Guidelines for Achieving a Compliant ICD-10-PCS Query

Editor's Note. This Practice Brief has been updated. See the latest version at Guidelines for Achieving a Compliant ICD-10-PCS Query . This version is made available for historical purposes only.

The complex and highly specific nature of ICD-10-PCS has changed the query process for inpatient procedures. Each code is constructed using individual characters that identify all aspects of the procedure. Assigning the correct ICD-10-PCS code requires precise and complete documentation. Incomplete and non-specific documentation may result in the inability to assign a code. Unlike ICD-9-CM procedure codes, ICD-10-PCS does not have an unspecified code option. Documentation describing a procedure must support the assignment of each character composing the applicable seven-character PCS code. A PCS code is not complete without all seven characters specified.

This Practice Brief provides guidance and solutions for managing an ICD-10-PCS query process that ensures complete provider documentation for accurate coding. The direction provided herein augments previous AHIMA guidance and includes advice specific to ICD-10-PCS queries. All professionals are strongly encouraged to adhere to these query guidelines regardless of their credential, role, title, or use of any technological tools involved in the query process.

When and When Not to Query

As a classification system with a new and unique coding structure, ICD-10-PCS requires a greater degree of specificity and granularity than required with ICD-9-CM procedure coding. Anyone who assigns codes must use the ICD-10-PCS coding conventions, the Centers for Medicare and Medicaid Services' ICD-10-PCS Official Guidelines for Coding and Reporting, and the American Hospital Association's *Coding Clinic for ICD-10-CM and ICD-10-PCS* as authoritative sources for the accurate assignment of ICD-10-PCS codes. The introduction to the ICD-10-PCS Official Guidelines for Coding and Reporting includes the following reminder for coding professionals:

> 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. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those procedures that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved.

As with diagnosis coding, queries may be necessary to obtain complete documentation to support ICD-10-PCS code assignment. The following excerpt from the guidelines, section A8, is essential in determining when to query:

> All seven characters must be specified to be a valid code. If the documentation is incomplete for coding purposes, the physician should be queried for the necessary information.

Not only do the guidelines address when a query may be appropriate, it also clarifies expectations regarding a provider's use of PCS terminology, such as terms associated with root operations:

> Many of the terms used to construct PCS codes are defined within the system. It is the coder's responsibility to determine what the documentation in the medical record equates to in the PCS definitions. The physician is not expected to use the terms used in PCS code descriptions, nor is the coder required to query the physician when the correlation between the documentation and the defined PCS terms is clear. Example: When the physician documents "partial resection" the coder can independently correlate "partial resection" to the root operation excision without querying the physician for clarification.

In most cases, the information necessary to assign a specific PCS code is included within the provider's procedure note or operative report. It is the coding professional's role to translate the provider's detailed procedural description into PCS

definitions through the coding professional's knowledge of anatomy, PCS character definitions, and guidelines. Generating a PCS query should be considered whenever any character cannot be assigned based on the choices within the applicable PCS table. Examples of when to send a query include:

- Documentation is conflicting, imprecise, incomplete, illegible, ambiguous, invalid, or inconsistent
- Documentation describes a procedure that is inconsistent with clinical tests resulting from the procedure, such as a pathology or cytology report
- There is insufficient information to assign the appropriate root operation (based on the objective of the procedure), body part, approach, device, or other PCS qualifier
- Laterality can't be determined from the documentation

Although open-ended queries are preferred, multiple choice and "yes/no" queries are also acceptable—and perhaps more appropriate when PCS limits the choices available for code assignment. Unlike diagnosis queries, the "yes/no" query format for PCS does not need to include the additional options associated with multiple choice queries, which are "other," "clinically undetermined," "clinically significant," and "integral to." These would not be appropriate in a definitive classification system that provides no option to code "undetermined" or "other," or when all options have been provided.

Guidelines for When and When Not to Write ICD-10-PCS Queries

While deciding when to write an ICD-10-PCS query, it is important to remember:

- **Do:** Research the official, authoritative resources mentioned in the above section prior to issuing a query.
  Example: Per *Coding Clinic*, when a catheter tip is documented as ending at the cavoatrial junction, the coding professional may assign the body part character for the superior vena cava without need for physician query.[1]

- **Do not:** Query due to a lack of knowledge. Clinical documentation improvement (CDI) professionals and coding professionals must understand anatomy. Determine the difference between a knowledge deficit and lack of documentation.
  Example: Documentation of removal of sigmoid colon from the descending colon to the rectum would be removal of the entire body part (Resection). Based on anatomy, it is not necessary to query for partial versus total removal.

- **Do not:** Query if a body part is specified by the physician but is not specified in PCS.
- **Do:** Follow the Body Part Key and the coding conventions for branches of body parts (ICD-10-PCS Coding Guideline B4.[2]).
  Example: Documentation states right anterior spinal artery; the PCS Body Part Key translates this anatomical term as "vertebral artery, right."

- **Do:** Query if a body part as defined in PCS is not documented.
  Example: Physician documents that the saphenous vein was harvested. PCS provides body part characters only for greater saphenous vein or lesser saphenous vein. A query would be necessary to determine greater or lesser saphenous vein. *Coding Clinic* provides guidance for facilities to work with providers to develop facility-specific coding guidelines, which will establish a default code based on common practice at that facility.2 A sample facility policy can be seen below.

- **Do not:** Query when the correlation between specific documentation and the defined PCS term is documented. It is the responsibility of the CDI professional or coding professional to make this translation.
  Example: Physician documentation states a portion of the duodenum was removed. Do not query for the term "Excision." The CDI professional or coding professional should apply knowledge of PCS definitions and appropriately translate as "Excision."

- **Do:** Query if the documentation describes a procedure inconsistent with findings on the pathology report.
  Example: The physician's operative report documents a total removal of the uterus and does not mention removal of the cervix, and cervix tissue is reflected in the pathology report. Do query the physician to clarify if the cervix was removed.

Figure 1: Sample Facility Policy

Purpose:
In accordance with ICD-10-CM/PCS Official Coding Guidelines, AHA Coding Clinic, and Cardiothoracic Surgery Service Line, to accurately code Saphenous Vein Harvesting at ABC Medical Center.

Policy:
When a patient has a coronary artery bypass graft (CABG), if the saphenous vein is harvested to complete the bypass it will always be coded as: a Greater Saphenous Vein UNLESS OTHERWISE STATED by the provider.

This policy may be altered or rescinded as the ICD-10-CM/PCS Official Coding Guidelines and AHA Coding Clinic change in future releases.

How and How Not to Query

A proper query ensures that the documentation in the health record is appropriate and compliant. A compliant query includes clinical evidence to justify why the query was generated as well as appropriate language. When a query is generated it is important that the clinical indicator(s) and evidence are provided in order to demonstrate proof of the unclear, incomplete, conflicting, and/or ambiguous documentation that lacks support. When addressing these clinical indicators it is important to understand that a CDI professional or coding professional can suspect a procedure based on clinical indicators or evidence, but cannot lead the physician to a specific conclusion. If a physician is led to a response it may result in improper coding. A query should not be presumptive, probing, directive, or any attribute that is leading the provider to a specific response about a procedure.

Another area of importance to consider when determining how to query is being cognizant of the coding language specific to ICD-10-PCS. ICD-10-PCS provides different language options than those utilized by physicians. Many of the terms used to construct PCS codes are defined within the PCS system only, and it is therefore the coding professional's responsibility to determine how the documentation correlates to the PCS definitions. The physician should not be expected to use the same terms used in PCS and a query should not be generated when the correlation between the documentation and the defined PCS terms is clear.

For instance, if a physician documents a title of the procedure as an "excision of the pancreas," and it is clear in the operative report documentation that the entire pancreas was removed, a coding professional should code this procedure as "resection of the pancreas" based on PCS root operation definitions. No query is needed in this situation.

There may, however, be other times when the documentation is unclear and the coding professional is therefore unable to determine proper coding based on PCS guidelines. It is very important to carefully review the operative report to understand if a physician performed multiple procedures or if different approaches were utilized. When the documentation is unclear, it will be necessary to query the physician to determine accurate code assignment.

Guidelines for How and How Not to Write ICD-10-PCS Queries

When deciding how and how not to query in PCS, it is important to remember:

- **Do not:** Lead the physician to a particular outcome that could result in improper coding. A good tip is to focus on asking if the details in the documentation support a more specific or different character value (for example, upper esophagus versus middle esophagus) than what is initially documented or which may be unclear.
- **Do not:** Formulate a query based on the physician's language. CDI and coding professionals must be aware of PCS definitions and when definitions are consistent with documentation from a physician a query may not be necessary. It is important that the CDI or coding professional use their knowledge to apply any correlations.
- **Do:** Query when documentation is unclear to assign a specific character value based on PCS guidelines (i.e., approaches, multiple sites).

It is important to be cognizant of coding versus physician language when addressing a query. Common clinical terminology should be used in queries, not PCS terms. For instance, avoid using terms such as “extirpation” to further clarify documentation of the removal of a foreign body. This is not the best way to communicate with physicians. Focusing on accurate and complete documentation in physician language is a better practice.

Queries by Character

While querying for the first two characters of ICD-10-PCS (Section and Body System) seems unnecessary, there will be times when a query will be necessary for the remaining five characters. The coding guidelines for each character should be reviewed for the development of a query.

Root Operation

It is important to remember that providers are not required to document the specific names of root operations. ICD-10-PCS coding guideline A11 specifically addresses documentation requirements for root operations.

In the event that a query is necessary for the root operation, consider the information needed for correct code assignment. Develop the query requesting specific documentation related to the intent of the procedure.

Clinical Scenario: 65-year-old female admitted with endometrial cancer and subsequently had a total abdominal hysterectomy and a common iliac lymphadenectomy. The operative note states "lymph nodes were removed."

Compliant Query: This patient had a total abdominal hysterectomy and common iliac lymphadenectomy. The Operative note states "lymph nodes were removed." Please further specify if a portion of or the entire lymph node chain was removed.

Body Part

The more specific the provider documentation is, the easier it is to assign the correct character for body part. There is no “other” or “unspecified” body part character, so the documentation must clearly define the area being operated on.

Before sending a query to clarify the body part character, the coding or CDI professional must review the ICD-10-PCS body part guidelines and understand how to use the Index and/or Body Part Key to assist in identifying the specific body part from the provider documentation.

Body Part Query Example

Patient was admitted with non-healing infected ulcer of the left leg. Excisional debridement was performed of the necrotic fascia, and although muscle tissue was identified in the Pathology report, the procedure report did not mention excision of muscle tissue. Did the debridement include muscle?

☐ Yes
☐ No

Approach

The approach character can be difficult to assign as procedures may involve multiple approaches. It is not expected that providers know each of the PCS approach types so the content of a query should include any reasonable choices for the actual approach. Remember, for a multiple choice PCS query the options of “other” or “undetermined” are not necessary.

Approach Query Example

Clinical Scenario: 35-year-old male was admitted after developing lower abdominal pain and a temperature of 102.2. The admitting diagnosis was appendicitis and he was taken to the OR for a laparoscopic appendectomy. The documentation within the operative note states the procedure performed was an open appendectomy and the body of the operative note states "there was an insertion of a 5 mm blunt port with a 5 mm scope introduction." The progress note post op day 1 states s/p open appendectomy with good wound healing to the incision.

Compliant Query: Patient was admitted with abdominal pain and a diagnosis of appendicitis and was taken to the OR. The operative note states this was an open appendectomy under the procedures performed, however there is no documentation of an incision within the body of the operative note and the orders are for a laparoscopic appendectomy. The progress note post op day 1 states this was an "open appendectomy with good wound healing to the incision." Can the approach used for this procedure be further specified? Please see possible options listed below:

- ☐ Open appendectomy (if so please clarify all supporting documentation within the operative note)
- ☐ Laparoscopic appendectomy (if so please clarify all supporting documentation within the operative note)
- ☐ Laparoscopic appendectomy converted to an open appendectomy (if so please clarify all supporting documentation within the operative note)

Device

Querying for the device character will generally involve inquiring whether the device was left in place at the conclusion of the procedure, or a request for more specificity about the device and/or where it was placed in the body. If the physician documents the device brand, check the ICD-10-PCS Device Key to map the specific device brand to the device type in PCS before sending a query.

The device character "Other Device" is the NOS option for device in ICD-10-PCS, but this option is not found in every PCS table, so a query may be necessary to identify the specific type of device.

Device Query Example

Patient was admitted to hospital with significant osteoarthritis of the right hip. The patient was taken to the operating room on 2/1/16 for a right total cemented hip replacement. Of the following choices, please indicate the type of hip replacement hardware used during this procedure:

- ☐ Ceramic
- ☐ Ceramic on polyethylene
- ☐ Metal
- ☐ Metal on polyethylene
- ☐ Other specified (i.e., brand/product name) _____

Qualifier

A query for character seven, qualifier, is going to be very specific depending on the particular case. Be sure to carefully review the PCS table to identify the qualifier characters available for the procedure being coded.

Qualifier Query Example

Patient was admitted with distended abdomen and shortness of breath. Upon admission, patient underwent an abdominal drainage of 30 cc of abdominal fluid.

Please specify whether this drainage was diagnostic and/or therapeutic:

☐ Diagnostic drainage
☐ Therapeutic drainage
☐ Both diagnostic and therapeutic

Provider Education

Ongoing education for providers regarding documentation requirements that support accurate ICD-10-PCS coding is essential for precise reporting. Another benefit to ongoing education is the possibility of a reduction in the number of queries sent. Educational sessions are great opportunities to build relationships between the coding staff, the CDI team, and the providers. This also gives the providers an opportunity to share any concerns they have or thoughts on what is or isn't working well. To determine the education topics, resources should be gathered from both internal and external resources.

Potential Internal Education Topics

Organizations should be trending the top procedure queries sent out. Data can be used to develop ongoing educational topics. In addition to top queries you can also focus on procedures that are performed within an organization. Understanding how a procedure is performed provides valuable information to apply accurate code assignment. Having a physician explain the operative mechanics of new or existing procedures will assist in developing educational opportunities on applicable documentation requirements for the physician.

Potential External Education Topics

External topics can come from a variety of places, such as the AHA's *Coding Clinic* publications and CMS' Official Coding Guidelines publications. It is important for both CDI and coding professionals to stay current on documentation requirements and share that information with providers.

Education Delivery Methods

- **Rounding:** Rounding with physicians is a good way to provide education specific to each patient. If scheduling doesn't allow for rounding time, then participating in grand rounds may be a good alternative.
- **Staff Meetings:** If providers have a regular staff meeting, the CDI team could request 10 minutes to go over hot topics with the group.
- **Posters and Flyers:** Placing posters and flyers in areas where providers document can be a valuable tool for having information readily available at the time they are documenting.
- **Newsletters and Blogs:** Providing ongoing newsletters and blogs will afford providers an easy way to learn of the latest documentation requirements.
- **Tip Sheets:** Tip sheets should be short and concise covering a specific documentation topic. This could be printed on flyers or pocket cards. For quick and easy access, a shared intranet site is a nice option.
- **Collaborative Education:** Have surgeons come to a coding/CDI meeting and discuss common procedures. Utilize real health records to facilitate discussion amongst the group. Consider scheduling visual learning opportunities for CDI and coding professionals by inviting them to the operating room or interventional radiology suite to view a procedure.
- **Physician Advisor:** Appoint an individual as the physician advisor. This individual should know the strategic system goals and advocate for inclusion of documentation concepts in these initiatives. Accurate data is central to any quality and efficiency improvement project.

More Query Examples

Additional examples of ICD-10-PCS queries for root operation, body part, approach, device, and qualifier are available above and in Appendix A: ICD-10-PCS Query Examples. A sample facility query policy is also available above.

Notes

[1] American Hospital Association. *Coding Clinic for ICD-10-CM and ICD-10-PCS* 2, no. 4 (Fourth Quarter 2015): 28-29.

[1] American Hospital Association. *Coding Clinic for ICD-10-CM and ICD-10-PCS* 1, no. 3 (Third Quarter 2014): 8.

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Appendix A: ICD-10-PCS Query Examples

Body Park Query Example

Dear Doctor, I have a question regarding the omentectomy portion of this procedure. Specifically, were both the greater and lesser omentum removed and to what extent (total or partial resection)? Without this information, we are unable to code the procedure. Thank you in advance for your time.

Procedure: Radical debulking of metastatic ovarian cancer
Op Note: "The entire infracolic omentum was mobilized free from the transverse colon after which the lesser sac was entered, and the omentum was removed from along the undersurface of the liver, several centimeters below the arcade itself, coming off the supracolic omentum which was grossly normal. Dissection was carried in the left upper side to the level of the base of the spleen. There was no palpable omental disease, either in what I removed or what was left."

What part of the omentum was removed (select all appropriate answers)?

GREATER omentum was:
- ☐ Totally removed
- ☐ Partially removed
- ☐ Not removed

LESSER omentum was:
- ☐ Totally removed
- ☐ Partially removed
- ☐ Not removed

Body Park Query Example

Clinical Scenario: A 26-year-old male with a history of continuous smoking since 16 years of age has noted increased shortness of breath, malaise, and fatigue with decreased appetite and weight loss. He has been admitted for excision of lung mass in the right upper lobe.

Compliant Query: This 26-year-old male has been diagnosed with adenocarcinoma of the right upper lobe of lung. The pathology report notes an entire right upper lobe, but the operative report notes the excision of a 1.5 cm mass. Please clarify this conflicting documentation regarding removal of the entire lobe of the lung vs. an excision of a lesion on the lobe.

Device Query Example

Clinical Scenario: A 45-year-old male who began experiencing dull chest pain was brought to the emergency department and diagnosed with an acute inferior myocardial infarction. A PTCA was performed for treatment of 70 percent stenosis of the distal right coronary artery. A stent was placed in the mid right coronary artery.

Compliant Query: Patient was admitted with an acute inferior myocardial infarction. A PTCA was performed for treatment of 70 percent stenosis of the distal right coronary artery and a stent was placed in the mid right coronary artery. Please specify the type of stent that was used in this procedure.

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