

Quality Queries for Quality ICD-10-PCS Codes

[Save to myBoK](#)

By Carol Maimone, RHIT, CCS

Physician queries have historically been an effective communication tool used by health information management (HIM) coding professionals to clarify documentation in the health record for accurate code assignment. The goal for any coding professional is to have all final coded diagnoses and procedures accurately reflect the patient's episode of care based upon clear and consistent practitioner documentation within the patient's health record. With the implementation of ICD-10-CM/PCS on October 1, 2015, there is an increased need and focus on ICD-10-PCS procedure code queries.

The outcome desired from a query is an update to the health record to better reflect a practitioner's intent and clinical thought processes. The amount of codes used in PCS and the complexity of the codes are much greater than those used in ICD-9. Each level of code selection in ICD-10-PCS can require a greater level of specificity that must be found within the documentation in the health record. ICD-10-PCS codes are not just new for coding professionals, but for practitioners as well. Despite adequate training and implementation preparation, moving to a new code set after so many years is an adjustment that will progress over time.

AHIMA's Standards of Ethical Coding specifically outline the course of action a coding professional should take: "Query provider (physician or other qualified healthcare practitioner) for clarification and additional documentation prior to code assignment when there is conflicting, incomplete, or ambiguous information in the health record regarding a significant reportable condition or procedure or other reportable data element dependent on health record documentation (e.g. present on admission indicator)."

All ICD-10-PCS codes must have seven characters to achieve a complete and accurate code. Each character is determined by the information found within the health record, most often specifically within the operative report. A query may be required for clarification in order to correctly assign one or more of these characters, such as the root operation/intent of the procedure, approach, or device used. The option to select an unspecified procedure code is not available in ICD-10-PCS as it was in ICD-9-CM.

Just as with ICD-9, the query and the query response should be documented in a manner that supports accurate code assignment. A compliant query includes clinical evidence from the patient record to justify the query. The query should contain all required elements including, but not limited to:

- Patient name
- Query date
- Date of service
- Health record number

The query should be written in a compliant fashion, taking care to avoid any leading suggestions. The query response should be signed and dated and be made part of the permanent medical record.

The American Hospital Association's *Coding Clinic* provides many examples of opportunities for an ICD-10-PCS query, such as the following scenario:

No, knife dissection is not sufficient language to be able to code the root operation "Excision." Knife dissection may only be referring to the means used to reach the procedure site, and doesn't necessarily say what was done at the site. Query the physician for more information when the documentation only states knife dissection. Use of a sharp instrument does not always indicate that an excisional debridement was performed. A code is assigned for excisional debridement when the provider documents "excisional debridement," and/or the documentation meets the root operation definition of "excision" (cutting out or off, without replacement, a portion of a body part).¹

Coding Clinic also instructs to query the provider for clarification when the specific type of bearing surface is not available in the health record, from either the provider's documentation or the manufacturer's product information/sticker.²

It is important to note, however, that the Centers for Medicare and Medicaid Services' 2016 ICD-10-PCS Official Guidelines for Coding and Reporting clarify the following in section A11:

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.³

This guideline is further clarified with the following 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."

It is recommended that a query process within a department or facility be tracked to identify trends. By identifying any recurring queried items, an education plan can then be put in place to assist both coding professionals and practitioners. HIM departments may want to consider distributing ongoing information to practitioners through methods such as newsletters or their clinical documentation improvement (CDI) program based upon query trends. Ensuring that all practitioners and surgeons understand the structure, format, and requirements of ICD-10-PCS codes will assist them in providing the specific information that the coding professional needs to assign a complete and accurate procedure code. The PCS query can be modified to serve not only as a means of answering a question—when created correctly it can also serve as an educational tool for providers. Ideally, as time progresses, queries will decrease as provider education and understanding increases. Consider involving multiple disciplines in the query creation process, such as coding professionals, CDI specialists, and providers. This can ensure an effective and compliant query design. Consider including an example of the required PCS code pieces that are needed in order to build a complete procedure code, such as the table example on page 51.

HIM professionals are being challenged more than ever with the specificity required to code successfully with ICD-10-PCS. A high level of coding accuracy is driven by the documentation found within the patient health record. Reevaluating and managing an effective query process specific to ICD-10-PCS can be an effective tool to improve clinical documentation, provide further education and insight, and, most importantly, increase the accuracy of the facility's coded data.

ICD-10-PCS Code Example: Piece-by-Piece

Character 1 Section	Character 2 Body System	Character 3 Root Operation	Character 4 Body Part	Character 5 Approach	Character 6 Device	Character 6 Qualifier
Medical and Surgical	Respiratory	Excision	Lower Lobe Bronchus, RT	Open	No Device	Diagnostic
0	B	B	6	0	Z	X

Notes

^[1] American Hospital Association. *Coding Clinic for ICD-10-CM/PCS* 2, no. 3 (Third Quarter 2015): 4.

^[2] American Hospital Association. *Coding Clinic for ICD-10-CM/PCS* 2, no. 3 (Third Quarter 2015): 18-19.

^[3] Centers for Medicare and Medicaid Services. "[ICD-10-PCS Official Guidelines for Coding and Reporting](#)." 2016.

References

AHIMA. "[Guidelines for Achieving a Compliant Query Practice](#)." *Journal of AHIMA* 84, no. 2 (February 2013): 50-53.

AHIMA House of Delegates. "[AHIMA Standards of Ethical Coding](#)." September 2008.

Carol Maimone is a former director of practice excellence at AHIMA.

Article citation:

Maimone, Carol. "Quality Queries for Quality ICD-10-PCS Codes" *Journal of AHIMA* 87, no.6 (June 2016): 50-52.

Driving the Power of Knowledge

Copyright 2022 by The American Health Information Management Association. All Rights Reserved.