Medical Record Documentation Querying … Meeting & Maintaining Compliance

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About the Presenter

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AHIMA ICD-10-CM/PCS Trainer

- Ms. Bryant has over 40 years of experience in HIM Coding and Compliance.
- Gloryanne is the Past-President and Director of CHIA having been an HIM volunteer on local, state and national levels and served on and led many CHIA, AHIMA, HFMA and ACDIS workgroups and committees.
- She is a sought-after advisor, mentor, national educator, speaker and author on clinical coding compliance and ethics, reimbursement, CDI, physician querying, coding regulations (ICD-10-CM/PCS, CPT, MS-DRGs, and HCCs).
- Over the past four years she was an Expert Witness and Consultant for clinical coding, documentation, charging and MS-DRGs. Currently she works part-time as an Independent HIM Coding Compliance Consultant.

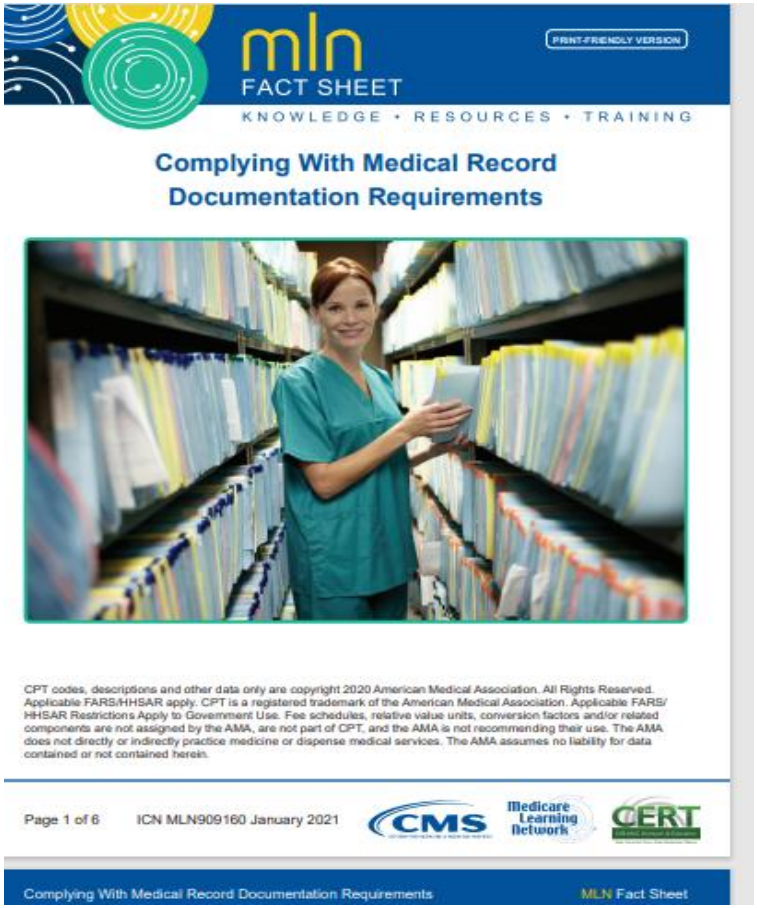
Goals/Objectives

- Learn more about types of querying, when to query and when not;
- Review clinical indicators and rationale for clinical validation;
- Enhance knowledge and understanding of the query process and compliant querying;
- Improve skills with case scenario review and discussion;
- Understand key strategies for improving your query process and compliance.

Clinical Documentation

- Demonstrates the clinician's rationale and medical decision making;
- Supports Medical Necessity rationale for tests and services;
- Tells the patient experience and their medical story;
- Communicates with other health care personnel;
- Reduces risk management exposure;
- Linked to quality scores;
- Drives the reimbursement for services and care.

CMS Fact Sheet: Documentation



mln FACT SHEET

PRINT-FRIENDLY VERSION

KNOWLEDGE • RESOURCES • TRAINING

Complying With Medical Record Documentation Requirements

CMS link: https://www.cms.gov/.pdfOutreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CERTMedRecDoc-FactSheet-ICN909160

Clinical Data . . . Coded Data

- Coded data expands beyond statistical reporting and diagnosis-related groups for accurate depictions of clinical scenarios;
- Coded data becomes administrative data to measure the quality of care;
- Coded data is used to validate the medical necessity;
- Coded data is used in Risk Management and Litigation;
- Coded data us used for Public Health and Research;
- Today almost everything that's documented in the health record, is translated into either an ICD-10 CM, ICD-10- PCS, or CPT® code = DATA!

THANK YOU FOR THE CLINCIAL CODING TRANSLATORS OF OUR HEALTHCARE WORLD!!

Clinical Documentation Query . . . Improve the Coding

- The documentation (coding) query has been around for years and years;
- Communication tool and process to clarify medical record documentation to support the code(s) assignment;
  - ICD-10-CM & PCS, and CPT code(s) – inpatient and outpatient settings
- Have a formal process determining the query is needed, submitting the query, tracking, checking for followup and closing the query;
  - Policy & Procedure (written)
- Formal templates are accepted and often used (See AHIMA or ACDIS for examples);
- A Documentation query can be generated by/from either Coding or CDI professionals.

What is a “Query”?

- In the healthcare world and in Health Information Management, the query is “A clarification request that is sent (delivered) to the provider (physician, nurse practitioner, physician assistant, etc.) who is legally responsible for the care of the patient and determining a diagnosis.”
- Synonymous terms for “query” include: clarification, clinical clarification, documentation alert, documentation clarification, and similar terminology.
- A compliant query is often the primary medical record communication tool that explains the appearance of documentation later in the admission.

Queries continue to be a mechanism that increases the precision of clinical documentation, which translates into accurate clinical coded data.

Clinical Documentation Integrity or Improvement (CDI)

- CDI programs in and of themselves are also crucial in validating that the hospital, physician office, rehab, etc., has all the complete and accurate documentation in the medical record encounters.
- Compliant clinical documentation also supports accurate quality of care reporting;
- Clinical documentation queries can aid in the capture of accurate and appropriate reimbursement via accurate and appropriate “Codes”;
- Yes, Reimbursement is driven by clinical coding and coding is driven by documentation;
- Capture the patient severity and acuity, risk of mortality;
- Documentation and coding tell the patient story!

Querying

- Querying provides a unique opportunity… yes, an opportunity!
- In order to query a provider (physician and non-physician) one MUST understand the clinical scenario and the provider's intent through the clarification of the documentation in the medical record.
- A query (clarification) can be verbal and/or written (including electronic).
- A query must follow established guidance found within the AHIMA/ACDIS Practice Brief, 2019.
  - https://bok.ahima.org/doc?oid=302673#.YYCPzW3MJpk
  - *This Practice Brief's purpose is to establish and support industry-wide best practices for the function of clinical documentation querying. Its intent is to integrate best practices into the healthcare industry's business and workflow processes and the overall function of querying. This Practice Brief should be used to guide organizational policy and process development for a compliant query practice . . .*

Querying (cont.)

- Basic Rules and Guidance for querying include:
  - Present only the facts identifying why the clarification is required;
  - Do NOT mention and/or list impact to any reimbursement (what-so-ever) nor the impact to a quality score;
  - Be compliant with the query practices outlined in the AHIMA/ACDIS Practice Brief including the scenarios;
  - A query process should have a quality review process for checks and balances and to maintain compliance.

Type of Queries

- To clarify specifically for coding (Diagnostic and/or Procedures)
  - Verbal Querying
  - Written (paper)
  - Written Electronic
- AI- Querying (technology generated, based on algorithms – clinical indicators and medical record data (lab, meds, etc.)
- Clinical Documentation Queries (concurrent)
- Clinical Validation Querying (clinically focus – often from a clinician to clinician)

Why Query??

- WHY QUERY??
  - Clarify the documentation in the health record, to tell the patient experience and story with accurate code assignments – first and foremost!
  - Obtain the patient encounter (details) clearly and concisely;
  - When clinical indicators are present in the health record along with supportive and relevant supporting diagnostic documentation;
  - Gain supporting documentation that demonstrates quality care and drives accurate measures;
  - Obtain supporting documentation that relates to reimbursement
  - Instructions within the Official Guidelines for Coding & Reporting to query in many situations.

Why Query?? (cont.)

- Patient quality
- Physician and facility scorecards
- Reimbursement/Payment structure
- Medical necessity
- Improves peer to peer communication
- Clarify an adverse clinical validation determination
- Risk management – litigation protection
- Third-party audit defense
- Assists with accurate coded data capture!

When to Query?

A query is indicated when the patient's health record fails to meet one of the following seven criteria:

1. Legibility (not too much anymore with EHR?)
2. Completeness
3. Clarity
4. Consistency
5. Precision
6. Reliability
7. Timeliness

When to Query (cont.)

- When a practitioner documents a diagnosis that does not appear to be supported by clinical indicator(s), Coding or CDI professionals should query to address the conflict.
- Think about this reporting guideline and how it fits into the query process for an inpatient secondary (other) diagnosis-
- For reporting purposes, the definition of 'other diagnoses' is interpreted as additional conditions that affect patient care in terms of requiring and of the following:
  - Clinical evaluation or
  - Therapeutic treatment or
  - Diagnostic procedures or
  - Extended length of hospital stay or
  - Increased nursing care or monitoring

When to Query? (cont.)

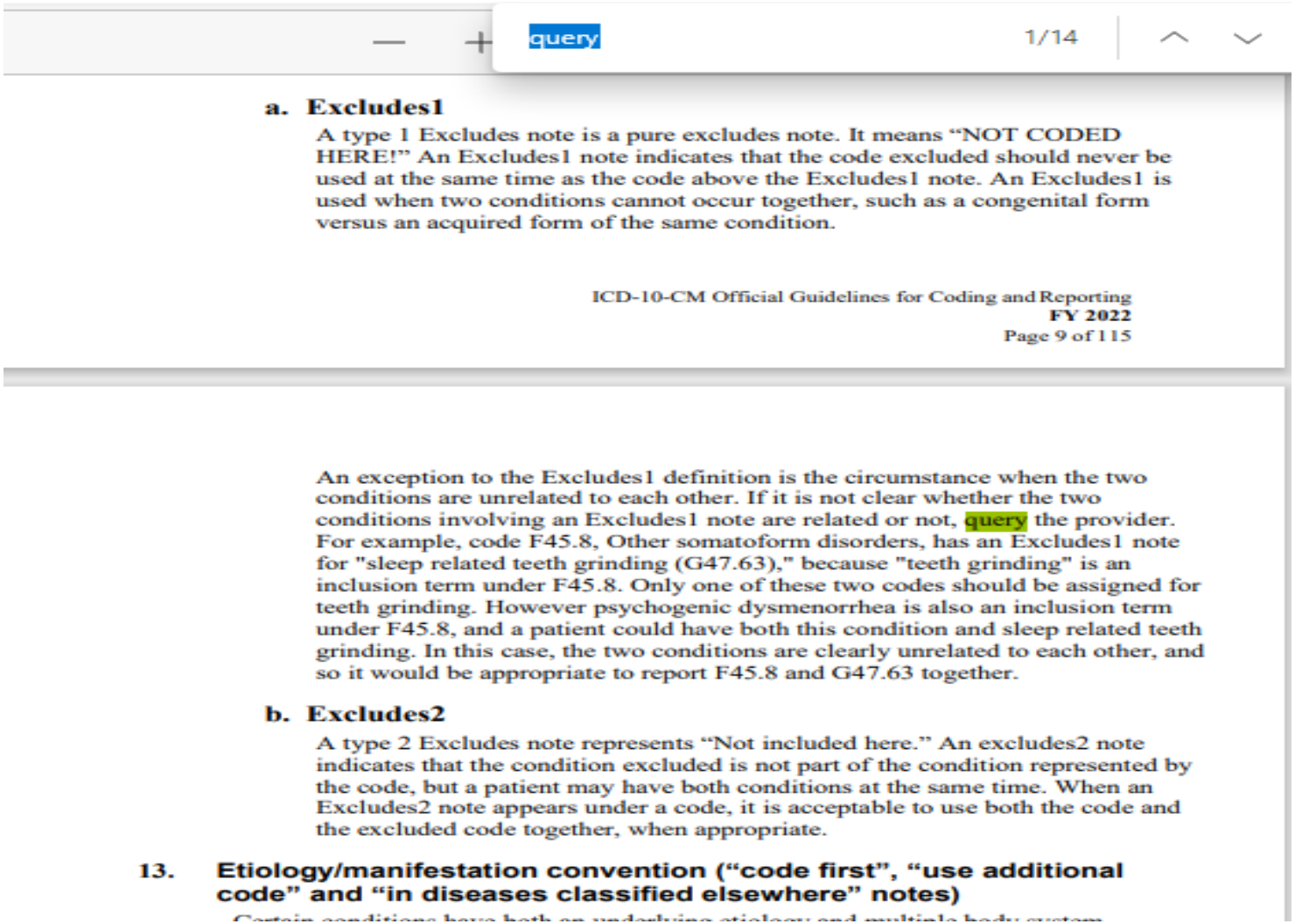
Queries may be created/developed in situations such as:

- Clinical indicators of a diagnosis but no documentation of the condition or diagnosis
- Clinical evidence for a higher degree of specificity or severity
- Uncertainty of a cause-and-effect relationship between two conditions or organisms
- No clinical indicators to support the diagnosis that is documented
- An underlying diagnosis not documented for presenting symptoms
- An underlying diagnosis not documented for treatment that is provided
- When patients are receiving drugs /medications or treatment without a diagnosis to support the therapy
- Determining the clinical significance of several abnormal test results

When to Query? (cont.)

- Establishing acuity of a condition versus past history to determine if the condition is active and not resolved.
- Determining the intensity of patient evaluation, treatment, and description of the thought process and complexity of medical decision-making.
- Clarifying diagnostic and therapeutic procedures, treatments, and tests ordered—including results.
- Lack of any changes in the patient's condition, including psychological and physical symptoms.
- Assisting in identifying any follow-up instructions or discharge planning.
- Clarifying each new or active condition, the disease manifestation, severity, precipitating event/cause, and/or complication/consequence.

When to Query? ICD-10-CM Official Guidelines – Query Instruction



When to Query? (cont.)

Query when instructed by Official Guidelines for Coding & Reporting:

Examples:

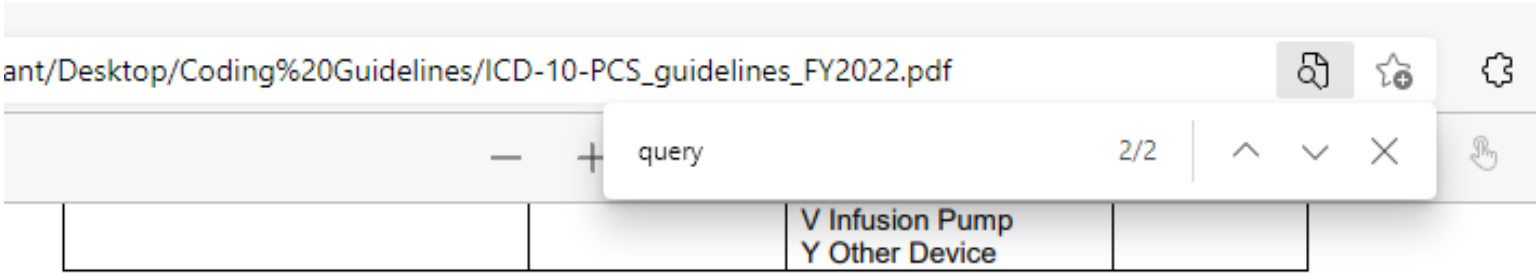
- Convention Guidelines #12. Excludes . . . An exception to the Excludes1 definition is the circumstance when the two conditions are unrelated to each other. If it is not clear whether the two conditions involving an Excludes1 note are related or not, **query the provider**.
- General Guideline #16. Documentation of Complications of Care . . . There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication. **Query the provider** for clarification, if the complication is not clearly documented.
- General Guideline #17 . . . Whenever the documentation is unclear regarding a borderline condition, coders are encouraged to **query for clarification**.

When to Query? (cont.)

Chapter 1 Specific Guideline (iv) Acute organ dysfunction that is not clearly associated with the sepsis.

- An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, **query** the provider.
- (b) Severe Sepsis . . . Due to the complex nature of severe sepsis, some cases **may require querying** the provider prior to assignment of the codes.
- Chapter 10 Specific Guideline 3) Sequencing of acute respiratory failure and another acute condition. . . If the documentation is not clear as to whether acute respiratory failure and another condition are equally responsible for occasioning the admission, **query** the provider for clarification.

ICD-10-PCS Official Guidelines – Query Instruction



A10
"And," when used in a code description, means "and/or," except when used to describe a combination of multiple body parts for which separate values exist for each body part (e.g., Skin and Subcutaneous Tissue used as a qualifier, where there are separate body part values for "Skin" and "Subcutaneous Tissue").
Example: Lower Arm and Wrist Muscle means lower arm and/or wrist muscle.

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.
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.

AHIMA/ACDIS Query Practice Brief

"Guidelines for Achieving a Compliant Query Practice" 2019 - Queries are utilized to support the ability to accurately assign a code and can be initiated by either coding or CDI professionals.

Queries may be necessary for (but are not limited to) the following instances:

- To support documentation of medical diagnoses or conditions that are clinically evident and meet Uniform Hospital Discharge Data Set (UHDDS) requirements but without the corresponding diagnoses or conditions stated.
- To resolve conflicting documentation between the attending provider and other treating providers (whether diagnostic or procedural) To clarify the reason for inpatient admission.
- **To seek clarification when it appears a documented diagnosis is not clinically supported.**
- To establish a diagnostic cause-and-effect relationship between medical conditions.
- To establish the acuity or specificity of a documented diagnosis to avoid reporting a default or unspecified code.

AHA Coding Clinic Tells Us to Query: Q1 2021 & Q2 2021

Q1 2021: A 54-year-old patient with a history of seizures was admitted to the hospital after being found passed out in the street, due to a syncopal episode and possible seizure activity. The provider documents the final diagnosis as “Likely pseudoseizures.” How should pseudoseizure in a patient with history of seizures be coded?

Response Since this patient has a history of seizures, **query** the physician for clarification, regarding whether this diagnosis represents a recurrent seizure versus a pseudoseizure, so that the appropriate code can be assigned.

Q2 2021: Clarification of Lead Placement in Bundle of His.

Response: Bundle of His lead placement may be approached from the left or right. In coding the placement of bundle of His leads, coding professionals should identify whether a lead placement is through a left or right approach. If the health record documentation is unclear, query the provider.

AHA Coding Clinic Tells Us to Query: Q3 2021

Clarification – Reporting Additional Diagnoses in Outpatient Setting . . .

In the case published in Coding Clinic, Third Quarter 2020, page 33, codes were not assigned for the mental health conditions, since there was no provider documentation that the mental health conditions or their treatment affected patient care and management for the current encounter. If the medical record is unclear or ambiguous regarding which condition(s) affected patient care and /or management of the patient, **query** the provider for clarification.

AHA Coding Clinic Instruct to Query

Yes, AHA Coding Clinic does instruct to query.

- 1st Quarter 2021 = 6 times
- 2nd Quarter 2021 = 5 times
- 3rd Quarter 2021 = 2 times
- 4th Quarter 2021 = 4 times

When NOT to Query?

- When there are “normal” diagnostics and other findings -
  - Even “one” abnormal lab value often IS NOT enough to support a query . . . So, think twice about querying.
  - When a person is ill, taking medications, - this can be stressful and an abnormal lab finding can be simply from the clinical circumstances and not a specific diagnosis or condition.
- Documentation does support the symptoms or appropriate treatment for the given diagnosis – don’t’ query.
- If you missed or avoided reading parts of the medical record encounter documentation – don’t query (yet).
  - Didn’t read/check Nursing Note, Therapies, etc.
  - Conflicting? Check the documentation carefully!!
  - Attending physician

When NOT to Query . . . (cont.)

- Clinical indicators are NOT present in the documentation;
  - Need those clinical indicators to support the query
- No documentation supporting that there is another or additional diagnosis;
  - Guessing or second-guessing the patient has a particular DX
- The encounter date and the query date are far apart, more than 30- 60 days apart (have a policy for this timeline) – hospital inpatient'
  - Some AAPC literature states within 48 hours of the encounter; for an E&M query
- Physician negatively towards queries……bring in assistance from the Physician Liaison or Physician Champion.

DO NOT QUERY . . .

- Provider documentation states the condition is "not clinically significant" ;
- Include financial information on the query;
- Give a financial reward for documenting certain diagnoses;
- Do not include quality scores or impact to MIPS.
- Per the AHIMA/ACDIS Practice Brief:
  - Examples of non-compliant queries include:
    - directing a provider to document a diagnosis that is not clinically supported but serves as an exclusion for a patient safety indicator, or
    - adding a non-reportable diagnosis, or
    - encouraging a provider to neutralize documentation suggestive of a post-surgical complication.

Decision to Query . . .

- What do you do when a diagnosis is documented BUT the clinical indicators are not present or not supporting the diagnosis?
- Do you CODE the diagnosis anyway?
- Do you IGNORE the diagnosis and not code it?
- ACTION: Generate and send a query to the provider to confirm the diagnosis - this is the right action to take!
- ACTION: Request a clinical validation be conducted if appropriate.
- ACTION: Request or Move to Query Escalation to your physician liaison.

How to Query?
(Query Format)

- Previous encounter information or work up in the outpatient setting may be referenced in queries for clinical clarification and/or validation if it is clinically pertinent to the present encounter.
- It is inappropriate to “mine” previous encounter documentation to generate queries not related to the present encounter.

How to Query? (cont.)
(Query Format)

- Query Encounter timing:
  - Concurrent with the patient encounter
  - Prebill (prior to the claim submission)
  - Retrospective (post-encounter claim submission) - use caution
- Written queries, whether paper or electronic, should be made utilizing compliant query templates;
- Verbal queries should be documented also and tracked;
- Query format;
  - Open-ended
  - Multiple choice
  - Yes/No

How to Query? (cont.) (Query Format)

Written/Electronic/Verbal:

Clear, concise, and non-leading (the title of the query should not be leading, and the query should include both supporting as well as conflicting documentation).

Simple and direct.

Itemize the clinical indicators or clues from the health record (example: nursing documentation, laboratory findings, radiological findings, etc.).

Query Vulnerabilities

- **Cloned notes and assessments:**
- This occurs when nurses or other providers copy and paste information from a previous visit into the current visit without verifying the accuracy of that information. In many cases, details are completely inaccurate or omitted entirely.
- There's also often a mismatch between the chief complaint/history of present illness and the assessment. For example, a patient complains of neck pain but the entire assessment addresses the patient's lower back pain.
- This incongruence can certainly benefit from a CDI and/or Coding specialist's analytical eye.

Query Vulnerabilities (cont.)

- EHR with “SMART” phrases, “Dot” phrases
- Suggesting a Diagnosis to the Physician
- Prompting the Physician with a specific Dx included
- Computer Assisted documentation or Artificial Intelligence (AI) can create incorrect diagnoses (caution)
- Not having written policies and procedures for the query process (step by step) is a risk.

Query Vulnerabilities (cont.)

ICD-10-CM Diagnosis Specificity:

Certain specialties, such as orthopedics, OB/GYN, internal medicine, and cardiology, see more ICD-10-CM codes than others.

These specialties could benefit from CDI that prompts greater specificity related to laterality, disease manifestation, anatomical location, and more.

An individual trained in CDI can help explain ICD-10 terminology to physicians and create ICD-10 favorite lists and shortcuts to alleviate the burden of sifting through diagnosis codes listed in the EHR—ultimately increasing productivity.

Unspecified CPT codes may prove to be particularly problematic in practices. That's because CPT codes—not diagnosis codes—drive reimbursement in the practice setting, BUT this leaves little incentive for physicians to pay attention to diagnoses for medical necessity, etc.

- However, Risk Adjustment is diagnosis focused! (Medicare Part C)

Query Vulnerabilities (cont.)

Medical necessity:

Physicians sometimes don't understand that medical necessity isn't synonymous with medical decision making.

The specific ICD-10 diagnosis codes that the physician chooses can either make or break a payer's decision to deem services medically necessary for the patient.

Many physicians don't even realize that local coverage determinations (LCDs) exist, requiring certain diagnoses as a prerequisite for payment.

As payers continue to update these LCDs with ICD-10, someone focused on CDI can monitor changes and ensure that documentation is updated accordingly.

Query QA/Review

Checks and Balances (have a formal process in place) – quality assurance review:

- **Written P&P (essential and primary)**

Maintain a spreadsheet with the status of the query, the date with the patient's identifying information as well as the provider's name.

If the query is unanswered, follow the established escalation process.

Monitoring of the query process will be an ongoing practice.

- Throughout the year
- Determine who will conduct this monitoring
- How to report monitoring findings
- Action to take

Conduct an annual quality assurance review on your querying processes, those encounters with a query and those without.

- Budget for this and obtain resources (i.e., external vendor support)

Query QA Review (cont.)

The internal QA auditing review frequency will vary by organization with a minimum recommendation of twice a year and as needed depending on the needs of the organization and the maturity of the program.

- New employee
- Significant change in the Coding classification or Guidelines (ICD-10-CM/PCS & CPT)
- Significant change in volume of queries
- Significant change in response rate of queries
- QA Review with detailed medical record review and query review
- New treatment protocol and/or new surgical procedure and/or device

Physicians who determine and assign their own diagnosis codes (and/or E/M levels) without any random review, or without CDI or coding professional intervention; then the opportunity could be lost to query a physician for greater specificity or higher E/M level assignment.

- In this case monitoring E/M level distribution is essential.
- Automated and electronic Diagnosis and CPT selection carries a risk

Query Q/A Review (cont.)

- When a physician is outside the norm (bell curve) for CPT, they should consider coding professional querying and educational intervention opportunities.
  - Follow compliance
  - Follow the AHIMA/ACDIS Practice Brief also
- **SO . . . Establish a query QA review process.**
  - Query Frequency, volume and reporting of review findings should be included in the process
    - Keep a record of the QA review results, etc.

Query Monitoring & Auditing

Per AHIMA Practice Brief -

A monitoring process should be ongoing and typically includes:

- A spreadsheet with the status of the query, the date with the patient's identifying information, and the provider's name.
- An escalation process for unanswered queries (see Query Escalation and Retention).
- Ongoing and continuous monitoring of the query process.

An auditing program with an audit frequency of at least twice a year, depending on the needs of the organization and the maturity of the program.

- Identify lost opportunities for greater specificity or appropriate E/M level assignment when physicians determine and assign their own E/M levels without subsequent random review. In this case, monitoring E/M level distribution is essential. When physicians are outside the norm (bell curve), they should consider coding professional intervention and querying opportunities.

Query Escalation

- When a physician/provider query goes unanswered, there needs to be a process in place to address this.
  - Have a written P&P for this!
  - Do you “Re-Query”?
- An unanswered query could have legal or compliance repercussions.
- Include “clinical validation” issues in your escalation process as well.
- A physician “advisor” is one choice
- NOTE: DO NOT OVER-USE ESCALATION (Caution)

Query Escalation (cont.)

- Per AAPC: Failing to thoroughly document signs and symptoms, assessments, and treatments of chronic diseases creates a ripple effect of misfortune.
- Develop an escalation policy for unanswered queries, and address staff concerns regarding queries.
- The escalation process may include referral to a physician advisor, the chief medical officer, or other administrative personnel.
  - This process needs physician approval and buy-in
    - Take to Medical Ex Committee

Query Retention

- Each query practice should develop an internal process and policy regarding query retention.
  - Have a written P&P for this!
- If the practitioner documents his or her response only on the query form itself, then the query.
- An important consideration in query retention is the ability to collect data for trend analysis, which provides the opportunity for process improvement and identification of educational needs; this will vary depending if the query process uses a paper or electronic format.

Query Retention (cont.)

- Do you have anything to hide with your queries?
  - Then why not include in the legal medical record!
- Best Practice: Queries should be transparent and retained
  - Part of the permanent health record
- Retaining written, templated, and verbal queries in document form is necessary to ensure CDI compliance.
- In the current climate of regulatory agencies (e.g., recovery audit contractors and Medicare administrative contractors - MAC), it's a good practice to maintain queries as part of the legal and permanent medical record to demonstrate compliant and ethical coding practices.

Clinical Indicators (Yes or No to Query)

Clinical indicators offer support within the record for the diagnoses applied to the patient. They can consist of:

- Laboratory or diagnostic test results
- Imaging studies
- Treatments- medications, interventions, infusions, services

Patient's response to treatment

- Patient assessments and plans of care (by all caregivers)
- Symptoms
- Observations
- Objective data- vital signs, height/weight, pain level, and site of pain (discomfort), etc.

Clinical Validation

- It is important to recognize that the process of clinical validation differs from the process of diagnosis-related groups (DRG) validation in the inpatient hospital setting.
- Clinical Validation: “The process of validating each diagnosis or procedure documented within the health record, ensuring it is **supported by clinical evidence**”
- MSDRG Validation: “The process in which the final DRG assignment is validated based upon the clinical documentation and the appropriate coding of the principal and secondary diagnoses, and any applicable procedures”.
- Performed by an individual with clinical expertise and knowledge.

Clinical Validation (Yes or Not to Query)

- Before querying, ask if there is a reason for clinical validation;
- This will take collaboration;
- Establishing a formal and detailed process;
- Provider engagement is essential for a robust clinical validation process.

Case Scenario #1

75-year-old female Patient presented with fatigue in the ER. She had Faint crackles noted at the bases during the ER physical exam. Temp was 99.2, with reports of feeling tired. She also has a history of Chronic kidney disease, stage 3 on H&P and Dx of Pneumonia, unknown organism. The Chest X-ray noted: Low lung volumes with bilateral infrahilar alveolar infiltrates. Checking creatinine (UA) every 8 hours and renal Ultrasound.

Started on IV antibiotics, continued for 1.5 days and chest crackles decreased. She was discharged on day 2 with significant improvement and no fever. Final progress note states CKD stage 3 now stable with community acquired pneumonia., improved. Treated with azithromycin 500 mg in NS 250 mL IVPB, levoFLOXacin tablet 500 mg and cefePIME 1 g in NS 100 mL mini-bag. Progress note documentation states avoided nephotoxic drugs. Respiratory therapy to see patient. Will have a Home health assessment ordered.

Discharged on oral antibiotics and followup with MD for CKD.

LOS 2 days.

Discussion Case #1

- To Query or NOT to Query?
- What do you think?
- Two diagnoses documented, Both were evaluated and treated.
- BUT Were they equal?
- What do you think is the Principal diagnosis?
- Do we need a Query?

Case Scenario #2

74yo M PMHx DLBCL, abdominal lymphoma who presented with weakness, fatigue, poor oral intake 2/2 severe oral and esophageal pain w food intake x 2 weeks and melena few days. Has been undergoing cancer treatment for past 2 weeks.

ER documentation: Temperature 36.3, Pulse 122, Respirations 20, WBC 5.5, Procalcitonin 0.45. Urine and Blood culture done on admit were negative. Some appearance of dehydration., with BP low at 98/60, documentation of Septic Shock present in ER.

GI consult and Infectious Disease consult ordered. Admitted 11/10/2020.Dietary consult ordered.

11/11/2020 Treated with cefePIME 2 g in NS 100 mL mini-bag. Improving. Dietician saw patient and fluid diet started.

11/12/2020 Progress note improving, will DC today ER and Infectious MD states Sepsis. Shock on admit. Recommend fluid diet for next 4-5 days. Discuss treatment plans with Oncologist.

LOS 2 days.

Discussion Case #2

- Query or NOT to Query?
- What do you think?
- Need a Documentation Query?
- Was SIRS Met?
- Was there a localized infection?
- Was there “organ failure?”
- What Dx was Present on Admission?
- Does OCG Section 1.A.19 apply here? The Code assignment and Clinical Criteria.
- Do we need a Clinical Validation query?

Is there Query Fatigue??

- **Fatigue for providers is well-known AND also for those generating the queries!**
- What % of cases do you query on?
  - Know your stats
- Identify ways to decrease redundancy in queries causing lack of provider participation
- Double check before querying: Yes/No to query?
- Identify pitfalls in clinical indicator application
- Same queries over and over ? ….Education is needed!
- Define compliant verbal queries
- Identify query best practices
  - Having a QA process/review

Remember . . . The Query Process

- When and When NOT to Query?
- The process of querying providers is an essential mechanism to improve data quality, documentation, clinical coding, resolution to reimbursement issues (denials).
- This process is also an effective approach to obtaining complete and concise information as required for coded data.
- Querying can help identify . . . Patterns of poor or inadequate documentation can be identified and addressed with provider education and training.

Remember . . . The Query Process (cont.)

- An effective query process will bridge the gap of communication between coders and providers.
- This process is a winning solution for physicians, coding professional, CDI specialists and healthcare organizations.
- Know when to query and when NOT to!
- **REMEMBER**: when implementing an effective query process, physician office practices are likely to demonstrate improvements in the quality of coded data and meet the needs established for healthcare compliance.

Remember . . . That a Query

Is a powerful communication “tool”.

- Work with providers
- Dialog, they want to understand the need and request

Is worded so that the provider can and will reply: “Based on your clinical judgment, can you provide a diagnosis/condition that represents the below-listed clinical indicators?”

- Not challenging the providers clinical judgement or knowledge

Has many benefits besides financial.

Must be compliant!

- Non-leading
- Timely
- Not financially focused

Remember . . .

- A query written just to confirm the diagnosis will not be enough to prevent outside auditor denials.
  - There needs to be clinical indicators present in the medical record and use those clinical indicators in your query.
- The goal of the query is to obtain the necessary clinical documentation to reflect the provider's rationale or clinical decision making and tell the patient story!
- It is possible to read too far into the clinical documentation and make connections that don't really exist. Before submitting a query, stop and consider the appropriateness.

Key Next Steps . . .

Focus on determining When and When Not to Query

- Second set of eyes – have your Manager/Supervisor take a look at a questionable encounter

Focus on collaboration: Collaboration among key staff members in the provider practice will help providers document better and more efficiently.

- Queries can be educational for providers

Focus on having a quality assurance (QA) review of queries – conduct a review, don't' wait!

Remember: the patient can and do review the medical records today, so helping to ensure complete and accurate clinical documentation is essential!!

Key Query Resources

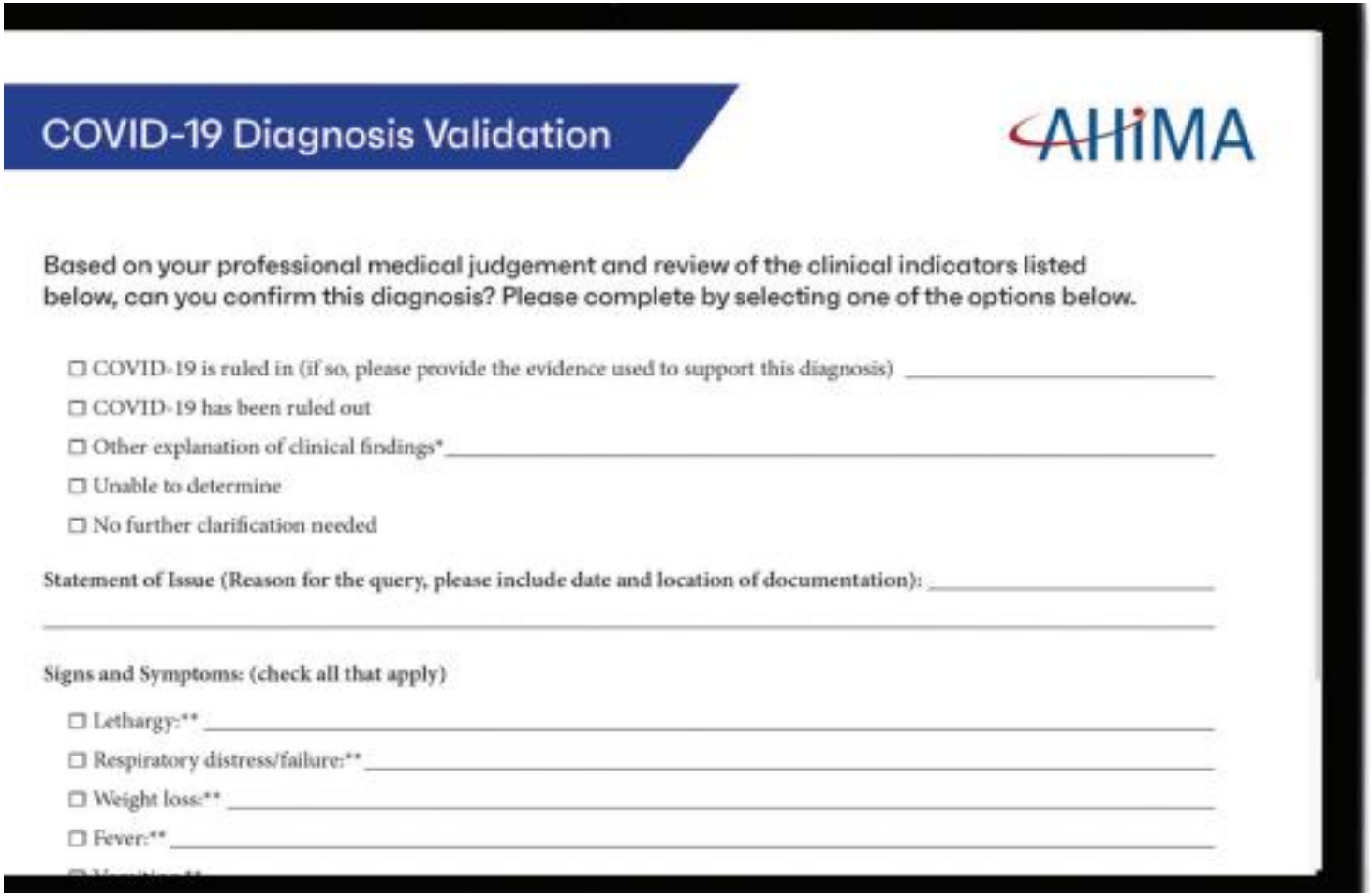
- **AHA Official Guidelines for Coding and Reporting**
- **AHA Coding Clinic on ICD-10-CM/PCS**
- AHA Coding Clinic on HCPCS
- AHIMA Standards of Ethical Coding
- AHIMA Ethical Standards for CDI
- **AHIMA/ACIDS Practice Brief: Complaint Query (2019 and other years)**
- AHIMA Clinical Validation
- AHIMA OP Query Toolkit
- AMA CPT Codebook and even AMA CPT Assistant
- ACDIS tools and online resources (toolkits)

"Bold" represents the 3 must have "QUERY" resources!

Other Helpful Resources

- AHIMA CDI information
- ACDIS query information
- Webinars
- Books
- Certification
- Query Templates (https://ahima.org/media/43fmla23/ahima-cdi-query-templates.pdf)
- CMS MLN: Complying With Medical Record Documentation Requirements
- Noridian, Jurisdiction E – Medicare Part B, Documentation Guidelines for Amended Medical Records, last updated on July 16, 2015: https://med.noridianmedicare.com/web/jeb/cert-reviews/mr/documentation-guidelines-for-amended-records
- Medicare Program Integrity Manual, Chapter 3 – Verifying Potential Errors and Taking Corrective Actions

AHIMA Clinical Validation Example



COVID-19 Diagnosis Validation

AHIMA

Based on your professional medical judgement and review of the clinical indicators listed below, can you confirm this diagnosis? Please complete by selecting one of the options below.

- ☐ COVID-19 is ruled in (if so, please provide the evidence used to support this diagnosis) _____
- ☐ COVID-19 has been ruled out
- ☐ Other explanation of clinical findings* _____
- ☐ Unable to determine
- ☐ No further clarification needed

Statement of Issue (Reason for the query, please include date and location of documentation): _____

_____

Signs and Symptoms: (check all that apply)

- ☐ Lethargy:** _____
- ☐ Respiratory distress/failure:** _____
- ☐ Weight loss:** _____
- ☐ Fever:** _____

Summary

- Following the AHIMA/ACDIS Practice Brief to obtain and maintain compliance
- There are different types of Queries
- Know When to Query
- Know When NOT to Query
- Each case, encounter and scenario is different
- Timely querying is important! (Have a P&P)
- Establish a QA review of queries
- Educate

Remember: Successful querying and clinical documentation improvement (CDI) programs facilitate the accurate representation of a patient's clinical status that translates into coded data

Questions?

- Are there any questions?
- Please contact MRA if you have any questions regarding the query process.

Thank you

Thank you for attending today!

References/Resources

- AHIMA/ACDIS Practice Brief, Compliant Query, 2019
  - https://bok.ahima.org/doc?oid=302673#.YYCPzW3MJpk
- Clinical Validation (acdis.org)
- CHIA, 2018
- https://forums.acdis.org/uploads/editor/p8/kuazsjp9dfy0.pdf (Updated 2019)
- ACDIS-White-Paper-Clinical-Validation_2017.pdf (ncha.org)
- https://www.scp-health.com/providers/blog/think-with-your-ink-4-reasons-why-proper-medical-record-documentation-is-vital#:~:text=Four%20Reasons%20to%20Document%20Medical%20Records%20Properly%201,associated%20with%20claims%20processing%2C%20and%20ensure%20appropriate%20reimbursement.
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3010959/
- Query Physicians to Improve Documentation and Dx Coding - AAPC Knowledge Center
- https://journal.ahima.org/physician-query-examples/#:~:text=A%20query%20can%20be%20a%20powerful%20communication%20tool,different%20forms%20of%20queries%20available%20to%20HIM%20professionals