

The Art and Science of Query Compliance

Kim Conner, BSN, CCDS, CCDS-O

CDI Education Specialist

HCPPro and ACDIS

Middleton, MA



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Presented By



- **Kim Conner, BSN, CCDS, CCDS-O**, is a CDI education specialist for ACDIS/HCPPro, a Simplify Compliance brand, based in Middleton, Massachusetts. She serves as a full-time instructor for HCPPro's CDI Boot Camps and *PROPEL* CDI advisory services. She is a subject matter expert for ACDIS and frequently writes for ACDIS publications, speaks at ACDIS events, and co-hosts the *ACDIS Podcast*. Conner has 20 years of clinical experience as a surgical intensive care unit/burn trauma nurse at large academic medical centers. In 2013, she shifted her focus from the bedside to CDI. During her career, she has been responsible for initiating CDI programs in both the inpatient and outpatient settings, developing ongoing education across the continuum of care, and, most recently, was a CDI director where she led education and support programs to maximize CDI success.

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Learning Outcomes

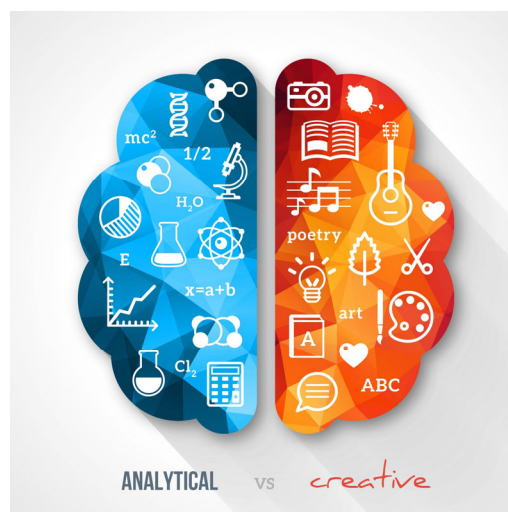
- At the completion of this educational activity, the learner will be able to:
 - Define the documentation burden on providers
 - Describe the regulatory guidance for outpatient query practice
 - Identify common outpatient query pitfalls
 - Compose a compliant query for various outpatient settings

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Composing a Query

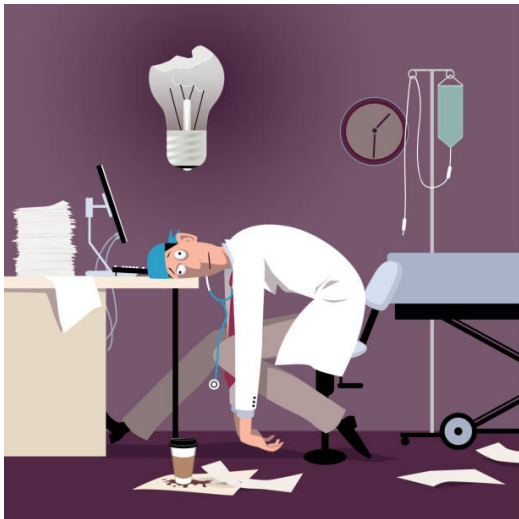
- Both an art and science
- Some of us are creative (artistic)
- Some of us are analytical (scientific)
- Great queries come from using both sides of our brain
- Query writing is a learned skill and there is a psychology behind every query
- Providers need to know the “what” and “why”



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There Is a Psychology to the Query Process



- Understanding the provider's side is essential to a successful query process
- Recognize the documentation burdens (coding, billing, CDI, evaluation and management [E/M])
- Providers document in clinical terms not coding terms
- EHRs promote "physicians can do their own ICD-10 coding" (what could possibly go wrong?)
- Providers may know codes, but they typically do not know coding rules

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A Rise in "Pajama Time" for the Outpatient Setting



- Burnout is a major issue that has been compounded by the COVID-19 pandemic (now moral injury)
- The second biggest reason for physician burnout, according to a survey from the American Medical Association (AMA), is time spent in the EHR
 - 46% of respondents to the survey stated time spent on EHR outside of normal scheduled hours was excessive
 - 30% of respondents spend more than six hours per week—almost a full workday per week—on the EHR outside of normal scheduled work time

<https://www.ama-assn.org/practice-management/physician-health/burnout-benchmark-28-unhappy-current-health-care-job>

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The Art and Science of Collaboration

- Outpatient CDI program focus will dictate the query process
- Not every discrepancy should result in the physician being queried
- CDI needs to balance between “nice to have” versus “need to have”
- Query fatigue is real
- Collaboration between CDI and providers is essential
- Educate to the “what” and “why,” this is an art and science!



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Outpatient Coding Guidelines

- The outpatient query process, not unlike the inpatient query process, requires an understanding of the *Official Guidelines for Coding and Reporting*
- There are some differences between inpatient and outpatient as outlined in Section IV of the *Official Guidelines for Coding and Reporting*
- Though the conventions and general guidelines apply to all settings, coding guidelines for outpatient and provider reporting of diagnoses will vary in several instances from those for inpatient diagnoses, recognizing that:
 - The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis does not apply to hospital-based outpatient services and provider-based office visits
 - Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatient reporting

ICD-10-CM Official Guidelines for Coding and Reporting FY 2023

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Outpatient Coding Guidelines: Uncertain Diagnoses

Uncertain diagnosis cannot be used to code a diagnosis in the outpatient setting

Code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit

There is query opportunity for emergency department, observation and/or primary care visit

A patient with “suspected pneumonia” in the outpatient setting would need a query to capture the diagnosis

If the documentation remains as an uncertain diagnosis, the presenting symptoms only will be captured (cough, fever, shortness of breath, etc.)

ICD-10-CM Official Guidelines for Coding and Reporting FY 2023

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Outpatient Coding Guidelines: Patients Receiving Diagnostic Services Only



- For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.
- Patient is seen by the primary care physician (PCP) for wrist pain. The provider orders an X-ray.
- The PCP documents “patient complained of right wrist pain, ordered X-ray, will follow up with results.”
- Radiologist (who is a physician) states the patient has a hairline fracture of the right scaphoid.
- A query to capture the fracture would not be needed in the outpatient setting.

ICD-10-CM Official Guidelines for Coding and Reporting FY 2023

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Query Compliance for the Outpatient Setting



- Outpatient queries follow the same regulatory guidance as the inpatient setting
- Every query should stand on its own
- Query format is the same for both settings
 - Open-ended
 - Multiple choice
 - Yes/no
- Queries for the outpatient may be shorter but are required to have appropriate clinical indicators included



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Query Compliance: Why Is It Important?



- We do not want to misrepresent the facts
- Government regulated (these are Medicare dollars)
 - Can be a target for an audit
 - Must give the money back if overpaid
 - Criminal prosecution for intentional misrepresentation (False Claims Act)
 - Nursing license can be jeopardized for unethical practice
- Queries are discoverable
- CDI has governing bodies that provide guidelines and best practice (ACDIS/AHIMA *Guidelines for Achieving a Compliant Query Practice*)

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Regulatory Guidance

- Federal Register directs hospitals to make attempts to improve all aspects of clinical documentation
- ***“We do not believe there is anything inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation in the medical record.”***



At last he had found the Regulatory Guidelines.

<http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf>, p. 208

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Queries Cannot Be Leading

- ACDIS/AHIMA *Guidelines for Achieving a Compliant Query Practice—2019 Update*:
 - “A leading query is one that is not supported by the clinical elements in the health record and/or directs a provider to a specific diagnosis or procedure.”
- ACDIS/AHIMA *Guidelines for Achieving a Compliant Query Practice—2022 Update*:
 - “A query must adhere to compliant, non-leading standards, permitting the provider to unbiasedly respond with a specific diagnosis or procedure. References to reimbursement must not occur. All relevant diagnoses, lab findings, diagnostic studies, procedures, etc. which illuminate the need for a query should be noted and cited as to the location within the medical record.”

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Is This a Leading Query?

Further clarification is needed for this patient's visit.

Documentation states “66-year-old patient well known to me with multiple recent hospital admissions due to infection.

Most recently discharged on April 10th after treatment for COPD exacerbation and pseudomonas infection.”

Patient is noted with “Uncontrolled diabetes secondary to chronic steroids.”

Patient has been instructed to minimize sick contacts and wear a mask when in public.

Please clarify below if patient is immunocompromised due to:

- Diabetes and COPD
- Chronic steroids
- Other (please specify)

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This Is a Leading Query

- The body of the query has great clinical indicators (science)
- The statement “please clarify below if patient is immunocompromised due to” is a leading statement
- The author has made an assumption and has not allowed for the provider to disagree with the newly introduced diagnosis
- Providing appropriate query choices is an art (right brain creativity)
- What if the choices were given differently...



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Non-Leading Query

Further clarification is needed for this patient's visit.

Documentation states “66-year-old patient well known to me with multiple recent hospital admissions due to infection.

Most recently discharged on April 10th after treatment for COPD exacerbation and pseudomonas infection.”

Patient is noted with “Uncontrolled diabetes secondary to chronic steroids.”

Patient has been instructed to minimize sick contacts and wear a mask when in public.

Given this patient's clinical presentation, please further clarify the diagnosis as:

- **Immunosuppressed/Immunocompromise due to medications**
- **Immunosuppressed/Immunocompromise due to medical condition**
- **Recurrent infections due to other cause (please specify cause, if known)**
- **Other (please specify)**



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HCC Capture

- For the outpatient setting, HCC capture is a dominant CDI focus as it is important to capture the “risk” and resources needed to care for patients
- For the inpatient setting, CDI focus has been typically on capturing acute conditions
- HCCs can be captured in many settings and are added to the 12-month claim history for a patient for every visit to the acute care setting, including inpatient, observation, and emergency services
- Not every patient seen in the outpatient setting is admitted to inpatient, so inpatient CDI is not a reliable resource for HCC capture
- Many HCCs (not all) are chronic conditions (not always a priority for the inpatient setting)

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Role of Prior Encounters: Outpatient

- Outpatient query process is typically prospective or retrospective
- Clinical indicators from prior encounters can be used if they are relevant to the encounter
- Data mining from a previous encounter for the purpose of finding a reason to query is not a compliant practice
- There must be relevant information within the current encounter to prompt the need for query
- How does this apply to the outpatient setting...



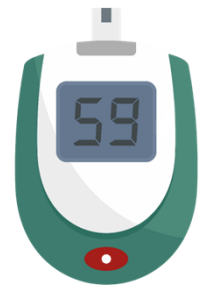
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Outpatient Coding Guidelines: Capturing Chronic Conditions



- 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)
- Code all documented conditions that coexist at the time of the encounter/visit and that require or affect patient care, treatment, or management
- Do not code conditions that were previously treated and no longer exist
- However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment



ICD-10-CM Official Guidelines for Coding and Reporting FY 2023

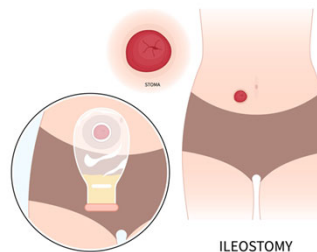
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Conditions Require Recapture Every Year



- There are certain conditions that require capture year over year (amputations or ostomies)
- Composing a compliant query is not as easy as it seems
- For example: “Dear Doctor, does the patient still have an amputated foot?”
- Although this seems an appropriate question, this would not be considered compliant
- This really is an art and science!



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Multiple Choice: Query Example for Amputation

This patient was seen today in the office. The active problem list includes a past procedure of a left great toe amputation performed in January 2022. The patient has a documented history of Type II diabetes mellitus (DM), and a foot assessment was performed at the time of this visit.

Please clarify in the patient's status as:

- Patient with left great toe amputation, DM foot assessment performed (please further specify findings)
- DM foot exam did not reveal an amputation site
- Other (please specify)

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Yes/No: Query Example for Amputation

This patient was seen today in the office. The active problem list includes a past procedure of a left great toe amputation performed in January 2022. The patient has a documented history of Type II DM, and a foot assessment was performed at the time of this visit.

Please document in the visit note one of the following:

- Yes, the patient has a left great toe amputation
- No, the DM foot exam did not reveal a left great toe amputation site

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Why Does Format Matter: Open-Ended Queries

- The most difficult to construct to elicit a desired provider response
- Pertinent clinical indicators (summary)
- The provider free texts a response which may or may not align with documentation needed to support code assignment
- Remember, providers do not document in coding terms, they need a little help from CDI



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Why Does Format Matter?

- Yes/no queries
 - Should only be employed to clarify documented diagnoses that needs further specification
 - Should not be used in circumstances where only clinical indicators of a condition are present (the diagnosis has not been established)
 - Should include the documentation in question with relevant clinical indicators and be constructed so that it can be answered with a “yes” or “no” response
 - Should include “other, please specify”
- The provider is confirming or ruling out a diagnosis
- Multiple choice queries can do more than support just one diagnosis...

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Why Does Format Matter?

- Multiple choice queries
 - Multiple choice query formats should include clinically significant and reasonable option(s) as supported by clinical indicator(s) in the health record, recognizing that occasionally there may be only one reasonable option
 - Providing a new diagnosis as an option in a multiple-choice list—as supported and substantiated by referenced clinical indicators from the health record—is not introducing new information
 - There is no mandatory or minimum number of choices necessary to constitute a compliant multiple-choice query

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Why Does Format Matter?

- Many disease processes for the outpatient setting are chronic, and queries may need to be sent to ask for specified treatment
- The multiple-choice query example for the amputation also supports M.E.A.T. for the DM (with complications) and the capture of the amputation
- The choice was “patient with left great toe amputation, DM foot assessment performed (please further specify findings)”
- So, what is M.E.A.T.?



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CDI Focus: Documentation of Chronic Conditions (M.E.A.T)

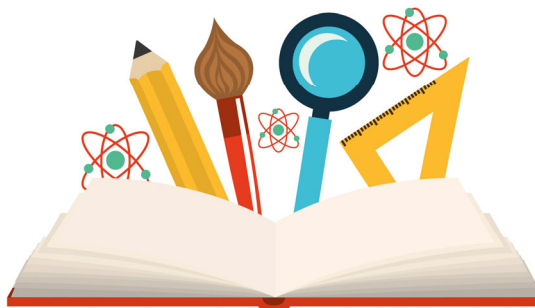
- Capturing chronic conditions should “meat” the following standards:
 - Monitoring: Documentation of signs, symptoms, progression of disease or improvement of disease, and/or ongoing surveillance of the chronic condition
 - Evaluation: Documentation of current state of the chronic conditions, physical exam findings, test results, medication effectiveness, response to treatment
 - Assessment: Documentation of discussion and/or counseling of chronic conditions (this includes advanced care planning which is a HEDIS measure)
 - Treatment: Documentation of care provided for the chronic condition

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Does the Documentation “Meat” M.E.A.T.

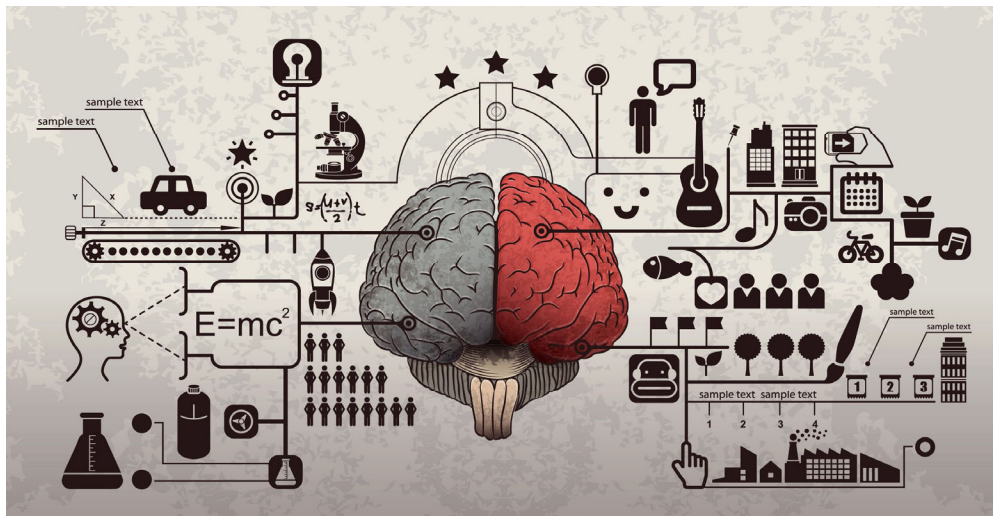
- Patient has a past medical history (PMH) of hypertension (HTN) documented in the PCP visit note
- The PCP states “the patient’s blood pressure is stable and will remain on current antihypertensives”
- Is the documentation sufficient?
- The patient’s blood pressure was taken (monitored, assessed, and evaluated)
- Continue with current antihypertensives (treatment)
- A query is not needed for this condition



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The Art and Science of Query Compliance: Observation



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Challenges of Observation Documentation

- Patients in observation status are typically being cared for by inpatient providers
- Documentation rules are different when it come to “uncertain diagnoses”
- Query potential to capture specified documentation to demonstrate the acuity of the patient
- For example, a patient is admitted to observation for chest pain and the provider states “likely PNA versus possible mild COPD exacerbation”
- Inpatient could capture this but not for outpatient



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Challenges of Observation Documentation “Uncertain Terms”

Uncertain	Definite
“Suggestive of...”	“Evidence of...”
Compatible with...”	“Treating...”
“Likely...”	“Early...”
“Suspicious for...”	“Results demonstrate...”
“Probable...”	“Significant for...”
“Concern for...”	“Element of...”

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Time to Use the Left and Right Brain

Further clarification is needed for this observation admission.

The patient was admitted with chest pain. The documentation states “likely PNA versus possible mild COPD exacerbation.” Chest x-ray is stated as negative for acute processes.

The patient was treated with IV antibiotics and transitioned to PO antibiotics prior to discharge.

The patient received nebulizers and a single dose of IV steroids and is ordered for PO steroid taper to be completed after discharge.

Please further specify the diagnoses the patient was treated for as:

- Evidence of PNA and mild COPD exacerbation, treated with antibiotics, steroids and nebulizers
- Treated for mild COPD exacerbation only, PNA ruled out after study
- Other (please specify)

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Queries Can Be Verbal

- Verbal queries must still comply with the ACDIS/AHIMA query guidelines
- Verbal queries need to be memorialized in writing to demonstrate compliance (what clinical indicators were used to ask the question)
- We cannot lead a physician to a diagnosis; however, the verbal query is much more interactive and educational in nature
- Discuss the clinical picture in the patient record, engage the physician in a discussion of what they were thinking when treating the patient, and get them to document that in the patient record



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Speaking the Same Language

The ED is a unique area for documentation

Debridements, I&D, and laceration repairs require more detailed documentation

CDI needs to speak more than one language to understand when a query is needed

Capture ED procedures to the highest degree of specificity to demonstrate the time required to treat the patient

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Verbal Query Example:

Hi Dr. Smith,

I see in your note that you performed a scalp laceration repair on patient Jones. You described the wound deep with ragged edges, and the repair was multilayered.

Can you further specify the deepest layer repaired and if the wound required debridement?



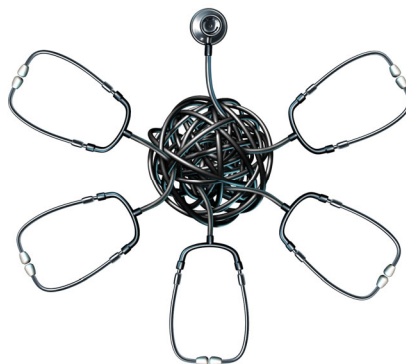
CDI Critical Thinking: Why is it important to ask this question?

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Was the Verbal Query Compliant?

- Why is it important to ask this question?
 - If not further specified, this will be captured as a simple repair. This is likely an intermediate repair or potentially a complex repair.
- What clinical indicators were used?
 - Multilayered repair on a scalp (layers are thin, doesn't take much to get to the muscle layer which would be an intermediate repair).
 - Ragged edges possibly need to be debrided for closure (if performed, this would be considered a complex repair).
- How do you memorialize this as it is a verbal query?
 - Dependent on how your organization holds on to queries.



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Risk Adjustment Data Validation (RADV Audits)

- Making accurate payments to MAOs is part of CMS' responsibility to ensure accurate payments across the Medicare program
- Studies and audits done separately by CMS and the OIG have shown that medical records do not always support the diagnoses reported by MAOs, which leads to billions of dollars in overpayments and increased costs to the Medicare program
- RADV audits are the main corrective action for those improper payments



<https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-risk-adjustment-data-validation-final-rule-cms-4185-f2-fact-sheet>

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Query Compliance Matters!

- Through RADV audits, a sample of beneficiary medical records are provided by MAOs, and CMS reviews those records to verify that diagnoses reported for risk adjusted payments are accurate and supported in the medical record
- Risk adjustment discrepancies can be aggregated to determine an overall level of payment error, which can then be extrapolated
- The HHS-OIG also undertakes audits of MAOs, similar to RADV audits, as part of its oversight functions
- CMS can collect the improper payments identified during those HHS-OIG audits, including the extrapolated amounts calculated by the HHS-OIG



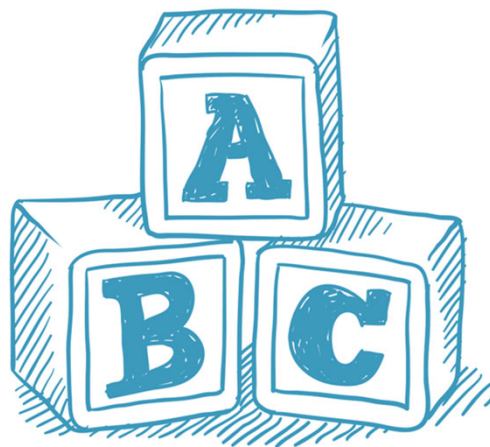
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Remember the Five “Cs” of Query Writing

- Foundation elements for queries
 - Compliance
 - Clarity
 - Clinical indicators
 - Clinically relevant options
 - Creativity

***Query compliance is truly an art
and a science!!!***



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Thank you. Questions?

kconner@hcpro.com

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