Acquired Conditions)
- POA (Present on Admission) status

Outpatient:
- First-listed diagnosis
- Any diagnosis that provides medical necessity for a procedure.
- Any CPT code
Why is good querying important?

Poorly written queries mean:

- Physicians get frustrated – they can’t figure out what you want.
- Coders get frustrated – you’re not getting helpful answers.
- Inefficient money flow (More queries = more revenue on hold)
- Red flags with payers – leading queries may not be accepted by 3\textsuperscript{rd} party payers; chart may be tagged for more intensive review.
Punctuation and formatting are important!

Not convinced? Check out these advertisements:

• Jewelry World: Now is your chance to have your ears pierced and get an extra pair to take home, too.
• For sale: A quilted high chair that can be made into a table, potty chair, rocking horse, refrigerator, spring coat, size 8 and fur collar.
• Dinner Special -- turkey $2.35; chicken or beef $2.25; children : $2.00.
Punctuation and formatting

Queries must be clear, easy to understand, and easy to navigate (i.e., it must be easy to locate the information in them).

No one cares if you mix up “who” and “whom.” But everyone cares if it’s hard to figure where one sentence ends and the next one begins.
Punctuation and formatting

Top flaws found in queries:

1. Run-on sentences
2. Too much fluff and padding ("formal" speech)
Punctuation and formatting

Ex. Run-on sentences (a.k.a. Periods are your friend.)

Ack! #1 –

Acute respiratory failure is noted on discharge summary 5/6 pneumonia and hypoxia. Patient admitted with sepsis 5/6 pneumonia For coding accuracy please please clarify.

Ack! #2

Patient had UTI on admission progress notes 2/13, 2/14, and 2/15 document severe sepsis/sepsis due to UTI… Also UTI was present on admission, was the sepsis if indicated above to be accurate diagnosis Present on admission?
Ex. Run-on sentences (a.k.a. Periods are your friend.)

Ack! #3 --

ER record and progress note 4/17 states sepsis 4/18 dc summary states patient was admitted for intra-abdominal abscess and possible Gastrocutaneous fistula. Progress note 4/19 states Acute Respiratory Failure however discharge summary says nothing about respiratory failure.
Ex. Run-on sentences

Better --

ER record and progress notes 4/17 and 4/18 state sepsis. Discharge summary states patient was admitted for intra-abdominal abscess and possible gastrocutaneous fistula. Progress note 4/19 states Acute Respiratory Failure. Discharge summary says nothing about respiratory failure.
Ex. Run-on sentences

Bulleted or numbered lists are even clearer – helps you clarify your thoughts, and helps the physician find information quickly.

- ER record and progress notes 4/17 and 4/18 state sepsis.
- DC summary states patient was admitted for intra-abdominal abscess and possible gastrocutaneous fistula.
- Progress note 4/19 states Acute Respiratory Failure.
- Discharge summary says nothing about respiratory failure.
Punctuation and formatting

Bulleted/numbered list format is good for the answer choices too.

Q. Can the type of anemia be further specified as anemia unspecified, anemia, chronic blood loss, iron deficiency, due to chronic disease, or anemia other type please specify.

Versus:
Can the anemia be further specified as:
1. Chronic blood loss anemia
2. Iron deficiency anemia
3. Anemia due to chronic disease; please specify chronic disease ________________
4. Anemia of other type; please specify ________________
5. Anemia, cannot be further specified
Ex. Too much fluff and padding (“formal” speech)

Our attention was recently drawn to the fact that there is an unclear relationship in this account at your earliest convenience please review the following documentation. The ER record and progress notes 4/17 and 4/18 state sepsis. DC summary states Patient was admitted for intra-abdominal abscess and possible Gastrocutaneous Fistula can you please let me know if there is there a relationship between sepsis and fistula. Coding requests your attention to this matter as it is needed for proper coding and is greatly appreciated thank you for your attention.
Our attention was recently drawn to the fact that there is an unclear relationship in this account at your earliest convenience please review the following documentation. The ER record and progress notes 4/17 and 4/18 state sepsis. DC summary states patient was admitted for intra-abdominal abscess and possible gastrocutaneous fistula. can you please let me know if there Is there a relationship between sepsis and fistula? Coding requests your attention to this matter as it is needed for proper coding and is greatly appreciated Thank you. for your attention.
Queries: Don’t lead me on
Queries: Don’t lead me on

“Leading queries” is one of the biggest query-related concerns expressed by coders. What makes a query “leading”? How can we format our questions so that it’s not leading?

Definition* of a leading query:

“A leading query is one that is not supported by clinical elements, and/or directs the provider to a specific diagnosis or procedure.”

*AHIMA Guidelines for Achieving a Compliant Query Practice, Journal of AHIMA February 2013
Queries: Don’t lead me on

Do’s:

1. All queries must be accompanied by the relevant clinical indicators (this supports why a query was initiated; the goal is to give physicians enough information so they don’t have to look up the medical records themselves).

2. The query must have multiple answer choices, or be open ended.

3. The query must be free from any reimbursement information. (Financial information could encourage the physician to choose a diagnosis or procedure that maximizes reimbursement, and is considered leading.)
Queries: Don’t lead me on

What are clinical indicators?

- Documented diagnoses
- Lab and pathology findings
- Risk factors
- Treatments
- Conflicting or unclear documentation
- Lack of documentation
- Anything that is making you question.

Be sure to include specific sources for your quoted indicators:
No: “Clinical documentation states _____”
Yes: “Progress note dated 1/2/13 states _____” → This is more helpful to the physician, and no one can argue that it’s not documented.
Example: Obtunded patient admitted with three day history of nausea and vomiting. CXR revealed RLL (right lower lobe) pneumonia. Discharge Summary states pneumonia.

**Leading query**: Does the patient have aspiration pneumonia? This diagnosis would change the DRG and resulting reimbursement.

**Non-leading query**: Discharge summary states pneumonia. Admitting H&P states patient has a 3-day history of nausea and vomiting prior to this admission. Based on your clinical judgment, can the etiology or type of the pneumonia be further specified?
Queries: 3 basic types

1. Open ended
2. Yes/No (which is really a variation of multiple choice)
3. Multiple choice

Reminder:

“A leading query is one that is not supported by clinical elements, and/or directs the provider to a specific diagnosis or procedure.”

All 3 types of queries must adhere to this definition.
Open-ended queries are the simplest format, and in some cases may be your only option.

Ex. Radiology order is for x-ray of the left lower leg. Radiology findings indicated no fracture. Please specify a diagnosis or signs/symptoms as the reason(s) you ordered this test. ____________________________

Ex. Radiology report states ‘subacute rib fractures’. Is this finding clinically significant? ________________

Ex. H&P states patient had 3 day history of nausea & vomiting prior to admission. Discharge summary states pneumonia. Can the type of pneumonia be further specified? __________
Queries: Open ended

The problem with open-ended queries: answers may not helpful to you or weren’t what you intended.

Ex. “Radiology order is for x-ray of the left lower leg. Radiology findings indicated no fracture. Please specify a diagnosis or signs/symptoms as the reason(s) you ordered this test. **Rule out fracture**.

Ex. Radiology report states ‘subacute rib fractures’. Is this finding clinically significant? **Yes**.

Ex. H&P states patient had 3 day history of nausea & vomiting prior to admission. Discharge summary states pneumonia. Can the type of pneumonia be further specified? **Right lower lobe**.
Queries: Yes/No vs. Multiple Choice

New diagnoses cannot be derived from a Yes/No query. Yes/No queries may be used to query for:

- POA determinations
- Substantiating or further specifying a diagnosis that is already present in the health record with interpretation by a physician
- Establishing a cause and effect relationship between documented diagnoses such as manifestation/etiology, complications, and conditions/diagnostic findings.
- Resolving conflicting documentation from multiple practitioners.
Queries: Yes/No vs. Multiple Choice

“Yes/No queries may **not** be used in circumstances where only clinical indicators are present but the condition or diagnosis has not yet been documented.”

Ex. Patient comes in with respiratory distress that later progresses to respiratory failure. The admitting H&P documents fever of 102 F, WBC 15,000, and CXR showing lung infiltrates. Discharge Summary documents pneumonia. Sepsis is not documented anywhere. (Yes/No format cannot be used to ask if sepsis is a possible diagnosis.)

AHIMA Guidelines for Achieving a Compliant Query Practice, Journal of AHIMA February 2013
In multiple choice queries, new diagnoses can be introduced as answer choices, as long as they are supported by referenced clinical indicators.

“Multiple choice query formats should include clinically significant and reasonable options as supported by clinical indicators in the health record… As such, providing a new diagnosis as an option in a multiple choice list – as supported and substantiated by referenced clinical indicators from the health record – is not introducing new information… It is not considered leading to include a new diagnosis as part of a multiple choice format when supported by clinical indicators.”
Queries: Putting it all together

Basic format of a good open-ended query:

Dear Dr. X,

1. “XYZ is documented…” and its source/date/etc..
2. Clinical indicator #2 and its source/date/etc..
3. Clinical indicator #3 and its source/date/etc..

Question: If possible, please further specify the diagnosis of XYZ: ______________________________
Basic format of a good Yes/No query:

Dear Dr. X,

1. “XYZ is documented…” and its source/date/etc..
2. Clinical indicator #2 and its source/date/etc..
3. Clinical indicator #3 and its source/date/etc..

Question: Was condition XYZ present on admission?

a) Yes
b) No
c) Cannot be clinically determined
Queries: Putting it all together

Basic format of a good multiple choice query:

Dear Dr. X,

1. “XYZ is documented…” and its source/date/etc..
2. Clinical indicator #2 and its source/date/etc..
3. Clinical indicator #3 and its source/date/etc..

Question: Can the diagnosis of XYZ be further specified as:
  a) Answer choice #1
  b) Answer choice #2
  c) Other, please specify __________________
  d) Cannot be further specified
Queries: What type should be used?

My personal recommendation:

**Whenever possible, use Multiple Choice format:**

- Use Yes/No queries only for POA queries. The meaning of a simple Yes or No can be ambiguous depending on how the query is written and how the writer and/or reader interpret the response.

- Open-ended queries also can elicit answers that are ambiguous or otherwise unhelpful to the coder.

The good news: Conversion to multiple choice is easy. Just write an open ended query, and add choices afterward.
Queries: What type can be used?

Example: H&P states “ETOH +”.

**Clinical indicators:** Dear Dr. Z, Admitting H&P states “ETOH +”. Coding guidelines do not allow us to code from symbols.

**Open-ended:** Please specify a diagnosis or condition represented by “ETOH +”. __________________

**Yes/No:** This format is not allowable in this situation

**Multiple choice:** Please specify a diagnosis or condition represented by “ETOH+”:
(1) positive blood alcohol level;
(2) alcohol abuse;
(3) alcohol dependence;
(4) history of alcohol abuse;
(5) Not clinically significant;
(6) Other ______.
Queries: What type can be used?

Example: H&P documents indwelling Foley. Discharge Summary diagnoses UTI.

**Clinical indicators:** Dear Dr. A, H&P documents indwelling Foley. Discharge Summary diagnoses UTI.

**Open-ended:** Can the etiology of the UTI be further specified?___

**Yes/No:** Is the UTI due to the foley? (1) Yes; (2) No; (3) Clinically undetermined; (4) Other ______.

**Multiple choice:** Can the etiology of the UTI be further specified: (1) No causal relationship between UTI and foley; (2) UTI due to foley; (3) Other ______; (4) Clinically undetermined
Hands-on practice

Practice Makes Permanent
Scenario: A patient is admitted with weakness and fatigue. “Severe urosepsis” is documented on the H&P and Progress Notes 1/2/13 and 1/3/13. H&P exam reveals elevated WBC of 16,000, a respiratory rate of 24, a temperature of 102 degrees, heart rate of 120, and altered mental status. Urinalysis shows large presence of bacteria and WBCs. Progress notes 1/2/13 and 1/5/13 state patient is given an IV antibiotic and IV fluid resuscitation.

Would you query? If yes, what would you query for?

Write a Multiple Choice query for this scenario.
Hands-on practice - #1

- “Severe urosepsis” is documented in H&P and Progress Notes 1/2/13 and 1/3/13.
- The H&P exam documents:
  - WBC count of 16,000,
  - etc.
- Progress notes 1/2/13 and 1/5/13 state patient is treated with IV antibiotic and IV fluid resuscitation.

Based on your clinical judgment, please clarify the diagnosis of “severe urosepsis”:

___ Sepsis due to UTI (specify organism if known) _______
___ UTI only (specify organism if known) ________
___ Other, please specify __________________________
Scenario: H&P states patient is admitted for syncope. The H&P also states patient has a current condition of breast cancer for which she is receiving weekly chemotherapy treatments. Discharge summary states anemia and hypotension. Progress Notes 1/2/13 and 1/3/13 indicate patient is treated with three whole blood transfusions and is prescribed iron supplements.

Would you query? If so, what would you query for?

Write a Multiple Choice query for this scenario.
Hands-on practice - #2

- H&P states that the patient is admitted with syncope.
- H&P states that the patient is being treated weekly with chemotherapy for breast cancer.
- Discharge Summary states diagnoses of...
- Progress Notes 1/2/13 and 1/3/13 state....

Based on your clinical judgment, can the type of anemia be further specified? Check all that apply.

- Anemia due to chemotherapy
- Anemia due to neoplastic disease
- Acute blood loss anemia
- Anemia of other type (please specify) ________________
- Anemia cannot be further specified
Summary

1. Write simply and clearly:
   • Try bulleted or numbered lists, for both the clinical indicators and the answer choices.

2. Non-leading queries:
   • Must include relevant, referenced clinical indicators.
     • Goal: give the physicians enough information so they don’t have to look up the medical records themselves
   • Must have multiple answer choices, or be open ended.
   • Must be free from reimbursement information.

3. Use Multiple Choice format whenever possible:
   • Write an open-ended question, then add answer choices.
Clinical indicators - suggestions

These are lists of clinical indicators that you can look for to help support your queries. This are not exhaustive lists; they are just to help point you in the right direction.

NOTE: None of these indicators are “proof” that the patient has a given condition. Dysphagia in a pneumonia patient isn’t proof of aspiration pneumonia. Treatment with high-powered antibiotics isn’t proof of sepsis.
Clinical indicators - suggestions

Aspiration Pneumonia

- Impaired gag reflex
- Esophageal disorder (obstruction, cancer, stenosis, varices)
- Dysphagia and/or positive swallowing study
- Positive infiltrate on chest x-ray
- Current aspiration and/or recent vomiting
- PEG tube
- NG tube
- Hx of aspiration pneumonia

- Nursing home patient
- S/P CVA
- Enterostomy status
Clinical indicators - suggestions

Sepsis

- Fever or hypothermia
- Tachypnea
- Tachycardia
- Increased WBC count
- Oliguria
- Hypotension
- Organ failure/dysfunction
- Metabolic acidosis (elevated lactate level, anion gap, or reduced blood pH)
- Acute onset of confusion associated with disease process/Altered mental status

- Shock
- Positive blood cultures
- Elderly or immunocompromised
- History of infected decubitus ulcer or vascular device
- Antibiotic treatment
- Sepsis protocol
Clinical indicators - suggestions

Urosepsis vs. UTI

- Fever or hypothermia
- Tachypnea
- Tachycardia
- Increased WBC count
- Oliguria
- Hypotension
- Metabolic acidosis (elevated lactate level, anion gap, or reduced blood pH)
- Acute onset of confusion /Altered mental status
- Shock
- Positive blood or urine cultures

- Indwelling urinary catheter
- Urinary catheter removed and/or replaced with a different catheter within 48 hours of symptoms or culture
- Fever with suprapubic tenderness or costovertebral angle pain or tenderness
- Urgency, frequency, dysuria with no indwelling catheter or within 48 hours of catheter removal and/or replacement with a different catheter
Clinical indicators - suggestions

Anemia

- Significant drop in H&H
- Hypotension
- Palpitations or rapid heart rate
- Blood transfusion(s)
- Syncope/dizzy/light headed
- Fatigue/lethargy/weakness
- Iron supplements
Clinical indicators - suggestions

Angina

- New and/or sudden onset of angina and/or chest pain symptoms
- Angina and/or chest pain occurs while laying down and/or at night
- Angina and/or chest pain occurs at rest
- EKG changes in ST segment
- Elevated cardiac enzymes
- Coronary Artery Disease
- Difficult to obtain pain relief with Nitroglycerin

- Angina following a Myocardial Infarction
- Ischemic Chest Pain
Clinical indicators - suggestions

Heart Failure

- Findings from Echocardiograms like abnormal EF’s
- Studies performed like echocardiograms, cardiac catheterization
- Pleural effusion with cardiac symptoms
- Edema or swelling in legs
- SOB when lying down
COPD

- Cough and/or airflow obstruction
- Orthopnea
- Hemoptysis
- IV steroids
- Decreased O2 saturations
- Patient’s home medications for COPD/asthma have been ordered to be given in an increased frequency
- Increased work breathing (e.g. retractions, use of accessory muscles, cyanosis, pursed breathing, wheezing, shortness of breath, etc.)

- Increased need for respiratory therapies > than at home (increased aerosol treatments, oxygen use, suctioning, etc.)
- Clear, yellow, or green mucus/sputum
- Increased allergy or hay fever symptoms
- Increased irritation or swelling of mucous lining of airways
- Exposure to smoke, chemicals, or air pollution
- Abnormal pulmonary function test, CT scan or CXR
- Chest pain or tightness
Clinical indicators - suggestions

Malnutrition

- Visible wasting away of muscle/tissue
- Enlargement/tenderness of liver/abdomen
- Signs of circulatory collapse (e.g. cold hands/feet, weak radial pulses, diminished consciousness)
- Dry, scaling, or peeling skin
- Severe pallor
- Brittle nails and/or hair loss
- Edema/fluid retention
- Low serum proteins

- Documented weight loss
- Dietary consult
- Inability to consume adequate caloric intake
- Physician/Dietician/Nursing BMI documentation
- Albumin < 2.8
- Feeding tube or TPN
Clinical indicators - suggestions

Acute Renal Failure

- Decreased urine production
- Edema
- Confusion
- Fatigue/lethargy
- Nausea & Vomiting/Diarrhea
- Abdominal pain
- Metal taste in mouth
- Increased BUN and/or creatinine
- Increased Potassium
- Anemia (male < 13.5, female < 12.0)
- Proteinuria

- Decreased creatinine clearance
- Metabolic acidosis
- Seizures
- Coma
- Abnormal GFR
Clinical indicators - suggestions

Chronic Kidney Disease (CKD)

- Serum Creatinine
- GFR
<table>
<thead>
<tr>
<th>Clinical indicators - suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Excisional Debridement</strong></td>
</tr>
<tr>
<td>Cutting away of necrotic/devitalized tissue or slough with sharp instrument (such as scissors, scalpel, or curette).</td>
</tr>
<tr>
<td><strong>Non-Excisional Debridement</strong></td>
</tr>
<tr>
<td>Removal of necrotic/devitalized tissue or slough by:</td>
</tr>
<tr>
<td>– flushing</td>
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<tr>
<td>– brushing</td>
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<tr>
<td>– irrigation or pressurized irrigation</td>
</tr>
<tr>
<td>– washing</td>
</tr>
<tr>
<td>– water scalpel/jet</td>
</tr>
<tr>
<td>– maggot therapy</td>
</tr>
<tr>
<td>– minor removal of loose fragments using scissors or by scraping with sharp instrument.</td>
</tr>
</tbody>
</table>
Clinical indicators - suggestions

CVA

- Aphasia and/or dysphasia (difficulty speaking)
- Dysphagia
- Impaired vision (diplopia, blurred vision)
- Changes in motor strength (paresis, plegia)
- Changes in mental status (e.g. confusion, apathy, loss of consciousness, etc.)
- Signs & symptoms of intracerebral pressure
- Sudden onset explosive headache
- Photophobia
- Neck rigidity
- Seizures
- Respiratory distress
- Shock
- Use of anti-thrombolytics (e.g. Recombinant tissue plasminogen activator (TPA) administered)
- Abnormal CT results
- Facial droop
- One-sided limb weakness
Clinical indicators - suggestions

Decubitus Ulcer

- Intact skin with non-blanching erythema (reddened area on skin)
- When compared to adjacent tissue may be firmer/softer or warmer/cooler
- Partial thickness loss of epidermis and/or dermis
- Abrasion, blister or shallow open crater
- Red/pink wound bed without slough
- Full thickness skin loss (bone, tendon, muscle are not exposed)

- Damage or necrosis into subcutaneous soft tissues
- Slough present but does not obscure the depth of tissue loss
- Undermining and/or tunneling
- Full thickness skin loss with exposed bone, tendon, or muscle
- Slough
- Extending into muscle and/or supporting structure (e.g. fascia, tendon, or joint capsule)
- Treated with skin or muscle graft
- Deep tissue injury not due to trauma
Clinical indicators - suggestions

Respiratory Failure

- Respiratory rate > 35/min
- Labored respirations (use of accessory muscles)
- PCO2 > 50 mm Hg (or PCO2 findings of 10-15 mm Hg above the patient’s normal level if patient has COPD)
- PaO2 < 60 mm Hg (or PaO2 findings of 10-15 mm Hg above the patient’s normal level if patient has COPD)
- ABG blood gas pH < 7.35
- SpO2 < 88% sat

- Hypoxemia (confusion)
- Hypercapnia (somnolence)
- Cyanosis
- Diffuse bilateral pulmonary infiltrates
- Acute drop of 10 mm of Hg in PaO2
- Treatment with minimum of 40% O2
- Respiratory treatments
Questions?
Resources

• “Establish a game plan for ICD-10 queries.” HCPro JustCoding. December 4, 2012
• “Developing Effective Queries in ICD-9 and ICD-10.” AHIMA audio seminar, April 12, 2012.