A Dive into Section I.A.19: Code Assignment and Clinical Criteria

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Have you ever wondered what it means to be an effective communicator? In his article "Why Communication Is Today's Most Important Skill," Greg Satell discusses Michael Faraday, who helped transform electricity from a curiosity to a modern-day workhorse. Faraday was a talented scientist but what made him a genius was his ability to explain the results of his experiments. His ability to effectively communicate his knowledge to others was a key factor that helped develop electricity into the everyday luxury it is today, utilized with the flip of a switch.

Even though Faraday was good at explaining his expertise, the listeners played just as important a role because they interpreted his message correctly. In effective communication, the role of the receiver is just as important as the role of the sender. If those listening to Faraday had misinterpreted his message, we might still be living by candlelight.

Effective communication is crucial in the world of healthcare. Data is being sent and received by numerous healthcare professionals daily, which is used to determine treatments and guide research. It is vital that the information being transmitted is accurate and clear so there is no misinterpretation at any point along this all-important communication highway.

One important communication tool utilized by clinical documentation improvement specialists (CDIS) and coding professionals for the accurate reporting of diagnoses and procedures is the ICD-10-CM/PCS Official Guidelines for Coding and Reporting. These guidelines are approved by four groups known as the "Cooperating Parties:" AHIMA, the American Hospital Association (AHA), the Centers for Medicare and Medicaid Services (CMS), and the National Center for Health Statistics (NCHS).

The authors of these guidelines and the readers of the guidelines share an equal level of responsibility in the proper interpretation of these rules. When many people are interpreting a communication, however, the numerous perspectives can unintentionally blur the line of meaning. One guideline that has been interpreted differently by many across the spectrum of coding and clinical documentation improvement (CDI), which has led to some confusion, is ICD-10 Guideline Section I.A.19: Code Assignment and Clinical Criteria. This article will dive into the three sentences that make up this guideline. Each sentence will have its meaning examined in order to bring some clarity.

Sentence One: "The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists."

In this sentence, the guideline is instructing the CDIS and/or coding professional to assign codes to the diagnoses that have been documented by the provider. This instruction means a diagnostic statement cannot be eliminated just because the CDIS or coding professional doesn't feel it is supported by the clinical evidence. It does not say anything that would restrict the use of a query when a potential gap in the clinical picture is identified. Therefore, in a situation where a diagnosis has been documented but there is a question regarding the clinical validity, it would be appropriate to send a compliant query.

A compliant clinical validation query should not lead or question a provider's medical judgement, but rather clarify what has been documented. Below are examples of a non-compliant clinical validation query that is leading and questioning medical judgement, and a compliant clinical validation query which is asking for clarity in the documentation.

Example of a Non-compliant Query

"Dr. Smith, Acute respiratory failure is not supported by the clinical evidence for this patient, please rule out this diagnosis in your documentation."

Example of a Compliant Query

"Dr. Smith, Acute respiratory failure is documented on the H&P on 3/5/xx. The documentation states the patient has non-labored breathing, a respiratory rate of 18, and the pulse oximetry reading is 95 percent on room air. Can you please provide the evidence used to support the diagnosis of acute respiratory failure?"

Sentence Two: "The provider's statement that the patient has a particular condition is sufficient."

This statement is reinforcing the fact that providers, who are licensed to make a diagnosis, are the only professionals who can diagnose a condition. This does not mean a coded diagnosis is exempt from a denial, as a payer may have their own clinician on staff to review for clinical validity. The payer clinician may not agree that a diagnosis is supported based on the evidence in the health record. Therefore, it is crucial that the professional charged with the responsibility of reviewing for clinical validation performs the review before the bill is dropped. If a gap is identified, a query would be needed to obtain clarification from the treating provider.

It is important to note that providers are responsible for establishing the patient's diagnosis, whereas the clinical validation personnel are responsible for reviewing the documentation for gaps or discrepancies.

Sentence Three: "Code assignment is not based on clinical criteria used by the provider to establish the diagnosis."

This statement is again reinforcing that the professional reviewing for clinical validation does not establish a diagnosis; their scope of practice only allows them to code and clarify what has been diagnosed. If a provider responds to a query and clarifies that a diagnosis is validated but the diagnosis does not appear to be supported by the clinical evidence, an escalation process is warranted. The escalation process may include other physicians to review a case. If a reviewing physician agrees with the clinical validation personnel, however, they cannot alter the documentation if they did not provide care to the patient. In this scenario, the reviewing physician will need to have a discussion or query the treating provider to determine if the documentation can be updated.

If the treating provider still feels the diagnosis is valid, then the diagnosis should be coded. If it is denied, then the treating providers should be brought into the denials process to determine if it should be appealed. This information can then be used for future education for providers when they are validating diagnoses.

An organization can be proactive by coming together with their medical groups to develop clinical standards for high-risk diagnoses. This would provide additional support to providers when they are making diagnoses and guide the clinical validation personnel to know when a clinical validation query is needed. When organizations work proactively together to develop a streamlined process of diagnosing, then the guideline A.19 becomes clear and supports the medical expertise of the provider teams.

References

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