Physician queries and the use of prior information: Reevaluating the role of the CDI specialist

WHITE PAPER

Summary: The following white paper examines the issue of whether to use information from a prior stay in order to clarify a diagnosis in the record, in light of new technologies and changes wrought by healthcare reform.

The electronic health record (EHR) has been a game-changer for CDI specialists. Information that was once buried in storage and hard to access is now at the fingertips of physicians and CDI specialists, leading to a more detailed reference and a richer picture of a patient's medical history. This new technological reality, however, brings challenges as well, particularly for CDI specialists trying to reconcile the greater data access afforded by EHRs with documentation and coding regulations developed during a different age.

In particular, CDI specialists face the dilemma of whether to apply information from prior encounters when querying a physician in order to clarify a diagnosis documented in a current admission or episode of care. The CDI profession is divided on this topic: Some are comfortable referencing the historical information within the query when it clarifies a currently documented condition relevant to the current episode of care; however, others believe this practice violates Uniform Hospital Discharge Data Set (UHDDS) definitions regarding an episode of care, as well as coding guidelines.

A search of the references offers conflicting guidance on this issue. Therefore, rather than focusing on one specific guideline or Coding Clinic, this white paper will review and examine the totality of guidance. The *ICD-9-CM Official Guidelines for Coding and Reporting* (referred to hereafter as the "Guidelines") are referenced in this article since the ICD-9 guidelines currently apply. However, these general guidelines (as opposed to chapter-specific guidelines) appear to be consistent between ICD-9-CM and ICD-10-CM and so this discussion remains relevant as the healthcare industry moves forward with ICD-10.

The guideline responsible for much of the confusion is located in Section III of the Guidelines, "Reporting Additional Diagnoses." It states, "Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded." The key here is the qualification "which have no bearing on the current hospital stay." Within this section is an additional guideline (A. Previous Conditions) that states the following:

> *If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be*

coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment. (1)

A problem arises with this guideline, however, when you consider the case of a diagnosis that relates to the current episode of care but lacks sufficient documentation to support specific code assignment. In order to report the most accurate code, which often affects reimbursement as a secondary diagnosis, some may reference additional information outside of the current episode of care within the query seeking additional clarification. Old records have always been available for the admitted patient; however, they aren't easily searched in paper form. Modern EHRs facilitate that search.

Within Section IV, "Diagnostic Coding and Reporting Guidelines for Outpatient Services," a section entitled "Chronic Diseases" states the following: "Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)." Although this guideline pertains to outpatient services, the concept appears relevant to the inpatient setting because queries referencing earlier episodes of care are often used to clarify chronic conditions such as CHF that aren't well documented within the current episode. In these instances, providers frequently don't provide the details needed for precise code assignment because it may seem redundant to them—the condition has already been addressed in detail elsewhere.

The Guidelines reference the term "encounter," stating, "The term encounter is used for all settings, including hospital admissions." The term "encounter" isn't clearly defined in UHDDS guidelines, but it is referenced in order to describe a facility-based type of encounter (e.g., inpatient, outpatient, emergency department, observation, ambulatory surgery, etc.).

We also need to consider how CMS defines "episode of care." Many recent CMS initiatives extend the episode of care to three days (or more) prior to the admission date and 30 days (or more) following the discharge date. For example, in the outpatient setting, reimbursement under the CMS-HCC module considers diagnoses reported during episodes of care throughout the course of a year to determine the highest severity of a condition upon which the prospective payment is based. The extended time periods defining the episode of care in the inpatient setting will also be used for assessing the quality of care as well as reimbursement under a proposed bundled payment system.

> *Much of CMS research efforts have focused on measures associated with episodes of care, that is, a series of separate, but clinically related services delivered over a defined time period … By definition, chronic conditions are ongoing and open-ended. To construct an episode to measure resource use, a practical time convention is needed. A 12-month period, usually a calendar year, has been used to group claims of the same diagnosis type into a chronic condition episode. (2)*

So should the constraints on using information from a prior encounter be reexamined now? The evidence for change is compelling. Using information from a prior stay can reduce unnecessary spending on diagnostic tests. An example is a patient whose most recent echo was a year ago; it seems reasonable for a CDI specialist to reference the prior ejection fraction to help clarify the type of CHF (which is documented in the current episode of care) in a query, because it would be wasteful and unnecessary for the echo to be repeated for the purpose of code assignment when the information is readily available.

Another example includes using previous lab work (a prior baseline renal function test, for example) in a query for kidney disease. Kidney diseases can be acute or chronic, so understanding prior renal function would allow the provider to correctly determine the impact of current lab values. In other words, through proper reference of prior information, a CDI specialist could help with clarifying the current condition as a new diagnosis, a worsening of a chronic condition, or an affirmation of the chronic condition.

The use of prior information is not unprecedented. The Guidelines, for example, require a coder to know if a prior diagnosis of HIV disease was ever reported when coding a current record of someone who is HIV positive. They state:

> *Patients with any known prior diagnosis of an HIV-related illness should be coded to 042. Once a patient has developed an HIV-related illness, the patient should always be assigned code 042 on every subsequent admission/encounter. Patients previously diagnosed with any HIV illness (042) should never be assigned to 795.71 or V08.*

In other words, once someone has been reported as having HIV disease, they should always be reported as having HIV disease, per coding guidelines. The only way 042 (B20 in ICD-10-CM) could be assigned by a coder is through the use of information from a prior stay. HIV status isn't always clear in the current episode of care, especially if the person has been asymptomatic for several years, so what is the responsibility of HIM/CDI to clarify this diagnosis based on past information? Should they be empowered to look back at previous documentation from months or even years prior?

And what about the examples of a prior echo or prior lab work? No official guidance exists for these scenarios. However, in the examples cited above, additional information appears usable in a query because it does have bearing on the current episode of care.

ACDIS notes that this is an issue currently without resolution and an instance in which regulatory standards have not kept up with new technologies and the proliferation of EHRs, which is mandated by CMS. If we don't allow information from prior stays, does this place artificial limitations on the use of technology and create undue administrative burdens on physicians, as well as HIM and CDI professionals? And what about the impact on patient care? Additionally, it does not seem to be the intent of CMS that this information be ignored, since CMS itself is in the process of instituting measures to make the delivery of healthcare more efficient, including redefining the episode of care as shown above.

Healthcare practice is fluid and ever-changing. For example, when the UHDDS references "episode of care," how should a CDI specialist or coder reconcile that with chronic conditions like HIV? At minimum, the time has come for the UHDDS to be updated to reflect the new reality of team medicine and CMS efforts—to promote consistency not only across episodes of care, but also across healthcare settings, moving beyond the definition of an episode of care as a discrete event by a single provider.

In this new EHR reality, there appears to be a need for additional regulatory guidance on how to compliantly reference prior relevant information. Some even view it as a moral obligation to the patient to carry forward prior information, noting that that personal health plans will in the future be carried with each patient. Yet we cannot simply leave this task up to a physician. Demanding that providers pull any relevant information forward into the present encounter puts an added, undue administrative burden on providers and takes them away from patient care; moreover, it limits the unique expertise of CDI and HIM professionals.

Finally, the following reference from ICD-9 Coding Clinic, Third Quarter 2013, provides additional information on this issue.

> **Question:** *Is there a guideline or rule that indicates that you should only use the medical record documentation for that specific visit/admission for diagnosis coding purposes? Does each visit or admission stand alone? Would the coder go back to previous encounter records to assist in the coding of a current visit or admission?*

Answer: *Documentation for the current encounter should clearly reflect those diagnoses that are current and relevant for that encounter. Conditions documented on previous encounters may not be clinically relevant on the current encounter. The physician is responsible for diagnosing and documenting all relevant conditions. A patient's historical problem list is not necessarily the same for every encounter/visit. It is the physician's responsibility to determine the diagnoses applicable to the current encounter and document in the patient's record. When reporting recurring conditions and the recurring condition is still valid for the outpatient encounter or inpatient admission, the recurring condition should be documented in the medical record with each encounter/admission. However, if the condition is not documented in the current health record, it would be inappropriate to go back to previous encounters to retrieve a diagnosis without physician confirmation.*

This is an area where coders and/or department managers may need to educate physicians and/or practice managers on the need to include complete diagnoses when outpatient services are ordered and to continue to document chronic or longstanding conditions on each admission/encounter record. Please note this advice applies to both ICD-9-CM and ICD-10-CM. (3)

This Coding Clinic guidance states that it would be "inappropriate to go back to previous encounters to retrieve a diagnosis," but again with a key qualifier—"without physician confirmation." This seems to be an ideal place for CDI intervention. CDI specialists should be empowered to find the information for the provider because the provider may not know what needs to be pulled forward and how to reference the information. Providers should not be encouraged to blindly copy and paste, or copy forward, but in their own words—as aided and guided by the CDI professional—should offer a review/interpretation of how the information affects the current episode of care.

Prompted by a CDI specialist with full access to the record, a provider could pull in any pertinent past information/diagnostic findings for clinical validation of the condition and support the clinical picture in his or her H&P documentation. This information then would become a part of the current record. The episode of care would then "stand alone" and be reportable.

However, ACDIS also notes that using information from a prior stay (or stays) does carry some degree of risk and operational considerations. For example, what if this prior information is not the most current? Patients are sometimes treated at other facilities, and depending upon the interoperability of the EHR, a hospital may not always have the most current information in the health record that the CDI specialist is accessing. Retrieving prior information may also harm

productivity; if a CDI specialist must look back for additional information, how far back should he or she go? He or she would need to clarify with the provider and have the information documented for the current episode of care—which would require additional time. Another concern is when a hospital stay is denied and records are sent to an auditor; typically, only the record for the current episode of care is sent, and if past information was used in a query, this information would not necessarily be available to the auditor.

When history meets a new era, challenges are inevitable. As an organization, ACDIS partners with the CDI community to provide insight and awareness regarding such issues. However, as a CDI profession, we must work together and interrogate the present to prepare for the future. Rather than take a firm stance on this issue, ACDIS encourages dialogue and due diligence to outline and adopt the practice that best suits CDI culture, workflow, expectation, and risk tolerance, while at the same time negotiating with an eye on the days to come.

What are your thoughts on the use of information from a prior stay? Please email Brian Murphy and the ACDIS Advisory Board at *bmurphy@acdis.org*.

REFERENCES

1. *Official ICD-9-CM Guidelines for Coding and Reporting.*
2. "Defining an Episode Logic for the Medicare Physician Resource Use Measurement Program: Background Paper for the November 10, 2009 Listening Session." *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/downloads/Defining_An_Episode_Logic_Backgrounder.pdf*.
3. "Assigning Codes Using Prior Encounters," AHA Coding Clinic for ICD-9-CM, Third Quarter 2013.