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THE LIVANTA CLAIMS REVIEW ADVISOR

A monthly publication to raise awareness, share findings, and provide guidance about Livanta's Claim Review Services

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Launching *The Livanta Claims Review Advisor*

In 2021, the Centers for Medicare & Medicaid Services (CMS) awarded Livanta a national contract to conduct claim reviews for Medicare. Claim review services represent an important activity of advancing Medicare's triple aim of better health, better care, and lower costs. Medicare's claim review program includes activities that evaluate two main types of Medicare Part A claims that have high potential for errors: hospital inpatient admissions of short duration and claims for which hospitals paid under the Inpatient Prospective Payment System (IPPS) re-submitted inpatient claims for a higher payment than what they had billed initially.

To share its review findings and provide guidance to healthcare organizations, Livanta is pleased to launch this publication, *The Livanta Claims Review Advisor*. Each month's content will highlight areas of interest for medical coders, billing professionals, clinical documentation improvement (CDI) professionals, physicians, and other practitioners. Livanta encourages its readers to share this content with others who may find it valuable. Those who wish to receive this publication directly by email can do so by subscribing on Livanta's website at **https://LivantaQIO.com/en/About/Publications**.

Livanta's Review Findings

In the past four months, Livanta has reviewed thousands of claims under its CMS contract and has found that some hospitals may benefit from training on the development of compliant query practices. For example, it is paramount that diagnoses documented on the queries are clinically supported in the medical record. This issue of *The Livanta Claims Review Advisor* reinforces basic principles and practices for developing compliant physician queries so that hospitals can avoid incorrect Part A claim submissions.

At Livanta, Higher Weighted Diagnosis Related Group (HWDRG) reviews are two-pronged: claims are validated by coding auditors and clinically reviewed by physicians. Livanta's coding auditors validate the DRGs based on the documentation, official coding guidelines from the American Health Information Management Association (AHIMA) Coding Clinics, and other authoritative coding references. Livanta's auditors adhere to the accepted principles of coding practice to validate the accuracy of the hospital codes that affect the DRG payment. Audits may also involve a clinical review by active, practicing physician reviewers. These physician reviewers determine the clinical validity of physician queries and documented diagnoses and procedures, as well as correct principal diagnosis assignment when appropriate. Livanta's rejections of requested HWDRGs can result from either coding audits, physician reviews, or both.

Advice in this publication is based on AHIMA 2019 Guidelines for Achieving a Compliant Query Practice, Standards of Ethical Coding, and Ethical Standards for CDI Professionals.
For additional guidance on this topic, continue reading this issue of *The Livanta Claims Review Advisor*.

HWDRG Validation

Livanta audits selected Part A claim adjustments submitted by hospitals paid under the IPPS. Claim adjustments that are audited involve those that result in a higher payment because the DRG was amended by the hospital to a DRG with a higher weight. These post-payment reviews are performed in accordance with 42 CFR 412.60(d)(2) and 476.71(c)(2) by Livanta's experienced, trained auditors.

An HWDRG claim adjustment may result from a physician query, which is defined by the **American Health Information Management Association (AHIMA)** as "a communication tool or process used to clarify documentation in the health record for documentation integrity and accurate code assignment for an individual encounter in any healthcare setting." Because physician queries are intended to result in more accurate or complete diagnostic or procedural documentation – details that can impact reimbursement or quality metrics – it is necessary for coding and CDI professionals to follow professional standards when conducting queries.

Physician Queries

When documentation in the health record is incomplete, imprecise, or conflicting, it is appropriate for the hospital coder to seek clarification from the applicable physician in the form of a clinical coding query. A query is a communication tool used by coding professionals to clarify the documentation in the medical record so that it may be accurately translated into the clinical codes used for reimbursement. Queries have traditionally been used as a mechanism to increase the precision of clinical documentation and to ensure that the clinical coding classification accurately depicts the physician's intent and clinical thought process.

Healthcare facilities should keep records of all queries, including verbal queries. These records should be maintained to demonstrate compliance with all query requirements and to demonstrate the fact that the query was correctly worded. Regardless of how queries are communicated, they need to meet the criteria below.

- They need to be succinct and understood easily.
- They need to include both clinical indicators from the health record, as well as any documentation that supports the need for the query.
- They need to be truthful in identifying the reason for the query request.
- They need to comply with the best practices outlined in this article, as well as in the links at the end of the article.
- Provider queries must never mention any impact on reimbursement or quality measures.

Queries can be initiated by coders or CDI professionals. However, it is best practice to only allow credentialed coders to make changes to the assigned codes to ensure that coding rules and guidelines are followed. Queries may be necessary in, but are not limited to, the following instances:

- To obtain supporting documentation of medical diagnoses or conditions that are clinically evident and meet Uniform Hospital Discharge Data Set (UHDDS) requirements for reporting;
- To resolve conflicting documentation between providers;
- To clarify which diagnosis occasioned the inpatient admission and was the primary focus of care (principal diagnosis). **(Note: The principal diagnosis must be well-supported in the body of the record, with both clinical indicators and documentation. If a new diagnosis is only stated as an answer to a query and not documented elsewhere, it should not be the principal diagnosis.)**;
- To seek clarification when there is evidence that a documented diagnosis is not clinically supported, or that it resolved before the admission;
- To establish or negate a cause-and-effect relationship between medical conditions;
- To establish further specificity of a diagnosis to prevent the need to report a non-specific code;
- To support the assignment of an appropriate Present on Admission (POA) indicator;
- To clarify whether a diagnosis was ruled in or ruled out; or
- To clarify the objective and/or extent of a procedure.

Compliant Query Practices

The objective of a query is to ensure that the documented diagnoses and procedures are accurately and completely reported. Compliant query practices encompass the principles outlined below.

The clinical indicator(s) that accompany a query must:

- Be specific to the patient and the episode of care;
- Encompass more than just documentation examples from the record; and
- Support the reason why a more complete or accurate diagnosis or procedure is sought or why a diagnosis requires additional clinical evidence and/or documentation to be reportable.

It is good practice to steer clear of queries that:

- Do not include clinical indicators that truly justify the query and/or justify the choices provided within a multiple-choice format;
- Encourage the provider to document a specific diagnosis or procedure; and
- Indicate any impact on reimbursement or quality metrics.

If a compliant query has been properly answered and authenticated by the provider responsible for the care of the patient and is part of the permanent health record, absence of the documented answer in a progress note, discharge summary, or addendum should not prohibit code assignment **as long as the answer is clinically supported in the record.** One exception is in regard to the principal diagnosis which should be documented throughout the record to support the fact that it occasioned the admission and was the primary focus of care.

How to Construct Queries

Written paper and electronic queries should be legible and written with correct grammar. Include all clinically supported options and other options that allow the provider to write an alternate response. Options may include *other, unknown, unable to determine, not clinically significant or integral to*, or similar phrases. Written queries can have the following formats:

- **Open-ended:** The question is worded in a way that asks for clarification without suggesting any particular answer(s). Think of an open-end question as a way to ask the provider for help in understanding documentation, clinical support, and/or the treatment given. The provider is free to write any response. This is the best method for ensuring that the query does not lead the physician to one particular answer.
- **Multiple choice:** This format is usually less leading than a yes/no question, but it still can be used inappropriately if most or all of the options given make the preferred answer clear to the provider. Multiple choice query formats should include only answers that are clinically significant, clinically supported, and reasonable. While it is acceptable to provide a new diagnosis as an option in a multiple-choice list—as supported and substantiated by referenced clinical indicators from the health record—do not include the new diagnosis in multiple different forms, as doing so would make it obvious that this is the desired answer.
- **Yes/No:** This type of question should be used only to clarify diagnoses that have already been documented but need further specification. Yes/No queries may not be used in situations where the related diagnosis was never documented, and only clinical indicators of the condition are present.

Below are some examples for when a yes/no query may be indicated:

- Determining the Present on Admission (POA) indicator;
- Confirming a diagnosis that is already documented in the current health record (i.e., findings in pathology, radiology, and other diagnostic reports) with interpretation by a physician;
- Determining the presence or absence of a cause-and-effect relationship between multiple documented conditions such as manifestation/etiology, complications, and conditions/diagnostic findings;
- When multiple providers have conflicting documentation.

Examples of Noncompliant Queries

The following five examples of actual physician queries are not in accordance with the above guidance. These are recent examples Livanta auditors have encountered in medical records undergoing HWDRG review. Note that queries are reviewed and sometimes rejected by Livanta's physician reviewers for clinical reasons, not strictly for coding reasons. Therefore, when submitting a response to a discussion letter for consideration, facilities should refrain from using coding guidelines to argue against these clinical decisions.

Example 1: Queries that suggest diagnoses that were not documented in the medical record at all and yet were confirmed by the physician and then sequenced as principal diagnoses.

o *Please indicate whether sepsis was present. The clinical indicators include a urinary tract infection, elevated white blood cell count, fever, and encephalopathy.*

Example 2: Queries to determine whether a diagnosis was present on admission, and when the physician answers affirmatively, the diagnosis is re-sequenced as the principal diagnosis when it was not what occasioned the admission, was not the focus of care, and/or did not require the most hospital resources when compared to other diagnoses.
o *Acute kidney injury was documented on the nephrology consult. Please indicate whether it was present on admission.*

Example 3: Multiple choice queries when the diagnosis was not documented in the record at all. In this example, even though the physician is given an option of "unknown," the query is still leading the physician to a specific diagnosis of encephalopathy.
o *Please document the etiology of the patient's confusion: metabolic encephalopathy, toxic encephalopathy, other encephalopathy, or unknown etiology.*

Example 4: Multiple choice queries when the options given have no clinical indicators, do not typically cause the listed symptoms, and/or were not documented in the record, making them "leading" queries.
o *Please document the etiology of the abdominal pain documented on the H&P: acute renal failure, UTI, or dehydration.*

Example 5: Queries that lack sufficient clinical indicators.
o *Per the nutritional consult, the patient was slightly malnourished. Please specify the severity level of the malnutrition. The clinical indicators include a BMI of 25.1, and an albumin level of 3.3. Options are severe malnutrition, moderate malnutrition, or mild malnutrition.*

Conclusion

With the goal of proper payment made in accordance with the appropriate supporting documentation in the medical record, Livanta hopes the information in this publication is helpful to your organization. Should you have questions, please email **ClaimReview@Livanta.com**.

References

AHIMA Guidelines for Achieving a Compliant Query Practice (2019 Update)
https://bok.ahima.org/doc?oid=302673#.YhevoTHMKUl

AHIMA Standards of Ethical Coding:
https://bok.ahima.org/codingstandards#.YhUYCzHMKUk

AHIMA Ethical Standards for CDI professionals:
https://bok.ahima.org/doc?oid=301868#.YhUZXzHMKUk

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