Insights to Coding and Data Quality

Reliability of documentation – What is a coder to do?

by Paul Evans, RHIA, CCS, CCS-P, CCDS

As Health Information Management (HIM) professionals, we all know that clear, concise and "reliable" documentation is the key to accurate coding. This article addresses some of the increasingly complex issues and challenges facing our profession regarding documentation in the context of the recently released ACDIS/AHIMA "Guidelines for Achieving a Compliant Query Practice."

Definitions for diseases change – are we staying current?

In my senior year of college, the physician teaching our pathophysiology class gave me the following assignment: "Define acute renal failure (ARF), based on signs, symptoms, laboratory findings, and cite abnormal laboratory values."

I recall this exact assignment because the subsequent grueling and frustrating undertaking I was compelled to take in order to "define ARF" was unforgettable – a bit like the basic training I undertook while in the Army. In other words, the experience made me stronger, but is not one I would voluntarily repeat. Bear in mind the year was 1989—the Internet was not available.

Initially, I thought the assignment would not be "too difficult." I had completed a number of clinical courses containing and citing precise definitions of other diseases and these had come to me easily–surely my research on this topic would be "easy" and I would quickly find one consistent definition of acute renal failure?

I could not have been more incorrect. I went to the university medical library where I found at least a dozen different "laborator defining" definitions for ARF—all involving different levels of serum *blood urea nitrogen* (BUN), creatinine and potassium, and most with a key value pertaining to creatinine. Bear in mind, when I say library, I am referring to actual books with indices, so the search was time-consuming because I could not simply "Google" ARF. Eventually, and after a lot of research and frustration, I settled on a definition that included, among other findings, the following key laboratory findings that 'seemed' to support the diagnosis:

- Sudden rise in serum creatinine of >1mg/dl/day
- Rapid BUN elevation > 20mg/dl)

The final "definition" I submitted was a bit more complex as it included a multitude of accompanying physical and laboratory findings supportive of the diagnosis, and ultimately, I completed the assignment to the satisfaction of my professor. But, in retrospect, I believe he assigned this task to me for a few reasons—I think he wanted me to comprehend the complexity and variation involved in attempting to establish a "universal definition" for a disease process. Also, I was a young senior in the College of Life Sciences, almost ready to graduate, and perhaps I had become a bit arrogant in his class as I had found it "easy" to define many of the other conditions assigned to us. I think he was trying to impose upon me the need to be prudent and thoughtful in my future work as an RHIA.

Consider that the definition I provided for ARF some time ago is now outdated. Today, most use the 2012 Kidney Disease: Improving Global Outcomes (KDIGO) Clinical Practice Guideline for Acute Kidney Injury Definition (ARF means "acute kidney injury") which defines AKI as:

- Increase in serum creatinine (SCr) by X0.3 mg/dl (X 26.5 lmol/l) within 48 hours;

Or

- Increase in SCr to X 1.5 times baseline, which is known or presumed to have occurred within the prior seven days; or

- Urine volume 0.5 ml/kg/h for 6 hours

Disease definitions and coding
How is any of this relevant to the field of coding, clinical documentation improvement (CDI), and compliance? Consider the significant changes in the philosophy and role of the coding professional and the CDI professional as reflected by the recently released ACDIS/AHIMA "Guidelines for Achieving a Compliant Query Practice," which states:*"When a practitioner documents a diagnosis that does not appear to be supported by the clinical indicators in the health record, it is currently advised that a query be generated to address the conflict or that the conflict bead dressed through the facility's escalation policy."*

Define, document, report
Is it now incumbent upon coding and CDI professionals to 'screen' diagnoses clearly written by a professional licensed to establish a diagnosis so that the condition may be "confirmed?" Furthermore, if a facility takes this stance, would uniform and standard disease definitions used at one institution be accepted by third parties?

It is my opinion that facilities should strive to create and promulgate among providers, quality teams, CDI professionals and coding professionals, to the extent practical, definitions for high-volume and problematic terms. I believe that seeking facility agreement for key conditions using evidence-based criteria approved by subject matter experts (and endorsed by compliance) can lead to greater accuracy of coding, with subsequent accurate and compliant billing and accurate used for quality purposes. To that end, all facilities should consider adoption of such definitions for topics such as:

Congestive Heart Failure
Sepsis
Acute Renal Failure
Staging of Chronic Kidney Disease
Respiratory Failure
Pneumonia
Anemia-type/etiology
Types of Pneumonia
Acute Myocardial Infarct

Stroke/TIA
Encephalopathy

Considerations
Compared to twenty years ago, the medical profession now employs updated criteria to establish more accurately (and more often) the existence of certain conditions such as acute renal failure, sepsis, stroke, and acute myocardial infarcts. If you are of the opinion that certain diseases are being reported (coded) with increasing frequency, next consider a few questions.

Is the coding/reporting of certain diseases increasing within certain populations due to epidemiological risk factors, or are certain diseases being reported more frequently because sensitive markers and diagnostic tools used to diagnosis these diseases have lead to more accurate disease classification? You can probably discern I am of the opinion that advances in the detection of diseases are leading to an increasing frequency in reporting these diseases.

As I review various journals and study disease definitions, I think back to the now antiquated definition of ARF I cited while obtaining my RHIA. (Consider that the definition I provided for ARF some time ago is outdated).

Implications for coding/MD relationship and coding work flow
How would (will) a physician react when a CDI reviewer or coder issues a query to confirm a clearly documented diagnosis that does not meet a facility-accepted universal definition of acute renal failure, acute myocardial infarct, stroke, etc.? How do we respectfully ensure the documentation in our facilities is "reliable," while at the same time respecting the latitude and training of our physicians? Does each facility make available a physician advisor who could assist with an escalation process?

It is sometimes stated by some outside of the coding profession that coders are simply "clerks" lacking formal education on such matters as anatomy and physiology, clinical pharmacology, pathophysiology, and other clinical courses. Those professional coders that have completed required science courses while obtaining degrees know this is not accurate. However, the coding profession has also been trained to "code" precisely and accurately what is documented without question. Indeed, our productivity standards and job descriptions are fashioned with this philosophy in mind.

I feel the updated ACDIS/AHIMA "Guidelines for Achieving a Compliant Query Practice" have placed the health information management (HIM) profession into a new paradigm in which, like it or not, the reliability of clearly documented data is being called into question by various industries. This means that now, more than ever, we (HIM leaders) need to ensure qualified coders are recognized as deserving of the same respect as other health care professionals.

Coding professionals, now more than ever, should consider the impact of updated research and medical definitions on coding, medical research, and epidemiological studies. No doubt, the new ACDIS/AHIMA query guidance will require additional research and outreach as we partner with physicians to ensure the complexity of care is properly classified. Doing so will doubtlessly decrease the number of episodes a coder can final code per shift.

Also, one key objective of coding is to ensure the nature of each case is accurately reported – this is not easy task, but ensuring this is done should lead to a better final product and, in my view, a more valued and satisfied coding staff. Indeed, it seems coders are now being asked to function as gatekeepers of clinical data, ensuring that key clinical parameters are met when conditions are documented. The health care industry must recognize this duty will add complexity and time to an already difficult process. Concurrently, the coding industry must meet this challenge and we must rededicate ourselves to the study of diseases, allowing staff more time to code in a more thoughtful manner.

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