



The Provider Query Toolkit

A Guide to Compliant Practices



Karen Newhouser, RN, BSN, CCDS, CCDS-O, CCS, CDIP, CCM

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Karen Newhouser is the clinical documentation integrity (CDI) content manager for AMN Healthcare Revenue Cycle Solutions in Tampa, Florida. In addition to several decades of experience as a nurse—mostly in the critical care sector—Newhouser has nearly two decades of experience in the CDI and case management realm. She is an expert in compliant query best practice, quality initiatives, clinical validation, provider engagement initiatives, auditing, and data analysis.

In addition to Newhouser's devotion to her family, writing and education are her passions, as evidenced by her commitment to sharing knowledge with others through speech and print as she strives to set others up for success. Newhouser has been a valued speaker at numerous ACDIS and American Health Information Management Association events geared toward both inpatient and outpatient settings.

Newhouser is the author of previous ACDIS titles, including *The CDI Specialist's Guide to Evaluation and Management*, and has coauthored the *CCDS-O Study Guide* and the *2020 ACDIS Outpatient Pocket Guide*.

Newhouser is a member of ACDIS, AHIMA, AAPC, CCMC, and Sigma Theta Tau International Honor Society of Nursing. She sat on the ACDIS Advisory Board from 2015–2018 and was honored to be named the 2015 ACDIS CDI Professional of the Year. Contact her at karen.newhouser@amnhealthcare.com.

Introduction

A query is the most important task a clinical documentation integrity (CDI) professional performs. From its roots when the CDI profession began in the mid-1980s, the goal for CDI has always been to create a precise, accurate, and complete health record. While the path back then was initially different than it is today, focusing on reimbursement was likely the only way hospital leadership would buy in to allowing CDI in the hospital setting. We live in a rapid-results world, and the promise of CDI to bring rapid results by identifying gaps in conditions that, when clarified, may result in a larger reimbursement due to a higher weighted diagnosis-related group (DRG) was likely enticing to hospital administrators.

The patient is at the center of healthcare, as every person in healthcare is working toward achieving one goal: providing safe, effective, quality care to patients. This goal is true regardless of where the patient exists in the continuum of care. CDI is rising to that challenge as it expands into the outpatient setting.

While CDI started with a focus on reimbursement, the CDI profession was born from a realization that the patient encounter wasn't always an accurate portrayal of the patient's health status. The CDI professional works collaboratively with providers to conduct a comprehensive analysis of the documentation in the health record to ensure it is precise, accurate, and complete. This can be done concurrently or prospectively, with concurrent reviews commonly utilized in the inpatient setting and prospective reviews commonly utilized in the outpatient setting.

Everyone who cares for the patient provides documentation in the health record, and as someone who has been in that role, I can say that all providers believe their documentation is complete to the best of their ability. Per the rules discussed in their education and training, this documentation may be complete, although therein lies the core issue. There has long been a disconnect between what providers are taught about documentation and how providers actually need to document to bill codes that are compliant in terms of medical necessity and that abide by the many coding rules and yearly coding or billing updates. This gap isn't the providers' or clinicians' fault. The issue stems

from superficial lessons on documentation during their training as healthcare professionals. All clinicians obtain training on documentation per the constraints of their profession; however, the training doesn't quite branch outside of their documentation silo. No one is proposing that clinicians learn all of the coding rules, as a clinician's focus must remain on the patient, not the codes. However, there are principles of coding that should be included in clinician training because it would benefit all involved in patient care. Until then, the CDI professional stands at the ready to provide education regarding these principles in the form of a query, the documentation communication tool.

The pathway to a compliant query begins with a comprehensive record review with a clinical eye. The CDI professional reviews the entire record for any gaps or discrepancies in the documentation according to the policies and procedures of the facility. Then, if necessary, the coding guidelines are referenced for an applicable coding guideline that would bridge the gap/discrepancy in the documentation. It is not always necessary to reference a coding guideline, as the documentation discrepancy may be obvious. For example, it doesn't take a coding guideline to query for a discrepancy where the documentation describes a left knee injury but suddenly switches to describe a right knee injury. This may seem like a small issue, but conflicting documentation concerning site has caused plenty of issues before. These are the types of errors that a CDI professional is programmed to detect and clarify.

A compliant query is driven by the best practice standards outlined in the ACDIS/AHIMA practice brief *Guidelines for Achieving a Compliant Query Practice (2019 Update)* and in the 2018 ACDIS practice brief *Queries in Outpatient CDI: Developing a Compliant, Effective Process*.

The best practice standards and comprehensive record reviews are critical; however, CDI professionals are merely spinning our wheels if not for the relationships we build along the way. It takes a team to create a safe, nurturing, and healing experience for the patient, and CDI professionals, as part of the health record team, do our part by ensuring that the patient's health record is flawless.

The entire health record team, consisting of the CDI, health information management (HIM), quality, and denials/compliance professionals, along with the providers, must work collectively toward the goal of patient satisfaction. Most patients can and do see their health records in this age of technological advances, and it is important that the health records accurately depict what they remember from their encounters and what was described to them by their providers and nurses. By having compliant queries developed by expert CDI professionals and thoughtfully considered and answered by the provider, we can ensure patients will be satisfied with their health record and the care they receive.

Always remember that the patient is the reason we go through what can sometimes be lengthy and complex processes to get things right. The patient is at the center of healthcare.

This book is dedicated to the patient and to all those who work tirelessly to provide quality care with a precise, accurate, and complete depiction of the patient's health status. You all make me a better nurse.

I also dedicate this book to my awesome children, who have given unconditional love and support during my career as a critical care nurse, case manager, CDI professional, and author. You make me a better mother.

I additionally dedicate this book to my incredible friends and peers who I have had the utmost honor to work alongside in Ontario, Canada; Dayton, Ohio; St. Louis, Missouri; and Tampa, Florida, as well as my dear mother and wonderful family and friends throughout the world. You make me a better person.

I never could have written this book without the support of the expert staff at ACDIS led by Brian Murphy and Melissa Varnavas, and especially my editor, Arielle Aronson. You make me a better writer.

Respectfully,

Karen

Chapter 1

Back to the Patient

From Reimbursement to Quality

The clinical documentation integrity (CDI) profession began in the mid-1980s with a directive to focus on reimbursement, which initially made sense considering that's where healthcare was focused at the time. It is in the best interest of everyone involved in healthcare that a facility focuses on maintaining fiscal responsibility, as this allows facilities to attract expert staff, update and maintain the equipment, and maintain the building in a way that allows it to function and care for patients. Yet to those who work in patient care, the mission to provide the right care is the primary focus rather than a focus on reimbursement. This push and pull of making money versus providing quality patient care may seem contrary, but the reality is that these priorities go hand in hand, as it takes money to provide high-quality patient care, because of the need for qualified staff, the best possible equipment, and up-to-date technology.

While reimbursement is truly a factor, it cannot be the focus, for the patient is at the nucleus of healthcare, and providing high-quality healthcare not only benefits the patient but also leads to the appropriate reimbursement. This rings true in the saying that "money follows quality; quality doesn't follow money." The CDI professional recognizes the patient as the focus and operates in a metaphorical swim lane alongside the clinical staff to focus on creating precise, accurate, and complete health record documentation that depicts the quality of the care provided.

History of quality in healthcare

CDI is a relatively recent process in healthcare, as quality movements date back to the 19th century, when the first quality efforts were being performed. Quality pioneers included Florence Nightingale,

whose efforts during the Crimean War in 1854 decreased the mortality rate from disease among British troops from 42.7% to 2.2% (Sheingold, 2014). Her improvements would have likely been overlooked had it not been for the meticulous records and charts she kept, which are regarded by some today as the first statistical quality measurements.

Nightingale was likely influenced by Dr. Ignaz Semmelweis, who linked handwashing and cleanliness to disease reduction in Viennese maternity wards in the 1840s. Some of these early efforts carried an influence across the Atlantic Ocean to the United States, where the government established a Sanitary Commission in 1861, which aimed to promote clean and healthy conditions in the Union Army camps and hospitals. Significant advances were also made following Louis Pasteur's discovery that disease was caused by microorganisms, a breakthrough that led to the adoption of antiseptic practices worldwide (Sheingold, 2014).

What those early quality pioneers had in common was a focus on patients beyond the sole conditions for which they were being treated. This is the historic foundation of today's modern-day quality focus.

The modern quality movement began with the landmark Institute of Medicine (IOM) study *To Err Is Human: Building a Safer Health System*, which highlighted the stark deficiencies in patient safety in hospitals (The Institute of Medicine, 2000). The study noted that experts estimated that tens of thousands of people die every year and hundreds of thousands are injured by the very health system from which they seek help. The study served as both a wake-up call and a call to action that transformed the quality landscape by uniting a variety of stakeholders to work toward a single goal: to increase the patient's safety and improve the patient's quality of care.

Medicare Quality Programs

Quality healthcare is a priority beyond the CDI profession. The Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) have demonstrated their emphasis on quality patient care by implementing a variety of programs aimed at encouraging facilities to achieve additional reimbursement and a better national reputation through performance in quality measures that include quality initiatives, pay for reporting, and public reporting. Modern quality measures provide a vehicle to drive high-quality healthcare toward the goal of effective, safe, efficient, patient-centered, equitable, and timely care (CMS, 2020).

A 2006 IOM report, *Preventing Medication Errors*, recommended the use of incentives “so that the profitability of hospitals, clinics, pharmacies, insurance companies, and manufacturers (are) aligned with patient safety goals; that is, the incentives should strengthen the business case for quality and safety” (The Institute of Medicine, 2006).

When healthcare providers receive incentives for better performance—that is, providing better care in a more cost-efficient manner and meeting preestablished targets for the delivery of quality healthcare—along with financial deterrents, such as withholding payments for negative consequences of care or

The specific HVBP performance measures within these domains are listed on the Quality Net website at <https://www.qualitynet.org/inpatient/hvbp/measures>.

Hospitals are evaluated based on whether they meet the performance standards for the measures by comparing their performance during the performance period to their performance during a three-quarter baseline period. Each hospital receives both an achievement and an improvement score for each measure. Then a total performance score is calculated by combining the greater of the hospital's achievement or improvement points for each measure to determine a score for each domain. CMS then converts each hospital's TPS into a value-based incentive payment.

Of the four domains, the safety and clinical outcomes are directly driven by documentation of the diagnoses and conditions. If there is precise, complete documentation that is then correctly coded, the data will reflect a high quality of care that will boost the hospital's performance in those domains. CDI professionals work within this space to assist the provider in documenting precisely, accurately, and completely in order to create trustworthy data that will reflect positively on the facility.

Hospital-Acquired Condition Reduction Program

Another P4P program created by the Affordable Care Act is the Hospital-Acquired Condition Reduction Program (HACRP). Hospital-acquired conditions (HAC) are conditions identified as high cost, high volume, or both; result in a higher payment DRG when present as a secondary diagnosis; and reasonably could have been prevented through the application of evidence-based guidelines. The HACRP adjusts payments to hospitals based on performance in HAC quality measures. Hospitals that rank in the worst-performing quartile of all participating hospitals receive a 1% payment reduction on hospital claims in 2020 (CMS, 2020).

The conditions for FY 2020 are:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma
 - Fractures
 - Dislocations
 - Intracranial injuries
 - Crushing injuries
 - Burn
 - Other injuries

better define clinical conditions or consequences that arise during an inpatient admission. Reporting options include (Optum360, 2020):

- Y = present at the time of inpatient admission
- N = not present at the time of inpatient admission
- U = documentation is insufficient to determine whether condition is present on admission
- W = provider is unable to clinically determine whether condition was present on admission

CDI professionals review the documentation for clinical evidence that a condition was potentially POA, and if the POA status is unclear, a query should be developed for clarification that each condition is correctly designated as POA or a HAC. Not all HACs meet the requirements to be included on the HAC list, so the CDI professional should not focus only on the conditions listed when reviewing the record for POA status.

An example of a query for POA status is found in Figure 1.1.

Figure 1.1: POA Status Query

Dear Provider,

Patient was admitted on May 1, 2019. Attending physician progress note on May 3, 2019, indicated a sacral pressure ulcer. ED nursing notes on day of admission describe a stage 2 sacral pressure ulcer. Wound care documentation on May 1, 2019, describes the presence of a stage 2 sacral pressure ulcer with treatment ordered.

Based on the above clinical indicators, in your clinical judgment, was the sacral pressure ulcer POA?

- Yes, the sacral pressure was POA
- No, the sacral pressure ulcer developed after admission
- Unable to clinically determine with the above indicators

Thank you,

Clinical Documentation Integrity Professional

Hospital Readmissions Reduction Program

The Hospital Readmissions Reduction Program (HRRP) is another ACA P4P program that reduces payments to Inpatient Prospective Payment System (IPPS) hospitals with excess readmissions beginning October 1, 2012. Payment reductions, capped at 3%, are applied to all Medicare fee-for-service base DRG payments. CMS includes the following six 30-day risk-standardized unplanned readmission measures in the program (CMS, 2020):

- Acute myocardial infarction (AMI)
- Chronic obstructive pulmonary disease

Chapter 2

The Watchful Eye

Those who have worked in healthcare know that everything in healthcare falls under a watchful eye. Those who have worked in a hospital know to expect additional focus from outside entities, and this additional oversight is for good cause. Because the patient is the most important person in the healthcare system, the patient's health and safety is the top priority. Oversight is key to keeping it a top priority, as oversight keeps everyone and everything on the right path, much like the laws that govern our daily lives. Without oversight, practice standards run the risk of breaking down as people begin to unknowingly stray from what is right.

The number of overseers has increased over the years, and clinical documentation integrity (CDI) staff likely welcome these watchful eyes. Although most oversight agencies have little real-time effect on the day-to-day workflow of the CDI professional, the results of a CDI professional's work, from the data that are collected through querying for medical necessity and clinical validation, are valuable to the overseer. CDI professionals have nothing to fear as long as they continue to develop compliant queries according to the best practice standards outlined in the query practice briefs *Queries in Outpatient CDI: Developing a Compliant, Effective Process*, published in 2018 by ACDIS, and *Guidelines for Achieving a Compliant Query Practice (2019 Update)*, published in 2019 by ACDIS and the American Health Information Management Association (AHIMA).

This chapter discusses some of the main oversight bodies at the time of this book's publication.

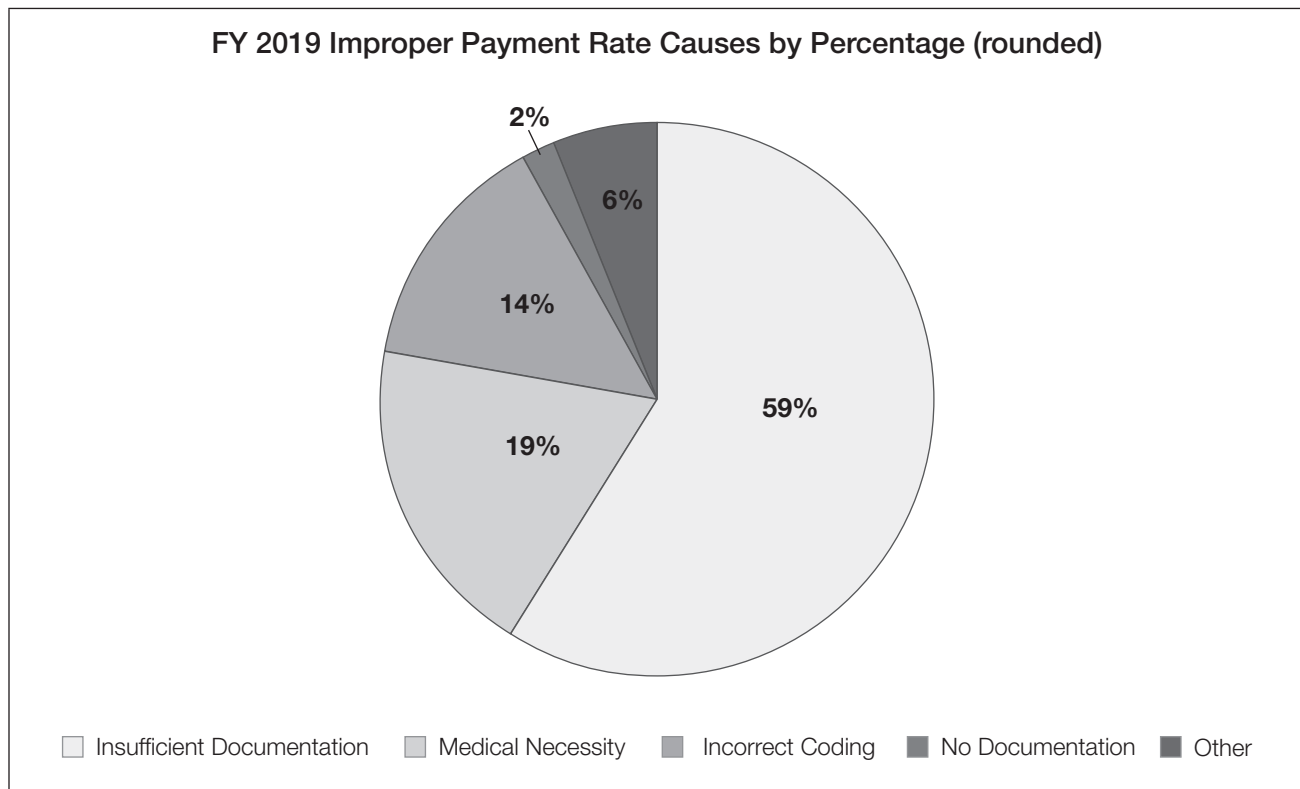
Medicare Administrative Contractor (MAC)

A MAC is a private healthcare insurer that has been awarded a geographical jurisdiction by the Centers for Medicare & Medicaid Services (CMS) to process Medicare Part A and Part B medical

4. No documentation: There is no response to repeated requests for medical records.
5. Other: This is used when the improper rate doesn't fit another category.

Figure 2.1 shows the distribution of the causes for improper rates for FY 2019.

Figure 2.1: FY 2019 Improper Payment Rate Causes



Source: 2019 Medicare Fee-for-Service Supplemental Improper Payment Data. Page 2. Retrieved from <https://www.cms.gov/files/document/2019-medicare-fee-service-supplemental-improper-payment-data.pdf>.

The graph in Figure 2.1 shows the top three causes of improper payments stem from documentation issues and combine to account for 92% of improper payments. Clearly, the CDI professional can assist in all three improper rate concerns by working to ensure documentation is complete and accurate. See Figure 2.2 for an example of insufficient documentation.

Figure 2.2: Insufficient Documentation Scenario

A hospital emergency department billed for an infusion of a medication. The encounter documentation did not contain an order for the medication, nor were there start and stop times documented. An outpatient CDI professional can audit the record and query the provider for the missing order and can also provide education to staff surrounding the importance of documenting infusion start and stop times.

Chapter 3

Documentation and Query Guidance Progression

A statement in the fiscal year (FY) 2008 Inpatient Prospective Payment System (IPPS) Final Rule describes government authority and permission for the query process while explaining the Centers for Medicare & Medicaid Services' (CMS) perspective on the responsibility of the provider to document support for diagnoses and conditions in the health record. It states (CMS, 2007):

We do not believe there is anything inappropriate, unethical, or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare Payment as long as the coding is fully and properly supported by documentation in the medical record.

Although this statement is from more than a dozen years ago, the meaning still holds true in that clinical documentation integrity (CDI) professionals are encouraged to query for documentation gaps and discrepancies in the quest for a precise, complete, and accurate health record that contains supported diagnoses. This serves to lessen the anxiety of those who are told that queries are not appropriate and provides an official source to quote from for those who may be uneasy regarding the query process.

In addition to the CMS guidance regarding documentation, there are other agencies and organizations who set forth rules and guidance regarding appropriate documentation.

The Joint Commission

The Joint Commission is an independent, nonprofit organization that accredits and certifies more than 22,000 healthcare organizations and programs in the United States. It emphasizes that facilities and physicians must ensure that (Cavagnac & Kruse, 2016):

- The health record contains sufficient information to:
 - Identify the patient
 - Support the diagnosis/condition
 - Justify the care, treatment, and services
 - Document the course and results of care, treatments, and services
 - Promote continuity of care among providers
- The review of health records is based on hospital-defined indicators that address:
 - Timeliness
 - Readability (whether handwritten or printed)
 - Quality
 - Consistency
 - Clarity
 - Accuracy
 - Completeness
 - Authentication of data and information contained within the record
- A concise discharge summary provides information to other caregivers and facilitates continuity of care by including:
 - The reason for hospitalization
 - Significant findings
 - Procedures performed and care, treatment, and services provided
 - The patient's condition at discharge
 - Information provided to the patient and family, as appropriate
- The hospital defines a complete record and the time frame within which the record is completed after discharge, not to exceed 30 days after discharge.

Medicare *Conditions of Participation (CoP)*

Just as CDI professionals have best practice briefs to guide their work, there are requirements that facilities must adhere to regarding health record documentation. The Medicare *CoPs* are federal regulations that must be adhered to in order for providers and suppliers to receive funding from

Chapter 4

Query Standards

Perhaps you have heard this adage: “Methods are many; principles are few. Principles never change; methods do.” The comfort in a compliant query practice is that the principles don’t change—a precise, accurate, and complete depiction of the patient’s health status without intentional regard for financial or quality impact remains the overarching goal. Queries are meant to obtain a thoughtful clarification from the provider using clinical evidence from the health record. This is true in both the inpatient and outpatient environments and echoed in the ACDIS/American Health Information Management Association (AHIMA) practice brief *Guidelines for Achieving a Compliant Query Practice (2019 Update)*, and the 2018 ACDIS practice brief *Queries in Outpatient CDI: Developing a Compliant, Effective Process*.

What Is a Query?

A query, also known as a *clarification*, is, in simple terms, a question. The query changes according to the health record and the clinical documentation integrity (CDI) professional’s goals as dictated by facility and regulatory guidelines. Just as in direct patient care, guidelines exist to direct the CDI profession; however, while the CDI profession operates outside of direct patient care, a CDI professional can significantly impact the health record integrity by querying and improving documentation based on the response.

A query is therefore much more than a question; it is the outcome of a process in which a concern, issue, or subject is thoroughly researched. The topic of that query is backed by clinical evidence in the health record. Queries are powerful and carry substantial weight by directly impacting the precise diagnoses and conditions in the health record, which illuminates the health status of the patient.

Figure 4.1: Example Concurrent Query for Associated Diagnosis for Body Mass Index (BMI)

Dear Provider,

Based on your judgment and review of the clinical evidence listed below, please select and document the most appropriate associated diagnosis:

- Obesity
- Morbid obesity
- Other ____ (please specify in documentation)
- Unable to clinically determine

The health record contains the following clinical evidence: BMI of 40 documented in the history and physical, nursing notation of “patient needs assistance with repositioning in bed,” and dietitian consult pending.

Thank you,

CDI Professional

Retrospective query

A retrospective query is performed in response to information gathered after the encounter. A few reasons that could necessitate a retrospective query include pathology results that were received after the encounter and details in the discharge summary that come to light after the discharge.

In the outpatient setting, a retrospective query could be developed in response to gaps in the problem list on review after the visit. See Figure 4.2 for an example of a retrospective query in the outpatient setting.

Figure 4.2: Retrospective Problem List Outpatient Query

Dear Provider,

Asthma was added to this patient’s problem list following her visit today.

Would you please document how this diagnosis was addressed or managed?

Thank you,

CDI Professional

Chapter 5

Coding Guidelines

Diagnosis-Related Groups (DRG)

The World Health Organization (WHO) maintains a worldwide disease classification system called the *International Classification of Diseases (ICD)*. This system began with a focus on morbidity and mortality and is used today to report patient information and collect data on diseases and conditions worldwide. In the United States, the 10th ICD revision (ICD-10) Clinical Modification (ICD-10-CM) codes are used to report diagnoses across all settings, and the ICD-10 Procedure Coding System (ICD-10-PCS) is used for inpatient procedure coding.

The outpatient setting uses the Current Procedural Terminology (CPT) code set to report services and procedures. Healthcare Common Procedural Coding System (HCPCS) codes are used to report services, procedures, and supplies for Medicare.

In addition to examining records for clinical gaps or discrepancies, CDI professionals compare documentation to coding best practices as described in coding guidelines and coding classifications for each care setting.

DRGs were designed at Yale University in the late 1960s under a contract with CMS, which was known at the time as the *Health Care Financing Administration*. DRGs provide a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. For more than two decades, the DRG classification system was a two-tier classification consisting of a base DRG plus a higher tier for some DRGs with the presence of a comorbidity or complication (CC) in the health record.



QUERY PEARLS

If the Erb's palsy is documented as related to the birth injury, this is significant because of the implications of future healthcare needs since there are continued issues related to the Erb's palsy. This relationship satisfies the conditions for reporting a secondary diagnosis.

Not every gap or question in the documentation requires a query. It takes time to analyze the documentation, apply any relevant coding guidelines, develop a compliant query, and finally see it through to the response. Due to the bandwidth needed for this process as well as nuances that exist within each facility, a documentation gap at one facility may not be significant in another facility. For example, the medical staff in hospital A may have mutually agreed that any hemoglobin (Hgb) above 10.0 is considered normal, whereas the medical staff in hospital B may have mutually agreed that any Hgb above 12.0 is considered normal.

This chapter will focus on the guidelines that are most often misinterpreted and will provide subsequent query examples to help give the reader a firm grasp of the intricacies of query development.

Conflicting Documentation

In query guidance, as stated in the ACDIS/American Health Information Management Association (AHIMA) query practice brief *Guidelines for Achieving a Compliant Query Practice (2019 Update)*, one reason to query is to resolve conflicting documentation between the attending provider and other treating providers (whether diagnostic or procedural).

Determining what constitutes conflicting documentation and when to query is a common problem clinical documentation integrity (CDI) professionals face. The goal of this section is to provide information that will help with the decision to query or not to query—for that is the question!

There are multiple guidelines, standards, and rules that speak to conflicting documentation. Conflicting information is mentioned twice in the *Official Guidelines for Coding and Reporting*. The first is in Section I.B.14, *Documentation by Clinicians Other Than the Patient's Provider*, where it states that conflicting documentation should be resolved by the attending provider or the provider of record regardless of whether conflicting documentation comes from the same provider or from discrepancies between providers.

The second mention of conflicting documentation in the *Official Guidelines for Coding and Reporting* is in the General Reporting Requirements in Appendix I, where it states, "Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider."

Chapter 6

The Electronic Health Record

From Paper to Processor

Technology is here to stay. Per the latest available data at publication from HealthIT.gov, as of 2017, 86% (nearly nine in 10) of office-based physicians had adopted any electronic health record (EHR), and 80% (nearly four in five) had adopted a certified EHR. In 2017, 96% of all nonfederal acute care hospitals possessed certified health information technology (IT). Small rural and critical access hospitals had the lowest rates at 93%, while 99% of large hospitals (more than 300 beds) had certified health IT and 97% of medium-sized hospitals (more than 100 beds) had certified health IT (Office of the National Coordinator for Health Information Technology, 2019).

While these statistics are lacking in current information (although that lag is true to form in healthcare), the information available from HealthIT.gov clearly shows continued growth in EHR adoption nationwide.

The government began its attempts to encourage use of EHR technology in 2009 via the Health Information Technology for Economic and Clinical Health (HITECH) Act. This piece of legislation introduced Meaningful Use (MU), an effort led by the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONC) that would require healthcare providers to utilize certified EHR technology in a meaningful manner while providing for electronic exchange of health information to improve the quality of care. MU was implemented in three stages. The first stage established requirements for electronic capture of clinical data. The second stage focused on encouraging use of certified EHR technology (CEHRT) to improve quality at the point of care and facilitate the exchange of information. The final stage, which was established for 2017,

Because of the increasing number of alerts facing the provider, it is important to be careful not to create too many documentation alerts to avoid adding to alert fatigue once the alerts begin to be sent directly to the provider. Being proactive allows for a positive outcome down the road.

The benefits of documentation alerts are that they can be fully customized to the culture of the facility, and because each facility should already have a query process in place that describes parameters such as when to query (when the serum level reaches a certain point, for example), or how many queries should be sent on a record at one time, the current query process is a good place to begin to set priorities in documentation alerts. It is imperative that a comprehensive team consisting of medical staff, quality, nursing, HIM, and CDI work together when addressing alert customization to outline a documentation alert process that addresses all concerns and will ensure success both now and in the future. Figure 6.1 outlines the steps to a successful electronic alert system.

Figure 6.1: Steps to a Successful Electronic Alert Program

1. Involve medical leadership within each specialty when implementing alerts.
 - a. Seek their expertise in how alerts are constructed to help minimize the number of false alarms.
 - b. Leverage their involvement to facilitate physician buy-in.
2. Stagger the rollout of alerts.
 - a. Roll out one alert per specialty every two weeks.
 - b. Prioritize the rollout based on impact; focus on quality impact alerts first.
3. Educate stakeholders prior to turning on an alert.
 - a. Provide education on the documentation needed for a particular diagnosis and explain what will trigger the alert.
 - b. Educate providers on the necessity and how it will help them with quality scores and other incentives.
 - c. Leverage CDI team for education and communication.
4. Track, trend, and monitor the number of alerts being triggered on a daily, weekly, and monthly basis.
 - a. Ensure that data can be tracked down to the individual provider level.
 - b. Use the data for process improvement, such as reconfiguring an alert or providing targeted education.
 - c. As the system becomes stable, an alert can be monitored on a less frequent basis.
5. Implement a methodology to keep alerts up to date.
 - a. Update alerts for changes in clinical indicators and/or standard treatment.
 - b. Add, revise, or retire alerts based on changes in quality and value-based program regulations.

Chapter 7

Outcomes

With the advent of big data, key performance indicators (KPI) have become a controversial topic as facilities consider the value of these measurements. Every facility is different, from the number of patients and varied services to the provider and insurance contracts. The unique culture of each facility makes it imperative to focus on the KPIs that would best serve that facility rather than using only those KPIs used at other facilities. In addition to facility culture variances, CDI has evolved as patient complexity has increased. The current healthcare environment includes patient safety indicators (PSI) and hospital-acquired condition (HAC) reviews, quality measure reviews, and deep comprehensive reviews focusing on documentation integrity rather than solely reimbursement. The traditional metrics simply don't seem to work in this new environment. Couple that with outpatient CDI, which requires its own set of metrics instead of merely transferring the inpatient CDI metrics to the outpatient setting, and most facilities are faced with multiple decisions on how to measure a CDI program.

Now that KPIs are added into the changing query landscape and there have been technological improvements, most facilities and organizations are thinking outside the box for KPIs that have value. Each facility must determine which measurements hold the most value and approach KPIs in a manner that stays true to the facility's culture and the mission. Decision-makers must recognize not only what is being measured, but also why and from what point of view. The risks and benefits of any data point must be evaluated before gathering, measurement, and monitoring begins.

Due to the uniqueness of each facility, this book is unable to list every meaningful KPI. The goal of this chapter is therefore to outline effective query metrics without dictating the exact query metrics a facility or organization should use, as each facility or organization must decide what is right for them.

may look similar on the surface, but the number of queries per case will more accurately reflect the amount of time the CDI professional is spending on the reviews and individual query development than the number of cases that included a query, because there is no guarantee that the maximum number of query opportunities on all records will be one.

There are several factors that a facility must take into consideration when determining the query rate, beginning with the case mix. The type of unit or floor the CDI professional covers affects the query rate metric. There may be more query opportunities on a critical care unit than on a urology floor due to the patient complexity.

Be cautious with this metric. Due to variables such as coverage, scheduling, and case mix that impact the number of queries, this should be viewed as a team metric compared month over month or quarter over quarter, because even though these factors would also affect team metrics, the ebb and flow of the variables even out over time. See Figure 7.1 for examples of variables that could affect the query rate.

Figure 7.1: Examples of Variables that Could Affect Query Rate

- A CDI professional covering the cardiovascular surgery step-down unit will have fewer query opportunities than the CDI professional in the cardiovascular surgery critical care unit, because all the documentation opportunities should have been identified during the time in the critical care unit.
- A CDI professional's query rate was significantly lower than that of her peers during the same time period because the CDI professional in question had surgery and was off work for a month during the previous quarter.
- A CDI professional covers the intensive care unit of a hospital that was recently designated as a Level 1 trauma center. This change in case mix will impact the number of query opportunities for that one CDI professional.

Any outliers that occur at the individual level, such as an unusually higher or lower query rate than the remainder of the team, can be addressed with metrics that measure query compliance.

Review rate

The review rate is a measurement of the number of cases reviewed compared to the total number of cases. The relationship between the review rate and the query rate goes hand in hand, because a query can't be developed if a health record was not reviewed; however, this metric isn't all about raw numbers.

Looking back at the query rate, even though the number of health records that had a query opportunity (with a subsequent query) is not the most optimal measurement for the query rate metric, it is valuable when considering the percentage of health records that *had*, or more importantly, the percentage of records that *did not have*, a query opportunity. Because a query cannot be developed until a health record is reviewed, the query rate ties in with the review rate.

Appendix

2020 ICD-10-CM Official Guidelines for Coding and Reporting

The following is a table of ICD-10-CM guidelines. This list is not all-inclusive; it instead pulls out guidelines of utmost importance to CDI professionals.

Table Appendix.1

I.A.11	Inclusion terms are terms that are synonymous with the code title or various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Inclusion terms are found under codes in the Tabular List as well as terms found only in the Alphabetic Index.
I.A.12.a	<p>A type 1 Excludes note means “NOT CODED HERE!” An Excludes1 note indicates that the excluded code should never be used at the same time as the code above the Excludes1 note.</p> <p>An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.</p> <p>An exception is a circumstance when the two conditions are unrelated to each other. If it is not clear whether the two conditions are related, query the provider.</p>
I.A.13	For conditions having an underlying etiology and multiple body system manifestations, ICD-10-CM convention requires sequencing the underlying condition first followed by the manifestation. Codes in brackets following another code in the Alphabetic Index, as well as “code first,” “use additional code,” and “in diseases classified elsewhere” provide sequencing direction.

Sample Query Audit Form

Table Appendix.3

Parameter	
Query subject	
Date of Auditor Review	
Date of Query	
Which of the following was the rationale for issuing the query?	
a. POA status	
b. Clinical indicators of a diagnosis but no documentation of the condition	
c. Request for clinical validation of a documented diagnosis	
d. Clinical evidence for higher degree of specificity or severity	
e. A cause-and-effect relationship between two conditions or organisms	
f. An underlying cause when the principal diagnosis is a symptom code	
g. Clarification of principal diagnosis	
h. Resolution of conflicting documentation (query to the attending)	
i. Other	
Did the query contain all relevant and cited clinical indicators?	
Did the query contain all reasonable, supported, and codable diagnosis options (not previously documented in the health record)?	
Did the query contain appropriate alternate (nonclinical) options?	
Was the query written in a compliant and nonleading format?	
Was the query absent of any mention or insinuation of an impact on financial or quality metrics?	
Was the query written in a clear and succinct manner using correct grammar, spelling, and punctuation?	
Were the natural language processing (NLP) generated codes for principal diagnosis, CCs, MCCs, HCCs, PSIs, and HACs verified and supported?	
Were all query opportunities identified? (No missed opportunities found using the same date of review)	
Does the chart contain enough documentation or clinical support to develop a query?	
Was the query addressed to the appropriate provider?	
Did the CDI professional provide a signature and contact information in the query?	
Is the query warranted?	
Comments:	

Source: Dressler, J. and Frey, S. Adapted by Newhouser, K. January 2020. ACDIS CDI Journal. Mar/Apr 2019. HCPro.

Sample Anemia Multiple-Choice Query

Disclaimer

- *The author and ACDIS recommend that, should you choose to use this sample, it must be adapted to your particular programmatic needs, EHR system requirements, organizational diagnostic criteria, and the patient.*
- *Query professionals must ensure that all clinical criteria are referenced and relevant to the question being asked.*
- *Query professionals must ensure that each clinical option is reasonable for the patient and that related clinical indicators are cited in the query.*

Dear Provider,

The health record contains the following clinical indicators:

- Hemoglobin (Hb)/Hematocrit (Hct) _____ on admission
- Hb/Hct _____ on xx/xx/xxxx
- Black tarry stools
- Chest pain
- Cold hands and feet
- Dark urine
- Dizziness and/or syncope
- Fatigue and/or weakness
- Hematochezia
- Hematuria
- Hemoptysis
- Jaundice
- Pallor
- Shortness of breath
- Tachycardia of _____
- History of:
 - NSAID use
 - Alcohol use
- Diagnostics:
 - Esophagogastroduodenoscopy (EGD)/colonoscopy results:

Sample Outpatient Open-Ended Query for Conflicting Documentation in the Emergency Department (ED)

Disclaimer

- *The author and ACDIS recommend that, should you choose to use this sample, it must be adapted to your particular programmatic needs, EHR system requirements, organizational diagnostic criteria, and the patient*
- *Query professionals must ensure that all clinical criteria are referenced and relevant to the question being asked*
- *Query professionals must ensure that each clinical option is reasonable for the patient and that related clinical indicators are cited in the query*

Dear Provider,

Your first note includes documentation that the patient has skin that is warm and dry with no rashes or lesions. Nursing documentation on admission indicates that there is a “stage 3 sacral pressure injury” requiring wet-to-dry dressing changes.

Please clarify the diagnosis in your ED notes.

Thank you,

CDI Professional

Phone #



OUTPATIENT QUERY FOR CONFLICTING DOCUMENTATION QUERY PEARLS

- *Clinical indicators are for example only and must be edited according to documentation in the patient's health record*
- *Follow your facility's policy and guidelines on query development*
- *Query the provider of record when conflicting documentation is identified*

The Provider Query Toolkit

A Guide to Compliant Practices

Queries are the hallmark of CDI specialists' work, no matter the setting or programmatic structure. Along with query compliance updates and coding guidelines, the introduction of electronic health records (EHR), clinical validation denials, quality programs, and more have made following industry and compliance standards more difficult.

The Provider Query Toolkit: A Guide to Compliant Practices provides a comprehensive analysis of query guidelines and easy-to-follow strategies to improve query processes. This valuable resource, perfect for both the new CDI specialist and those looking for a refresher on CDI query fundamentals, examines recent changes in coding and payer nuances, denial trends, query compliance, and quality programs impacting the CDI specialist.

About Simplify Compliance

Simplify Compliance, with its three pillars of thought leadership, expertise, and application, provides critical insight, analysis, tools, and training to healthcare organizations nationwide. It empowers healthcare professionals with solution-focused information and intelligence to help their facilities and systems achieve compliance, financial performance, leadership, and organizational excellence. In addition, Simplify Compliance nurtures and provides access to productive C-suite relationships and engaged professional networks, deploys subject matter expertise deep into key functional areas, and enhances the utility of proprietary decision-support knowledge.

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