



# **2010 Physician Query Benchmarking Report**

# 2010 query survey shows range of practices

## Adherence to guidelines lacks consistency

Verbal or written, concurrent or retrospective—any way you slice it, physician queries continue to be one of CDI specialists’ most important tools. When ACDIS first examined how CDI programs conduct their query practices in 2009, the results stood as a baseline from which programs could define common query activities.

That first survey asked CDI specialists 20 questions ranging from the type of queries they conduct to how they track and analyze the impact of queries. It illustrated that most CDI programs query physicians concurrently when information in the medical record appears to be incomplete or clinically unclear. The 2009 report also indicated that CDI specialists find leaving written queries in the patient medical record the best way to ensure a physician response.

The *2010 Physician Query Benchmarking Report* included many similar questions while expanding to cover new query concerns. The survey, which concluded in December 2010, asked participants more than 40 questions and garnered 382 responses. As the following report demonstrates, some of the

results remain the same, but new trends appear to be emerging in the CDI profession as well.

### Concurrent, retrospective reviews

CDI programs continue to focus on concurrent review (98%), but an increasing number (58%) indicated they also conduct retrospective, pre-bill queries. (See Figure 1.)

“It shows there are multiple stages to documentation improvement,” says **Gloryanne Bryant, RHIA, CCS, CCDS**, regional managing director of HIM (NCAL revenue cycle) for Kaiser Foundation Health Plan, Inc. & Hospitals in Oakland, CA. “To me, it also illustrates that there must be good collaboration between the CDI and health information management/coding departments. CDI programs are not singularly focused on concurrent review anymore, and that is an interesting trend.”

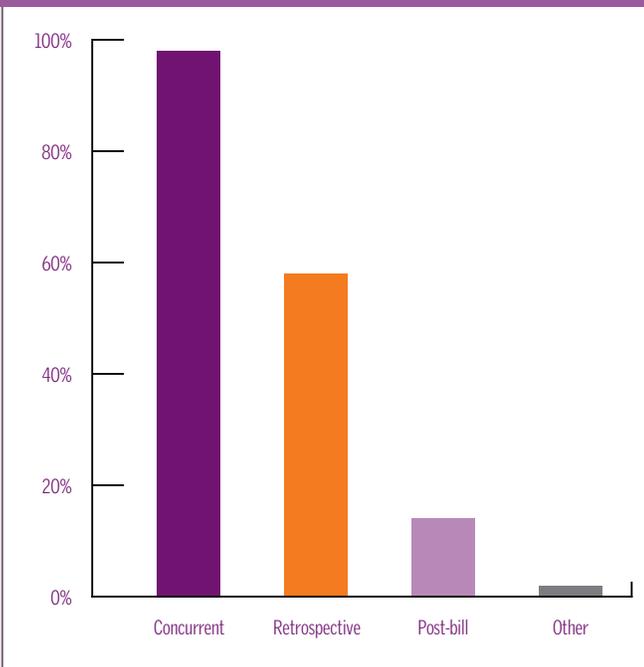
The number of retrospective reviews was larger than expected for **Donald A. Butler, RN, CCDS**, CDI manager at Pitt County Memorial Hospital in Greenville, NC. Butler wonders what types of records constitute that 58%: Were they short-stay discharges which CDI staff were unable to examine while the patient was still in the hospital, or are CDI staff increasingly handling all query types regardless of where the record sits in the billing cycle? However, 62% of respondents indicated that the HIM/coding department follows up on/closes out post-discharge queries (see Figure 2), which raises concerns for Butler. “Is this a perceived best practice or a reflection of traditional divisions of labor and facility structure?” he asks.

At some facilities, CDI staff are responsible for initiating queries while HIM/coding staff maintain responsibility for query follow-up, says **Gail B. Marini, RN, MM, CCS, LNC**, CDI manager at South Shore Hospital in Weymouth, MA, and a member of the ACDIS advisory board. Nevertheless, “I am amazed that the majority said their queries are not closed out by CDI specialists,” Marini says.

“It raises some additional questions for me,” says Butler. “Is there a lack of agreement between CDI and HIM, or a lack of ownership of the query process? If there are a large number of queries not resolved prior to discharge, what does that say about the CDI department’s efforts?”

Bryant, however, thinks that the responses indicate a collaborative approach to documentation improvement—that when

**Figure 1: What type of queries does your CDI program issue?**



CDI cannot clear the record prior to discharge, HIM/coding staff are willing and able to step in and continue the query process. “I think it goes back to both departments need[ing] to be engaged in the process and willing to work together to ensure the completeness of the medical record,” Bryant says.

Although 58% of respondents indicated that they perform daily concurrent medical record reviews, 24% indicated they review records every other day. (See Figure 3.)

“We query daily so the medical record is as clean as it can be for the coder,” says Marini. “If the facility is looking at records every other day, then there probably is still going to be a good number of retrospective queries needed.”

Another 15% of respondents indicated differing review frequencies. (See Figure 4 for some of their responses.) The most common pattern of record review is a first review at admission and a second review between the third and fifth days of the patient’s stay. Other respondents indicated that due to multiple responsibilities and limited staff they primarily review cases for documentation improvement as clinically needed or by DRG.

### Documentation priorities

The highest number of respondents (67%) indicated their facility prioritizes queries for documentation completeness regardless of financial or other impact. (See Figure 5.)

“It’s nice to see that there is a shift away from the almighty dollar,” says Virginia Bailey, RN, CCDS, CDI specialist at Morton Plant North Bay Hospital in New Port Richey, FL. Many CDI programs owe their origins to the implementation of the MS-DRG system. As such, CDI was seen as a way to optimize physician documentation, increase CC/MCC capture rates, and improve overall reimbursement. While most agree there is nothing wrong with increased reimbursement resulting from CDI efforts, increases in case-mix index must accurately reflect the care that patients receive while in the facility, she says.

When Bryant talks to “CDI staff one-on-one, they [say] they are reviewing for financial impact. If these data are true, though, this seems to be good news.”

“I do think most facilities review cases based on DRG,” agrees Marini. “But at least [according to this survey] they seem to be aware that complete and accurate documentation should be the priority.”

When asked, “Do you query for clarity, completeness, severity, specificity, etc., when the query does not affect reimbursement?” 43% said, “Yes, always”; 44% said “Yes, frequently”; and 9% said “Yes, occasionally.” (See Figure 6.)

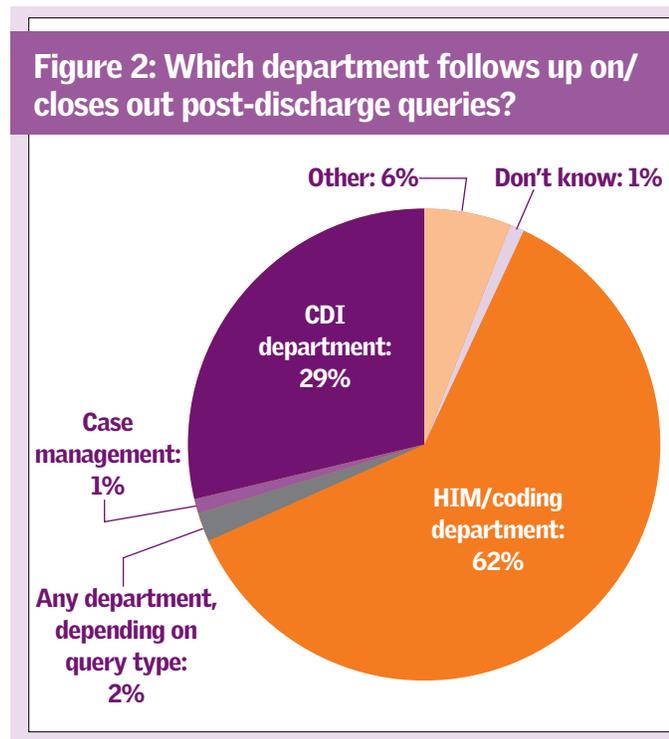
“This is a nice trend, and one I hope we will continue to see,” says Butler. “It is nice to know that CDI programs are focused on more than just the money.”

### Verbal or written, paper or electronic

The majority of physician queries remain paper-based/written (63%), followed by electronic-based written queries (20%), and an equal mix of verbal and written queries (12%). (See Figure 7.) In response to the question, “Which method of query delivery do your physicians prefer?” 45% indicated that their physicians have no preference, followed by 29% whose physicians prefer written queries and 15% whose physicians prefer an equal mix of verbal and written queries. (See Figure 8.)

In identifying the most effective query technique, 48% said that leaving a paper query in the patient’s chart is their preferred method, followed by 34% who said verbal conversations/discussions with the physician are most effective. (See Figure 9.)

Results illustrate that CDI specialists most frequently use paper queries, that their physicians want them to use paper queries, and that they get the best response rates when they leave a paper query in the medical record. But Butler



*continued on p. 4*

## Query survey

*continued from p. 3*

wonders whether the high percentage of those respondents who indicated that the paper query is the most effective technique simply reflects the fact that leaving a paper query is standard practice for those facilities.

“Is it a true reflection of query efficiency or just a reflection of what the majority of CDI programs currently do?” Butler asks.

At Kaiser, Bryant specifically surveys physicians to determine which query method works best for them and then democratically follows physicians’ suggestions. “I wonder how many [CDI programs] actually ask the physicians about their preferences,” she says.

The number of those who said electronic queries were most effective surprised **William Haik, MD, FCCP**, director of DRG Review, Inc., in Fort Walton Beach, FL. “Basically because I just don’t like [electronic queries],” he says.

Physicians are pummeled all day long with a multitude of questions from a variety of departments, Haik says.

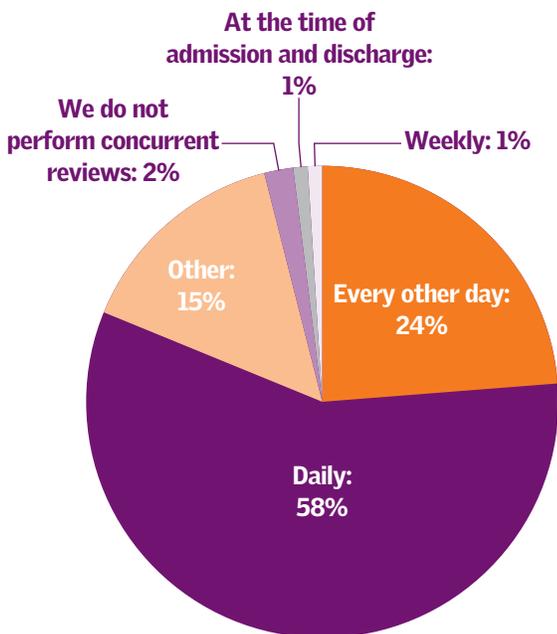
“Under an all-electronic process, it is just too easy to pass along a question to the physician rather than to try to determine the answer for oneself,” he explains.

In fact, according to the survey, the number of electronic query systems in the industry remains relatively low at 33%, with 48% of respondents indicating that they do not have an electronic query system. Sixteen percent of respondents indicated that they are in the process of implementing an electronic health record (EHR). (See Figure 10.)

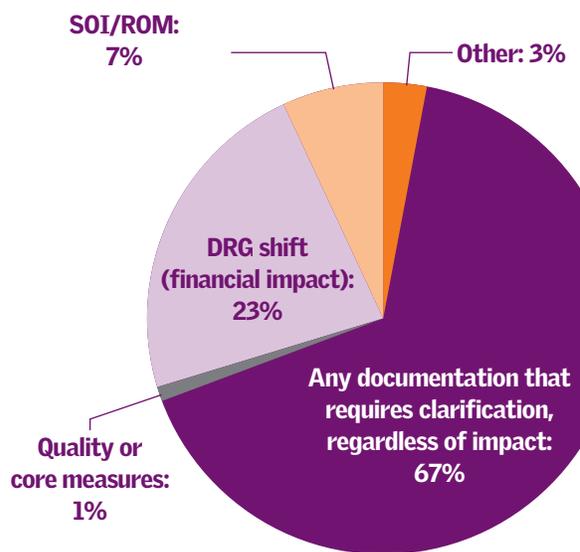
**Figure 4: Other responses to frequency of concurrent review**

- » At time of admit, then every third day until “optimized”
- » We review daily when there is no CC or MCC, otherwise we review every other day
- » I am a one-person show, so it depends on the census and other responsibilities
- » At 48 hours post-admission
- » On the second day and if LOS is greater than five days
- » It depends on the needs of the case

**Figure 3: What is the frequency of your concurrent review?**



**Figure 5: What type of queries does your CDI program prioritize?**



“Most programs are still in some sort of hybrid [part electronic, part paper-based] system,” says Marini.

Electronic query systems can include a number of benefits. For example, 21% indicated their electronic query system includes standard query templates, 12% said it includes batch printing capabilities, and 23% said it provides audit and reporting capabilities. (See Figure 11.)

Of those who have an electronic query system, 10% indicated that CDI specialists’ productivity has improved, 2% said productivity has decreased, and 8% said they have experienced no change. (See Figure 12.)

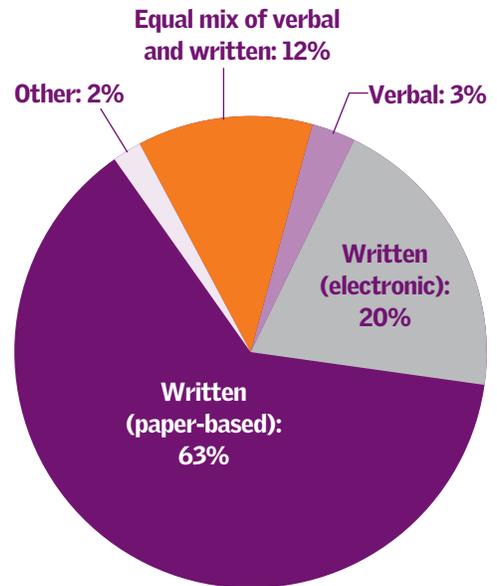
“I think we still live primarily in a paper environment,” says Bryant. “As more facilities implement full electronic health records, we’ll start to see the number of electronic query systems rise.”

### Query templates, consultants

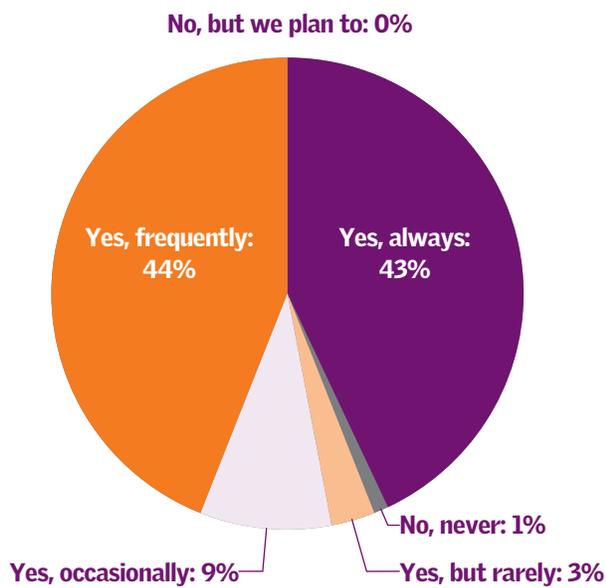
More than 80% of respondents indicated that they use query templates: Thirty-one percent said they always use them; 36% said they frequently use them; and 16% said

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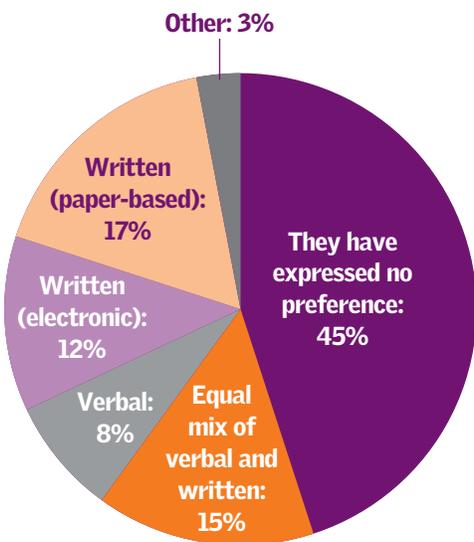
**Figure 7: Are the majority of your queries:**



**Figure 6: Do you query for clarity, completeness, severity, specificity, etc., when the query does not affect reimbursement?**



**Figure 8: Which method of query delivery do your physicians prefer?**



## Query survey

continued from p. 5

they use templates occasionally. Another 13% indicated they never use templates. (See Figure 13.) These numbers surprise Haik, who says he doesn't see templates frequently and doesn't advocate their use. "Most [of our] queries are freely written with information taken from the patient charts and asking a specific question related to that information," he says.

Butler doesn't use templates at his facility either. "We customize each query to the situation at hand," he says. "I can see how there would be value to [a query template] depending on how you use it and what elements the template contains."

The survey shows a variety of influences in the generation of query templates. CDI specialists were most involved in their creation, at 55%, followed by coding staff (39%),

consultants or vendors (34%), CDI managers (28%), and physician advisors (20%). (See Figure 14.)

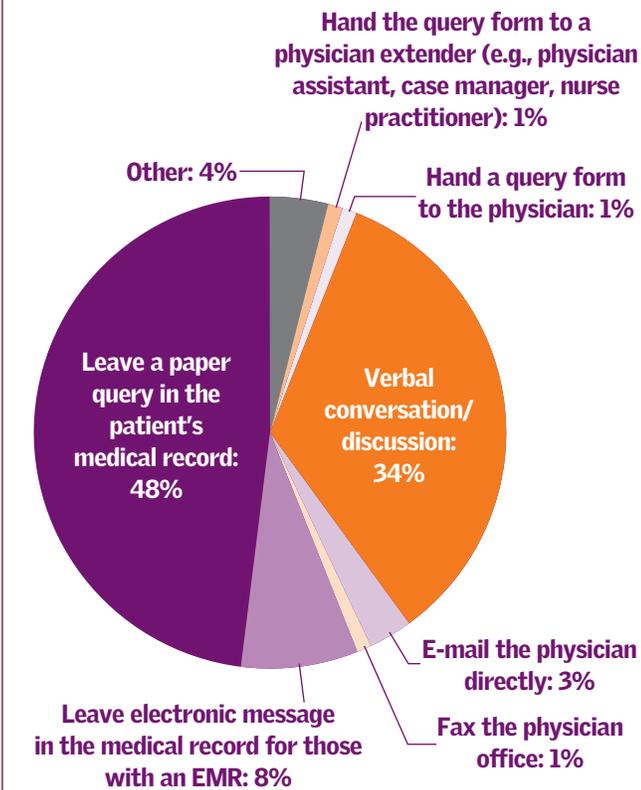
At South Shore Hospital, Marini begins query template creation with the CDI staff and then seeks physician advisor/medical staff input. With a draft form in hand, she then seeks coder and compliance input before finalizing the form. Based on her own experiences, Marini expected the ratios of involvement to range closer together.

Many programs do not employ a CDI manager and instead opt for CDI specialists to report directly to the HIM director, Bailey says. This may account for the high ratio of CDI staff who indicated their involvement in query design and the low responses for CDI manager-level involvement.

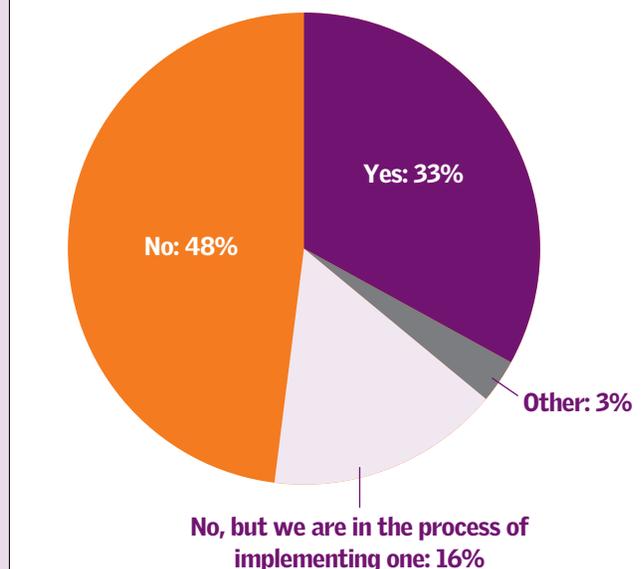
Nevertheless, "at some point there needs to be some oversight as to how these queries are drafted," Bailey says.

Many vendors include query templates as part of their contract with a facility, Butler says. Once the contract expires, a new vendor may come in or new staff may be hired, leaving staff in the dark about who drafted the original templates, he says. If the CDI program has a manager specifically assigned to it, that person should be involved in query template creation and regular review and evaluation of those forms, Butler says.

**Figure 9: Which of the following techniques do you find most effective when querying a physician?**



**Figure 10: Does your facility have an electronic query system either as part of your EMR or another software system?**



However, 12% indicated they do not review their query forms for compliance at all. Those who do audit their forms do so primarily monthly or on an as-needed basis (28% each), with such reviews primarily conducted by the CDI manager (45%) or HIM/coding department (31%). (See Figures I5 and I6.)

“At a minimum, query forms should be audited annually,” says Butler. “You don’t want to have a query form in circulation that has inappropriate clinical indicators on it.”

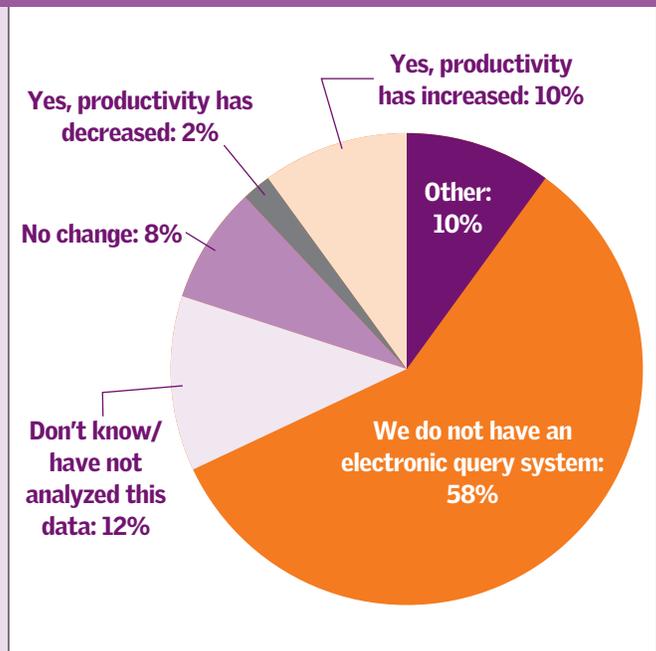
CDI query processes should include a quality assurance component, says Bryant. “How to do this and the frequency of this process is, of course, open to discussion. Clearly, based on this survey, regular monitoring of the query forms and processes is something we need to work on.”

### AHIMA influence

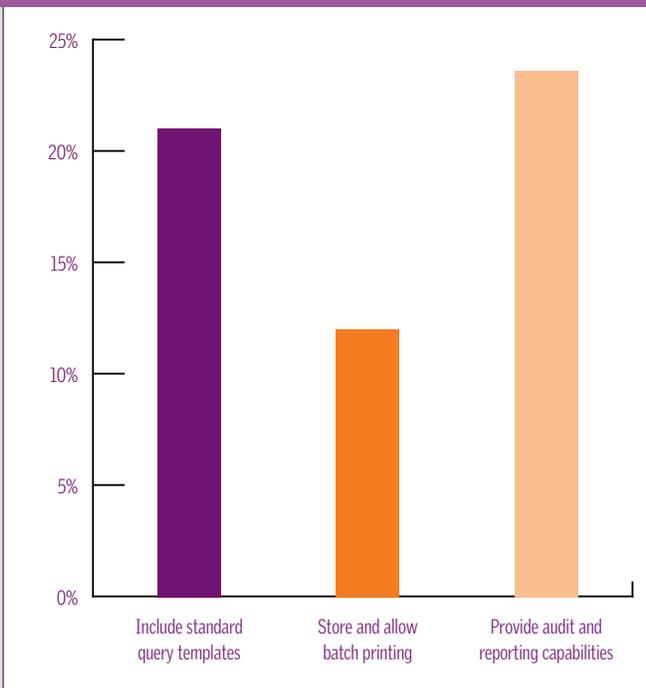
Of those who use query templates, 54% use ACDIS or AHIMA guidance to construct them. The second highest number of respondents use consultants as their source for template information. (See Figure I7.)

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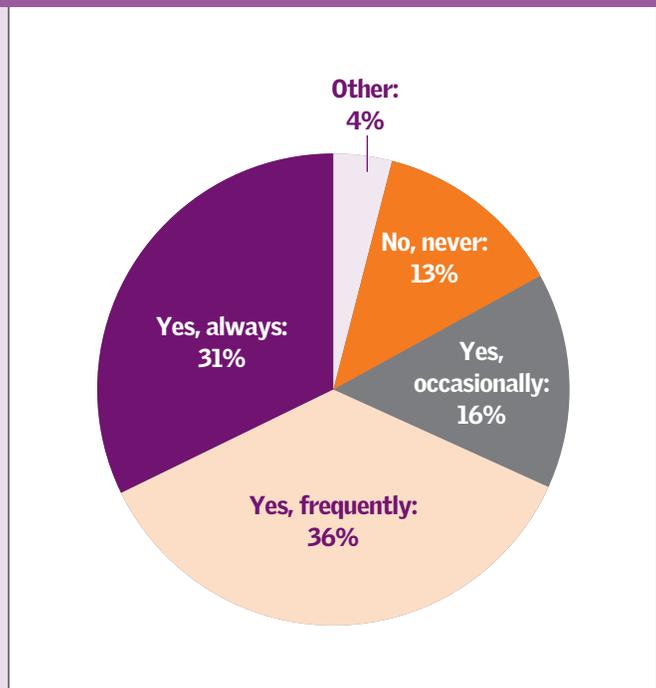
**Figure 12: If you have an electronic query system, have you seen a change in CDI specialist productivity after implementing it?**



**Figure 11: If you have an electronic query system, does it:**



**Figure 13: Do you use templates in your written/electronic queries?**



## Query survey

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Of those who selected “other,” most suggested they receive query templates from their hospital corporate offices or use multiple sources to influence their CDI program’s query creation.

“I found it very interesting that [CDI programs] depend on consultants as much as on the [ACDIS and AHIMA] associations,” Bailey says.

“It is bothersome to me that so many [programs] are getting their templates from consultants,” Haik says. Anecdotally, he recalls the Office of the Inspector General (OIG) investigating a facility for its high volume of sepsis claims. Upon examination, it found a high rate of sepsis queries, many of which were leading in nature, and had been provided by a consultant group.)

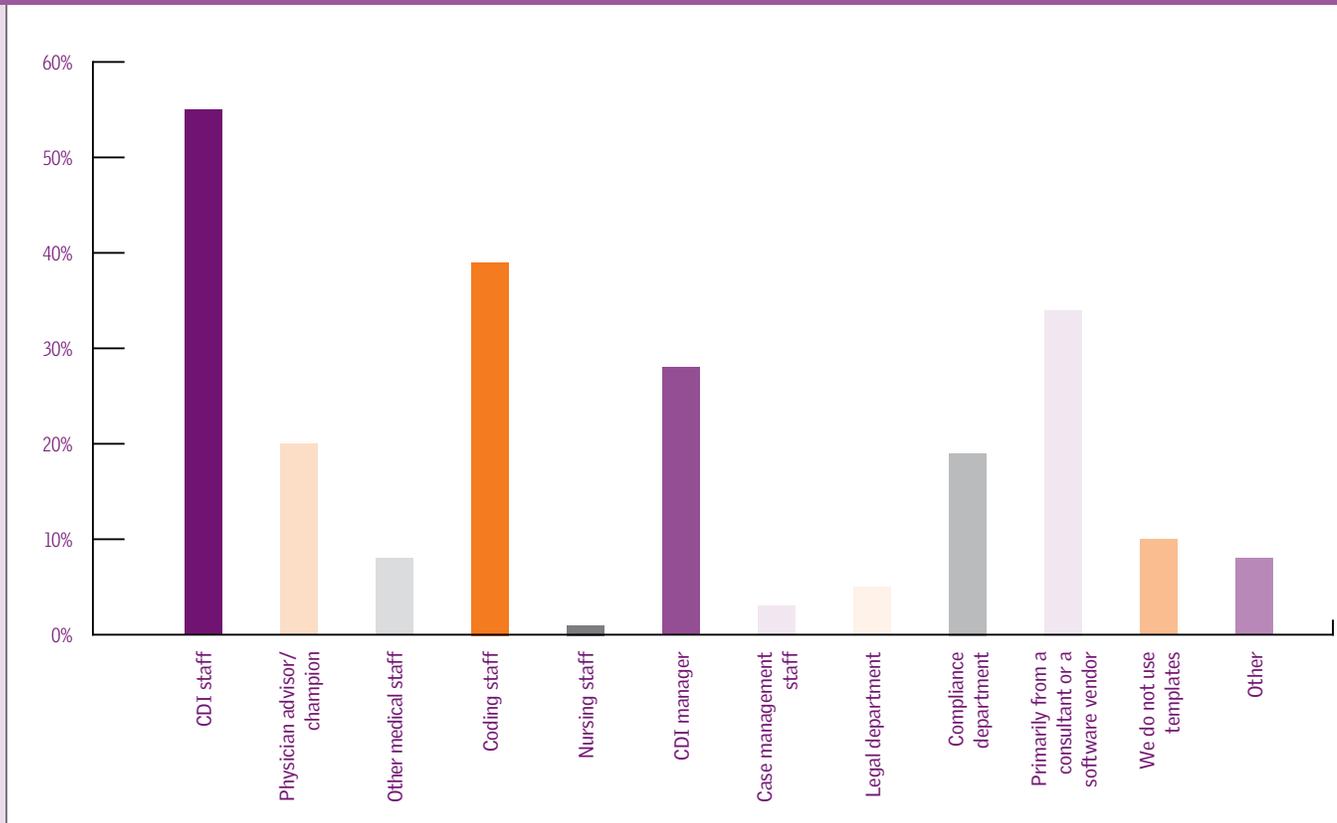
That’s not to say that all query forms from consultants contain inherent compliance risks, says Haik. “I guess what I’d have to say about that is simply do not take the consultant’s

word for it. Check out the forms and make sure that the advice they give falls in line with accepted practices throughout the industry.”

AHIMA has published several documents in the past decade to help define the query process. (See Figure A for a list of these documents as well as Web links.) Multiple ACDIS advisory board members worked closely with AHIMA on several of these publications. Since AHIMA is one of the four Cooperating Parties (in conjunction with the AHA, the National Center for Health Statistics, and CMS), which work together to clarify coding guidelines, some suggest its CDI-related publications may one day bear regulatory weight with CMS’ various audit contractors. For now, however, the association itself has indicated that its documents should be used as “industry best practice” rather than regulation or law.

Consultants may use query guidance obtained from ACDIS and AHIMA releases, says Bryant, “but it is the responsibility of the facility administration to perform due

**Figure 14: Who was involved in developing your query templates/forms (check all that apply)?**



diligence to be sure their facility's queries are based on the most appropriate guidance."

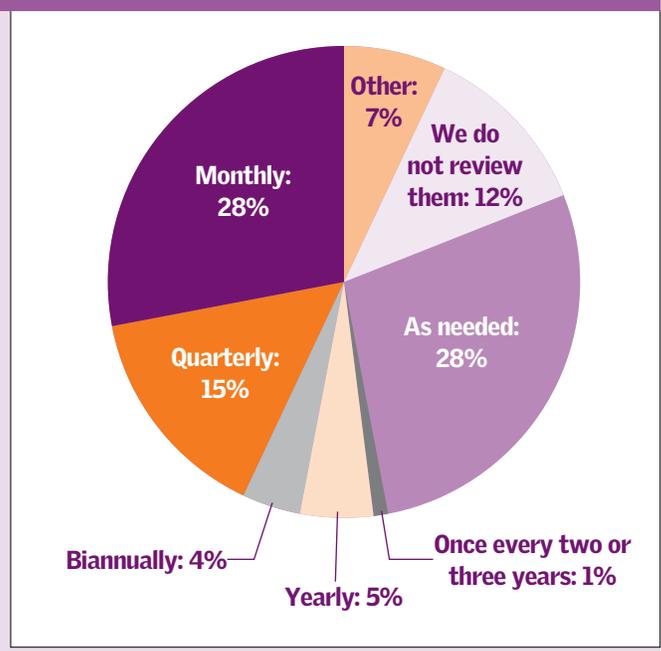
The survey shows 54% of respondents' query forms "fully" follow AHIMA guidance, followed by 21% who have read the guidance and include applicable suggestions in their program policies and procedures. However, 12% said they either did not know or had not read the latest guidance. (See Figure 18.)

"Now that's scary," says Haik, who also worries about the additional 8% of respondents who said they have separate policies for how CDI specialists handle query dissemination versus how HIM/coders deliver queries.

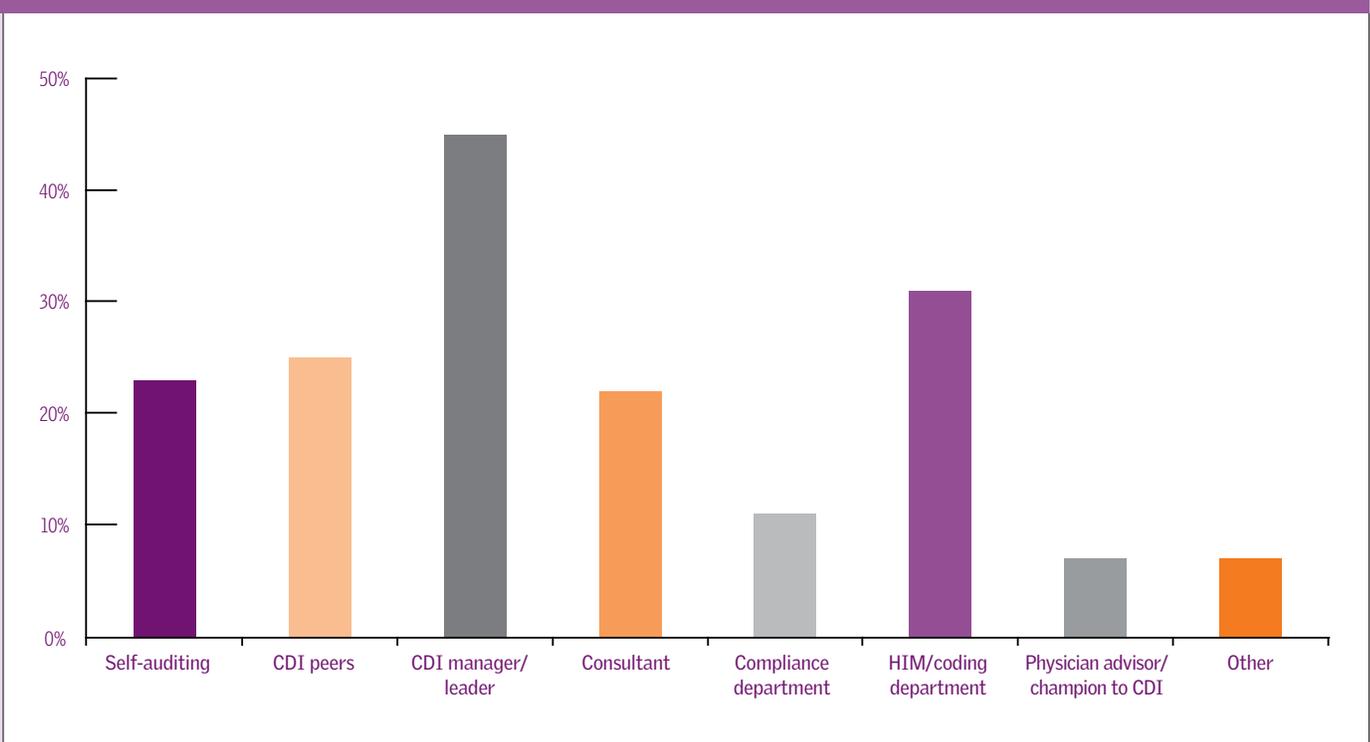
"I understand that some view CDI as 'different' from the HIM, and it is," says Butler. Nevertheless, AHIMA has long experience with physician queries and "a great stance" in its recommendations, "so why *not* follow them?" Butler asks. "I am a CDI professional, not a coding professional, but we need to follow the best guidance out there. I am not saying 'blindly follow,' but if your facility makes the choice

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**Figure 15: How often do you review/audit your query forms for compliance?**



**Figure 16: If you conduct query reviews, who reviews/audits your query forms for compliance (check all that apply)?**



## Query survey

continued from p. 9

to establish policies that differ from those of the industry, it should have solid reasoning written in its policies and procedures for that process.”

Eighty-three percent of respondents did indicate awareness and at least partial adherence to AHIMA query recommendations, when added together. “These numbers still need to shift,” says Bryant. “But overall awareness of AHIMA query guidance seemed strong.”

### Formatting the query template

AHIMA’s 2008 guidance, *Managing an Effective Query Process*, outlines the format queries should follow and the various elements they should include.

The guidance states that queries should meet the following criteria:

- » Be written with precise language
- » Identify clinical indications from the health record

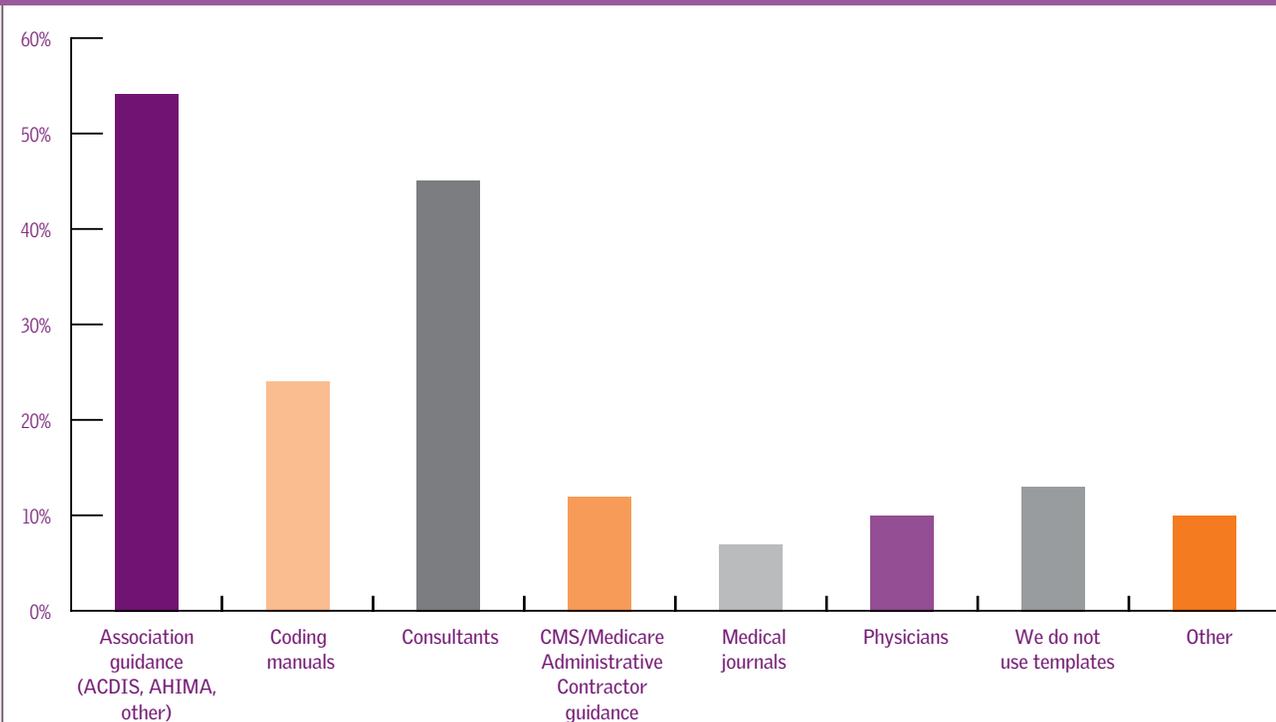
- » Ask the provider to provide a clinical interpretation of these facts based on his or her professional judgment of the case

The guidance says multiple-choice formats may be used as long as the choices are all clinically reasonable “regardless

### Figure A: Related AHIMA query guidance

- » *Ethical Standards for Clinical Documentation Improvement Specialists*: <http://tinyurl.com/2ayhh75>
- » *Code of Ethics*: <http://tinyurl.com/2esuzs3>
- » *Standards for Ethical Coding*: <http://tinyurl.com/2e47dd6>
- » *Managing an Effective Query Process*: <http://tinyurl.com/67o3bs3>
- » *Guidance for Clinical Documentation Improvement Programs*: <http://tinyurl.com/23wvnur>
- » *Clinical Documentation Improvement Toolkit*: <http://tinyurl.com/25u9k6c>

Figure 17: Where did you obtain your information or source for the query templates/forms (check all that apply)?



of impact on reimbursement or quality reporting” and as long as the query contains options for “other” and “unable to determine.”

According to the survey, 81% indicated their templates include specific clinical data taken directly from patients’ charts. (See Figure 19.) That number should be closer to 100%, says Butler, adding that “all queries should include specific clinical data from the patient chart.”

Butler suggests that perhaps CDI specialists do not include specific patient data *in their templates* but do include that information once they pull the appropriate template and submit it to the physician.

The number of respondents who said they include space for open-ended responses seems similarly low (71%) to Butler, considering AHIMA’s recommendations. The 61% who stated their queries contain specific diagnosis phrase options could also be a concern if the forms simply provide a single possible diagnosis, or if they contain three non-plausible clinical diagnoses and only one plausible option.

“These could be considered leading queries and open the facility to unwarranted risks,” Butler says.

According to the *Managing an Effective Query Process* brief:

*Queries that appear to lead the provider to document a particular response could result in allegations of inappropriate upcoding. The query format should not sound presumptive, directing, prodding, probing, or as though the provider is being led to make an assumption.*

Another risk comes from including pre- and post-query DRGs or DRG relative weights directly on the query forms. “That’s just risky,” says Butler.

### Query policies, procedures

In the formation of policies and procedures, 68% of respondents indicated they have standards for written queries, compared with 39% who indicated they have standard procedures for verbal queries. (See Figures 20 and 21. See Figure 22 for data on which departments create these policies.)

“In general, it is good practice to have policies and procedures in place to support your actions,” says Bryant. “I’d like to see those rates move closer to 80% by next year’s survey. CDI programs really need to get that in order.”

The 2008 AHIMA query guidance addresses the issue of verbal queries. It states:

*Verbal queries have become more common as a component of the concurrent query process. The desired result of a verbal query is*

*documentation by the provider that supports the coding of a condition, diagnosis, or procedure. Therefore entities should develop specific policies to clearly address this practice and avoid potential compliance risks.*

(See Figure B for additional suggestions from AHIMA.)

Many programs have one policy to address all queries regardless of type, which may account for the disparity, Butler says. He also theorizes that programs without official policies and procedures may think that they are safer from government audits than those programs with a written policy in place.

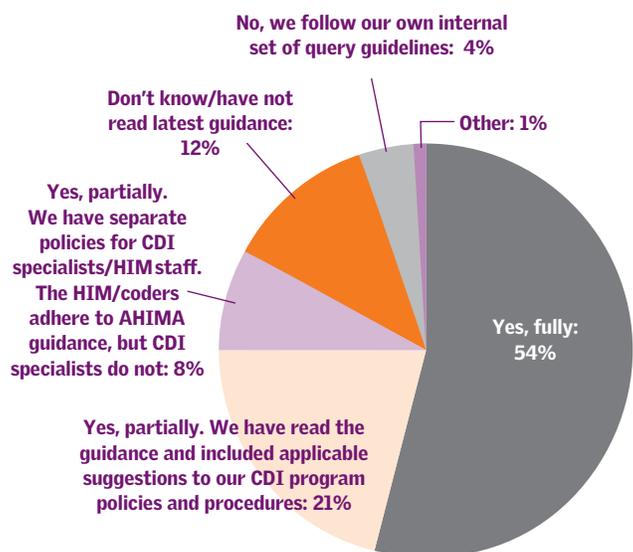
“If you do not have a query policy in place, that does not let you off the hook,” Butler says. “Any auditor examining your program will ask for your policies and procedures. If you do not have one in place, they will apply their own standards to your process. Such a situation could lead to adverse effects.”

The AHA’s *Coding Clinic for ICD-9-CM* supports the development of guidelines for querying physicians as well. It states:

*Facilities can work together with their medical staff to develop facility specific coding guidelines which promote complete documentation*

*continued on p. 13*

**Figure 18: Do your query forms follow the AHIMA physician query guidance?**



## Figure B: AHIMA says clarify for five criteria

The 2008 AHIMA brief *Managing an Effective Query Process* suggests that facilities develop their own internal policies and procedures for when and how to query physician documentation in the medical record. It identifies the following five issues that might warrant clarification:

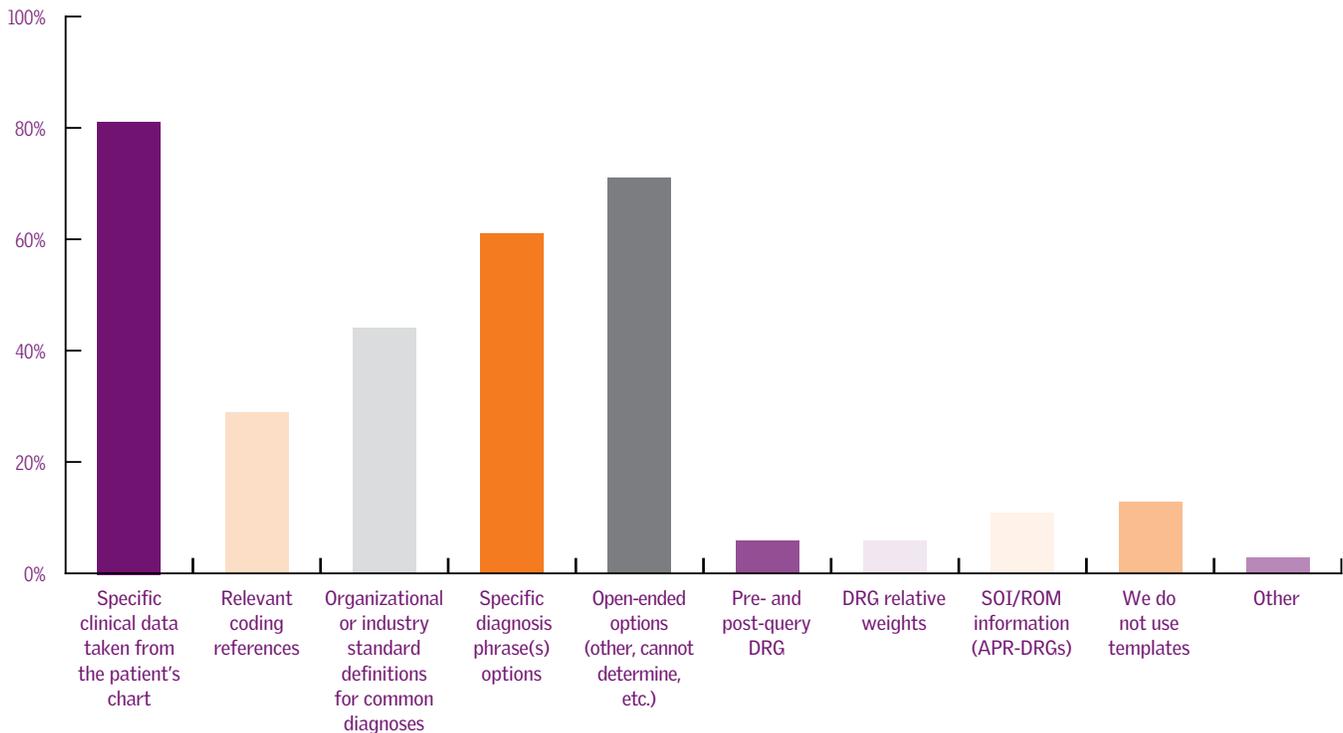
- » **Legibility.** This might include an illegible handwritten entry in the provider's progress notes, for example. It could also include an inability to read the provider's assessment on the date of discharge.
- » **Completeness.** This might include a report indicating abnormal test results without notation of the clinical significance of the results (e.g., an x-ray shows a compression fracture of lumbar vertebrae in a patient with osteoporosis and no evidence of injury).
- » **Clarity.** This might include symptoms noted without statement of a cause or suspected cause (e.g.,

the patient is admitted with abdominal pain, fever, and chest pain, and no underlying cause or suspected cause is documented).

- » **Consistency.** This might include a disagreement between two or more treating providers with respect to a diagnosis (e.g., the patient presents with shortness of breath; the pulmonologist documents pneumonia as the cause and the attending documents congestive heart failure).
- » **Precision.** This might include an instance where clinical reports and clinical condition suggest a more specific diagnosis than is documented (e.g., congestive heart failure is documented when an echocardiogram and the patient's documented clinical condition on admission suggest acute or chronic diastolic congestive heart failure).

Source: AHIMA, *Managing an Effective Query Process*.

## Figure 19: What elements do your query templates contain (check all that apply)?



## Query survey

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*needed for consistent coding assignment. Any guidelines developed must be applied consistently to all records coded.*

Those programs without formal policies and procedures governing their practices should look to industry guidance and create one, Butler says.

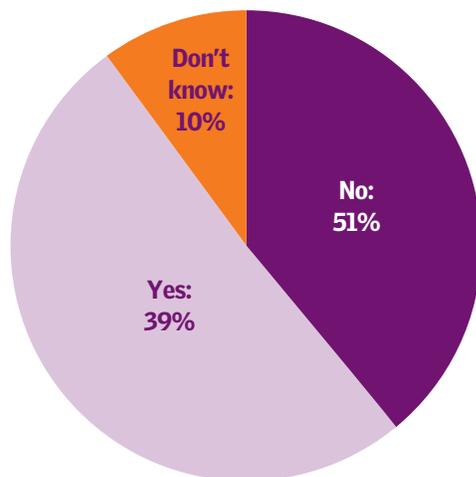
### Query retention

Whether to retain written queries as a permanent part of the medical record (or whether to retain them at all) remains a matter of some debate. Some industry experts believe that including queries as a part of the record may open the facility to unnecessary liability and Recovery Audit Contractor (RAC) scrutiny. Others say query forms should be transparent and used to defend facility practices against investigations from the Office of Inspector General and the RACs.

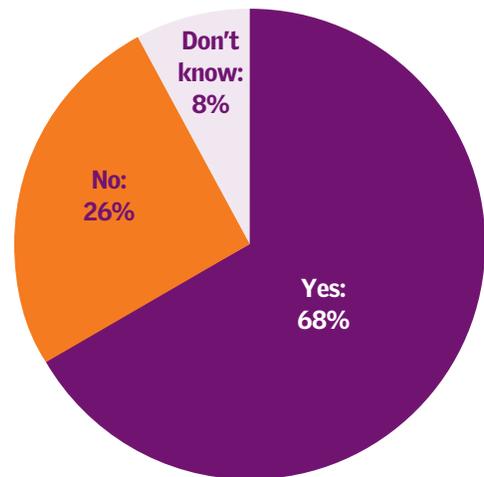
The majority of survey respondents said they do not keep queries as a permanent part of the medical record.

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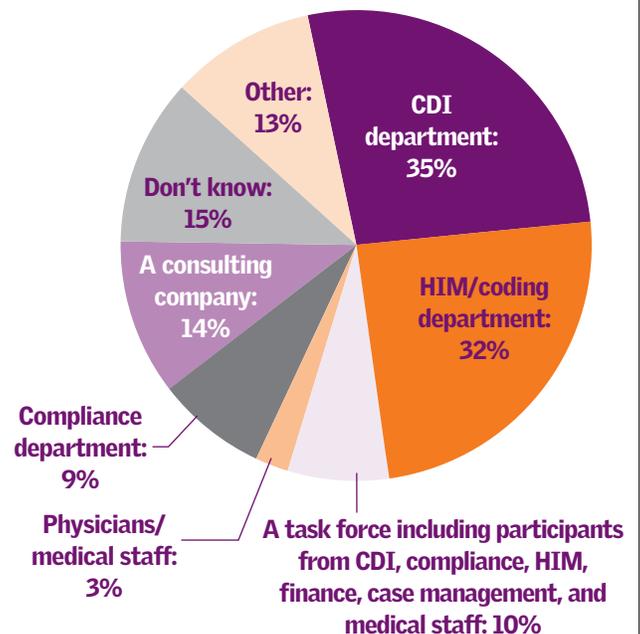
**Figure 21: Does your facility have a standard policy for verbal queries?**



**Figure 20: Does your facility have a standard policy for written/electronic queries?**



**Figure 22: If your facility has a standard policy for verbal/written query dissemination, who created it?**



## Query survey

continued from p. 13

However, more than half of all respondents keep their queries, “just not all keep them part of the permanent health record,” Bryant says. (See Figure 23.)

This seems indicative of CDI practices, Haik says. “If the CDI program directs physicians to respond to the query by documenting further specificity in the patient’s medical record, then the program typically does not keep the query,” he says.

However, Haik does recommend that facilities retain queries in some manner for CDI program benchmarking and self-analysis as well as for transparency’s sake. “My feeling is you should keep them.”

In 2010, a few RACs, namely CGI, Inc., and Connolly Consulting Associates, Inc. (the RACs for regions B and C, respectively) began requesting query forms along with other medical record requests on a regular basis. CMS remains vague on whether facilities need to comply with those requests, and different programs have different policies. (For more information, see “RACs request queries as complex reviews roll out” in the July 2010 edition of *CDI Journal*.)

Nearly 30% of respondents said they do not submit queries to the RAC. However, 18% submit queries if they are part of the permanent record, and 15% submit any queries auditors request. (See Figure 24.) “The RACs are asking for them,” says Bailey. “My advice would be to develop a process and make all your facility responses to the RAC uniform.”

## Query tracking

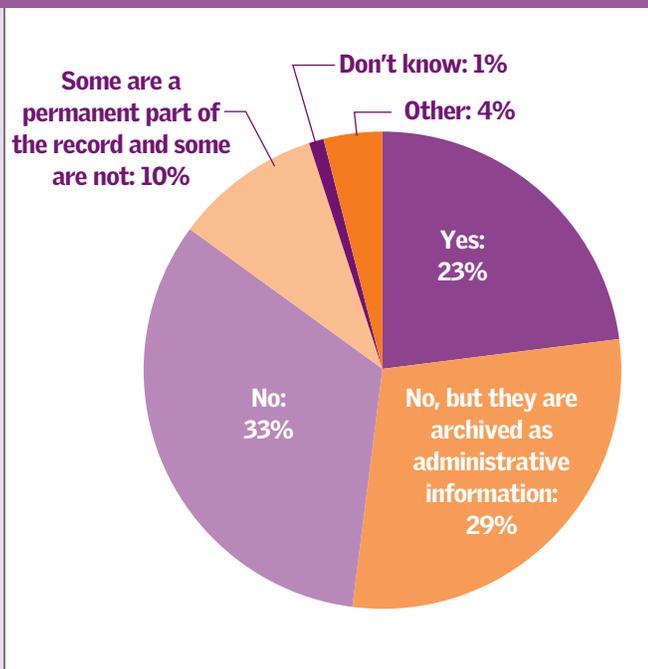
According to the survey, CDI programs use a wide variety of methods to track their queries. These include electronic databases (36%), Excel spreadsheets (21%), allowing the consultants to maintain the database (18%), and saving paper queries in a binder (18%). (See Figure 25 for more detail.)

Regardless of method, such information must be kept and monitored to “identify opportunities for improvement across the spectrum of care, as well as to provide feedback” to CDI specialists and physicians, according to *The Physician Queries Handbook*.

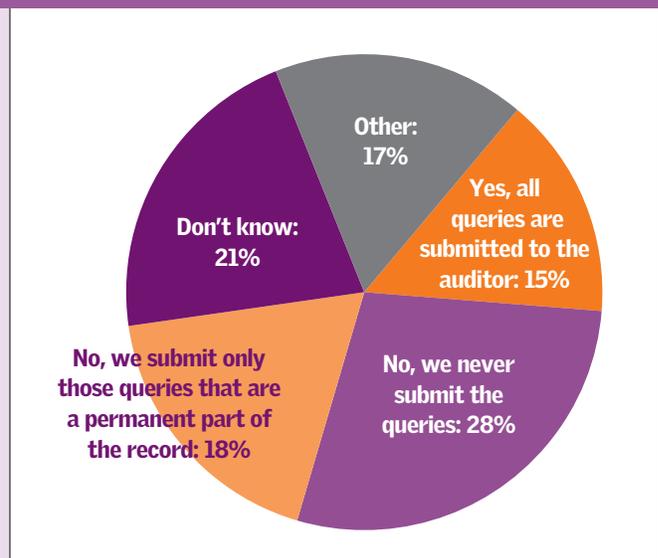
Regarding monitoring query delivery and physician responses, most facilities (see Figure 26) track the origin of the inquiry (i.e., whether coding or CDI staff initiated the query) (71%),

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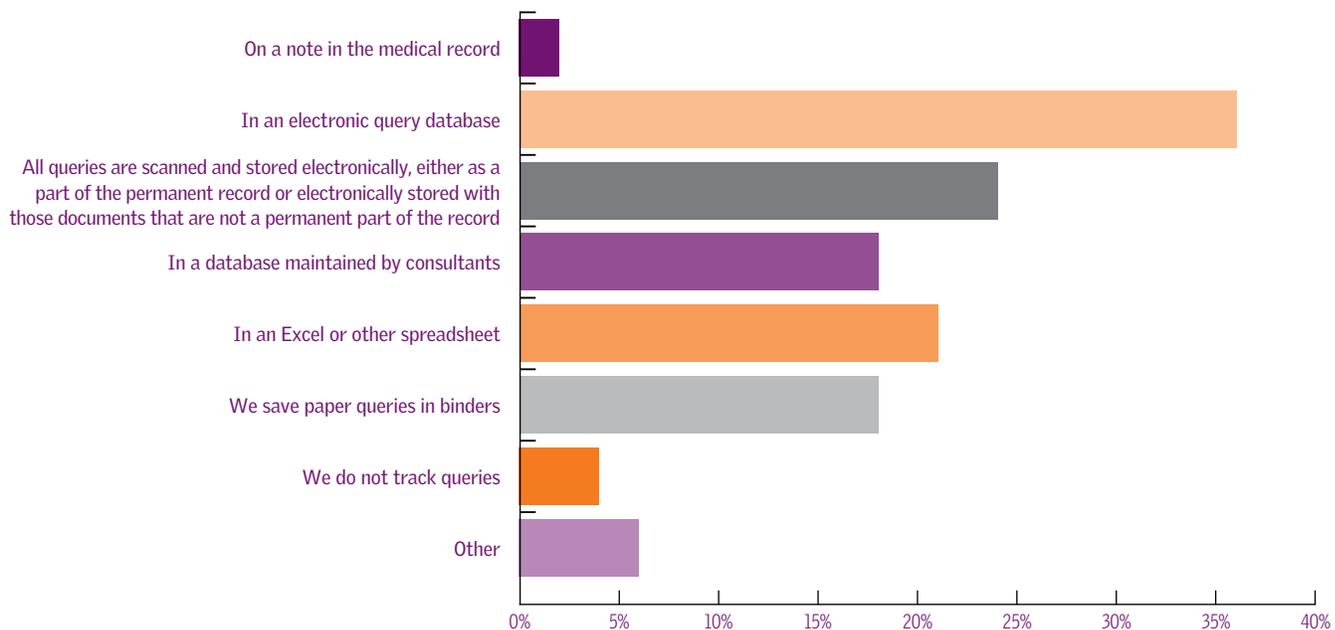
**Figure 23: Are your query forms part of the patient’s permanent medical record?**



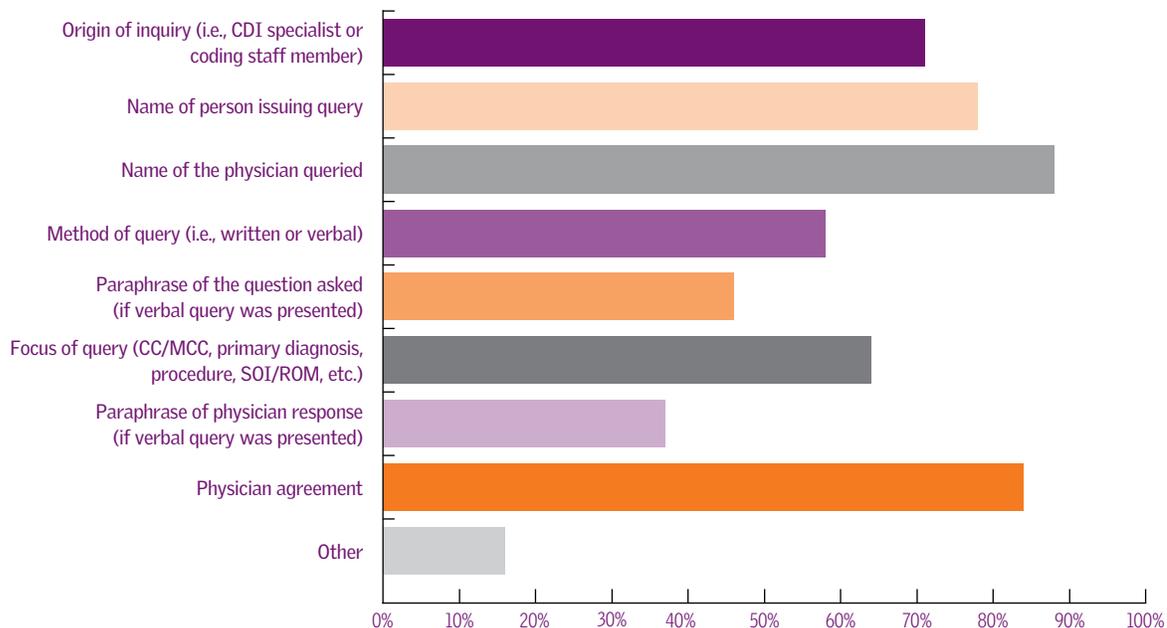
**Figure 24: If your query forms are not a permanent part of the medical record, do you provide the query as part of Recovery Audit Contractor, legal, or external audit requests?**



**Figure 25: How do you track (compile, aggregate, store, and/or retrieve) written and/or verbal queries?**



**Figure 26: Which of the following items do you track in regard to query dissemination and physician response (check all that apply)?**



## Query survey

*continued from p. 14*

the name of the person submitting the query (78%), and the name of the physician being queried (88%) among other items.

Although most of the responses were high for all options, Butler thinks CDI programs should consistently monitor all these items. “If you want to show the impact of your program, you need this information,” he says.

To monitor query success, most respondents (76%) track the final DRG assignment, followed by 75% who indicated their facilities judge query success by the percentage of physicians’ positive versus negative responses. (See Figure 27.)

“Certain elements should be required for all programs regardless of financial impact. The first several are important to track, but if it is not your facility’s focus, then you may not monitor those,” Butler says.

CDI programs should also analyze the effectiveness and quality of their queries. (See Figure 28.) At a minimum, Butler recommends pulling at least two cases per month per CDI staff member to review the queries for content and quality.

“This goes to accountability [and] to the quality of work performed in the CDI program,” he says.

In general, CDI programs should examine what query tracking elements they monitor and how they use that data to improve performance, Bryant says. “Are there elements [within this survey] that other programs track and you do not? If so, why not?” she asks.

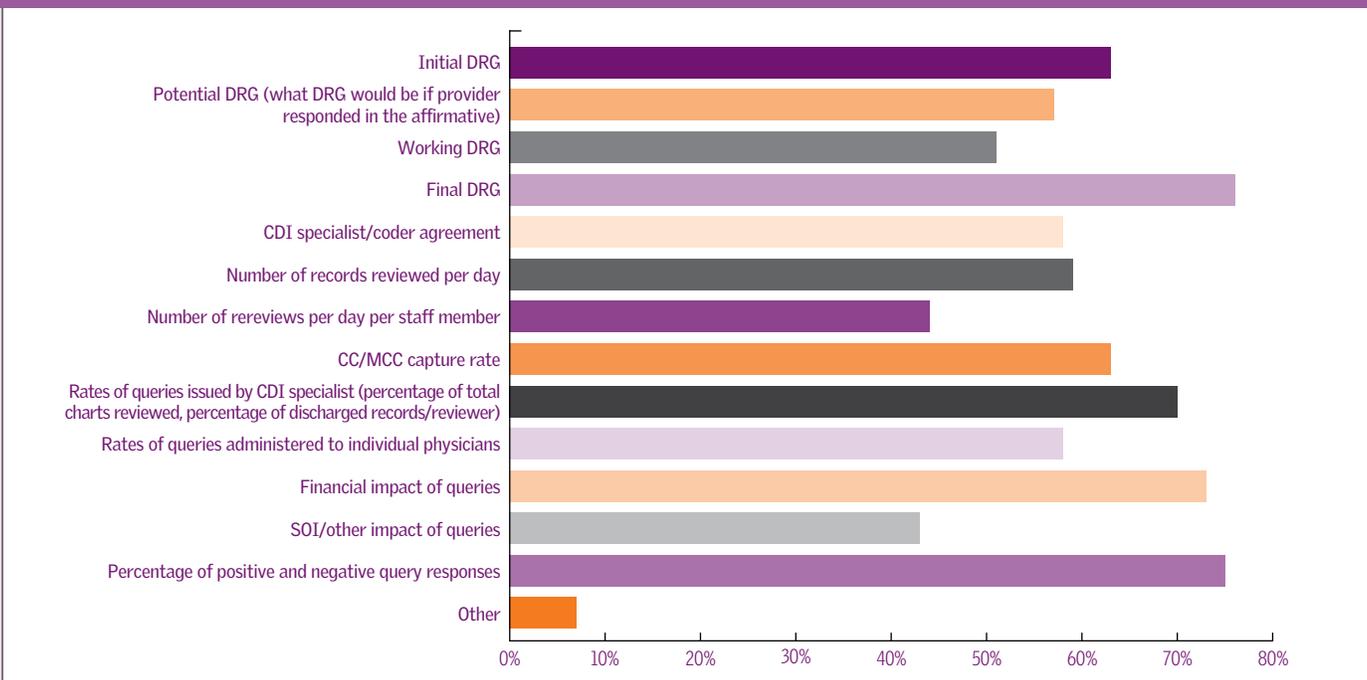
The CDI manager needs to review not just the percentage of charts examined by the team, but also the number and type of queries left on the chart. A change in CMS documentation requirements may affect query percentages in a given period of time, for example. Similarly, if such reviews illustrate repeated clarification for a specific condition, perhaps additional physician education for the condition is warranted; CDI staff may also require additional training on clinical indicators for that particular diagnosis.

### CDI specialist productivity

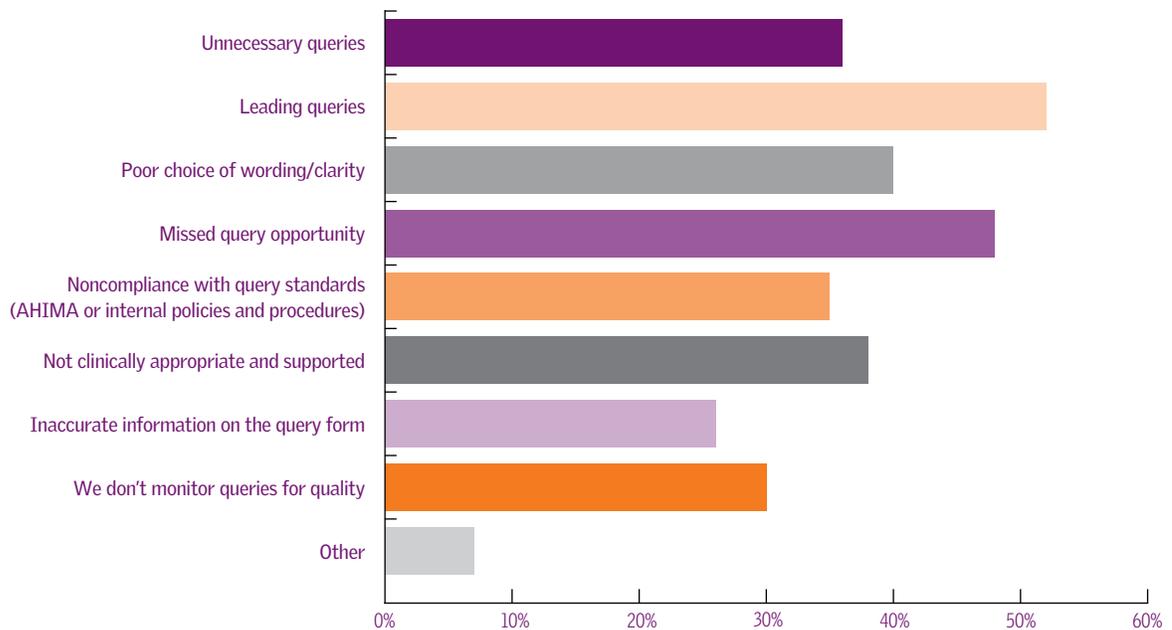
A variety of factors influence CDI staff members’ productivity. (See Figures 29–32.) A new specialist may take up to

*continued on p. 18*

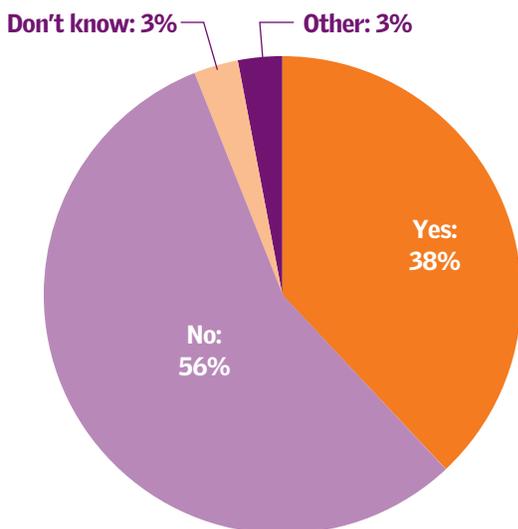
**Figure 27: Which of the following do you audit/monitor as indicators for query performance (check all that apply)?**



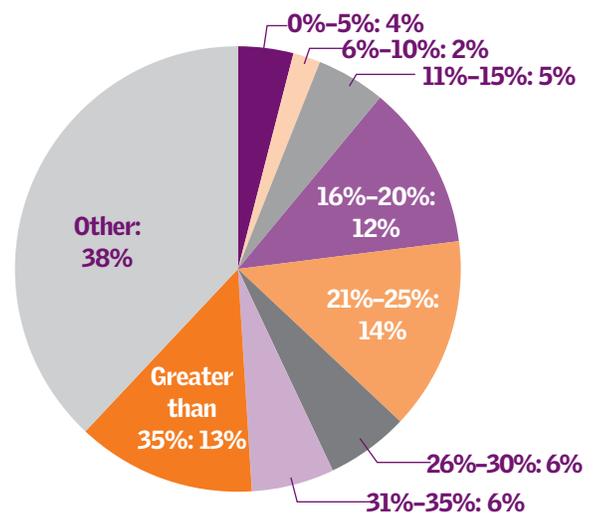
**Figure 28: Do you audit/monitor the following indicators for query quality (check all that apply)?**



**Figure 29: Do CDI specialists at your facility have a set query quota they must (or are expected to) meet?**



**Figure 30: If a query quota exists, what percentage of charts does your program expect CDI specialists to query? If you have a volume quota, please choose an equivalent percentage of your reviewed cases.**



**Figure 31: Other responses to the question from Figure 30**

- » 20–22 charts per day
- » We do not have a quota but we measure the volume, the response rate, and the financial and quality impact
- » All Medicare, MedicareAdvantage, and commercial insurer paying by DRG
- » Benchmark is 25%, but this is not a requirement
- » The expectation is set for total cases to review, not queries, as some cases may not require a query
- » 60% of all initial and rereviewed charts combined
- » Quality comes first, we have no query quota

## Query survey

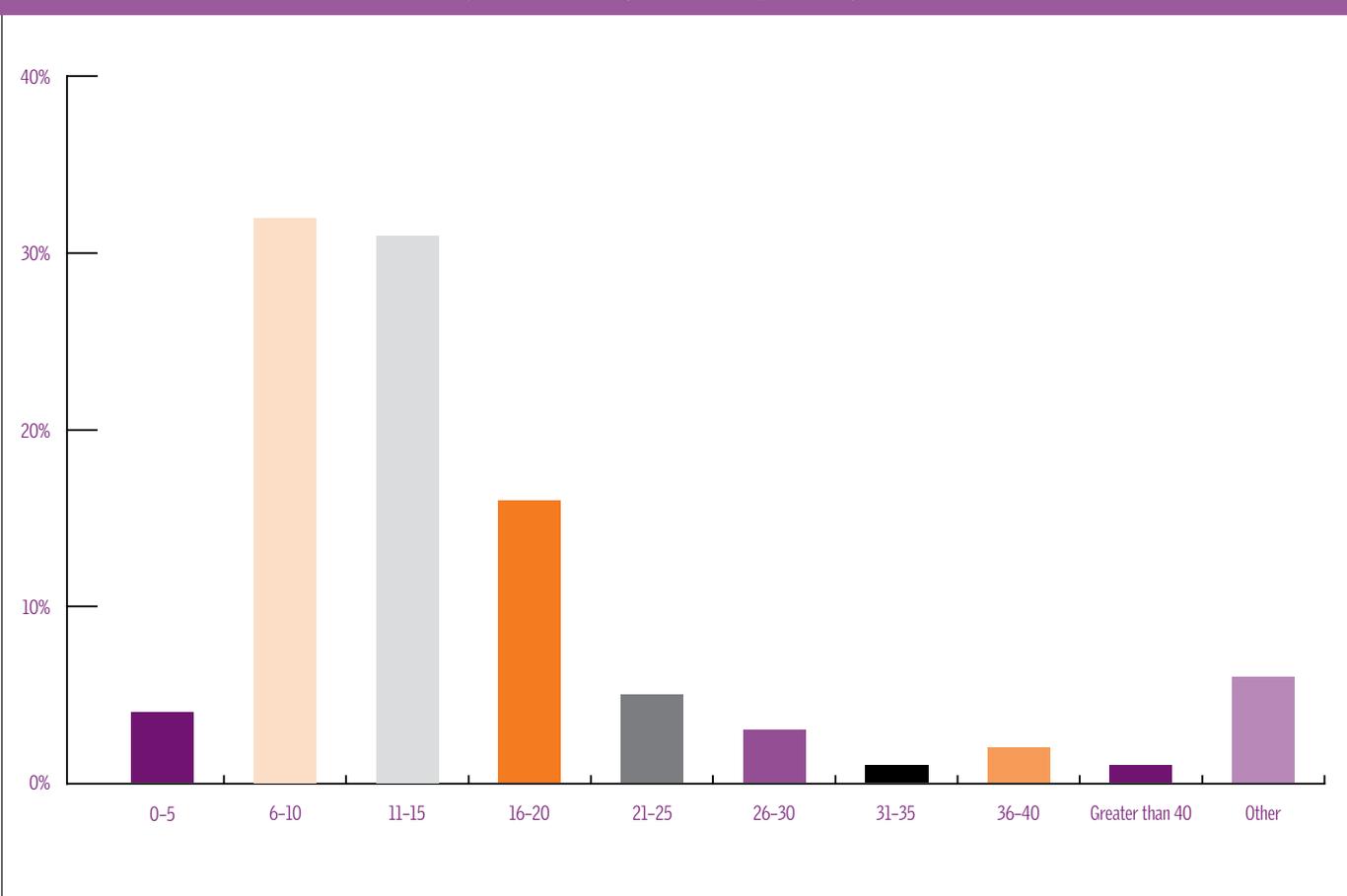
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six months to become proficient at a basic level while more experienced CDI staff spot documentation improvement opportunities easily. Therefore, it's important to keep these factors in mind when reviewing query data for CDI productivity.

Most programs (32%) indicated that a CDI specialist reviews between six and 10 new patient charts per day, with a slightly smaller number of respondents indicating that their CDI specialists review 11–15 charts daily (31%). (See Figure 32.) Rereviews echoed this trend, with 27% indicating they perform between six and 10 rereviews per day and 22% reexamining 11–15 records daily. (See Figure 33.)

For programs where the CDI specialist has additional responsibilities, reviews may require additional time and

**Figure 32: How many new patient charts does an average CDI specialist (one full-time staff member) in your facility review per day?**



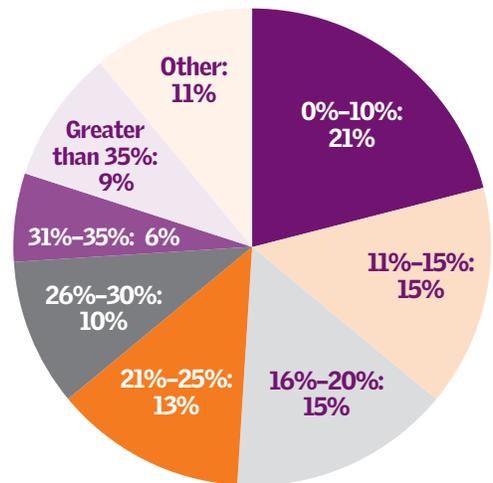
productivity will differ. For example, it typically requires less time to review a record for DRG assignment as opposed to those programs which also focus on capturing SOI/ROM.

A number of questions in the *2010 Physician Query Benchmarking Report* asked participants to indicate their query rates, response rates, and more. For example, Figure 34 illustrates the percentage of cases reviewed that require more than one query. Twenty-one percent of respondents indicated that between 0% and 10% of their records require more than one query, but the percentage ranges were fairly evenly represented.

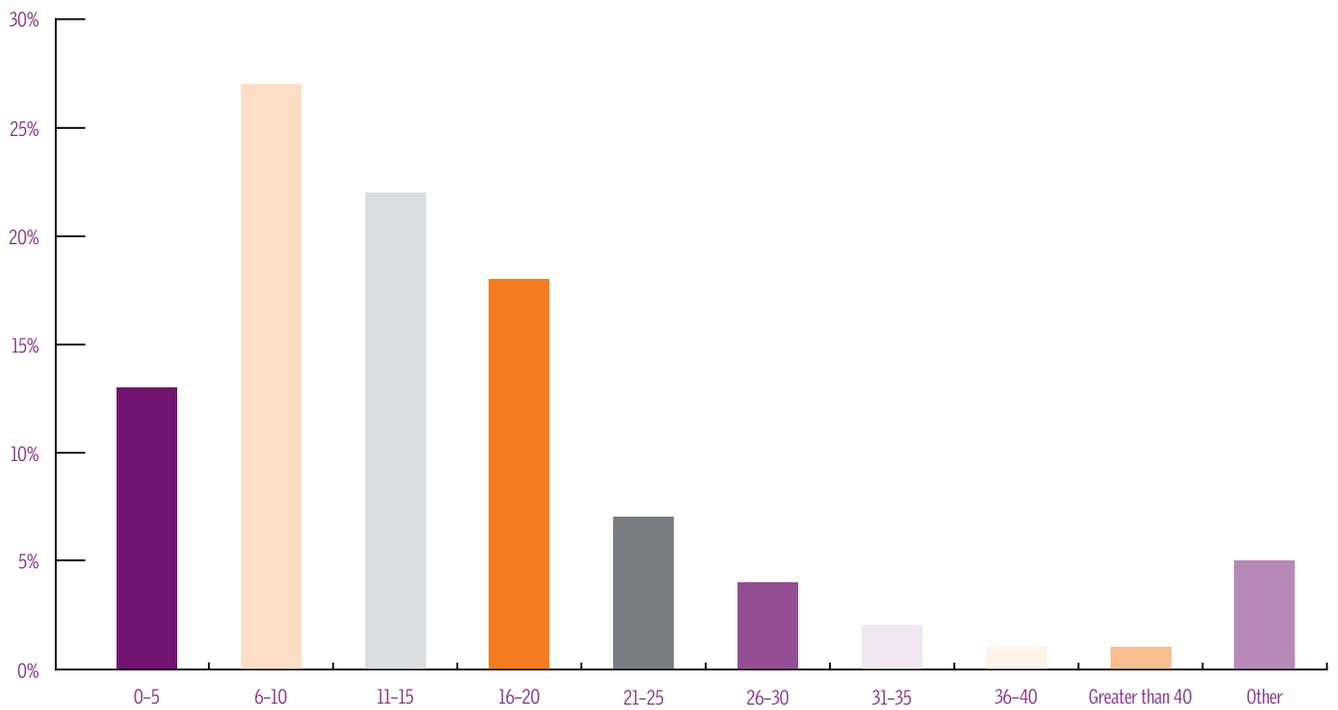
Most facilities place a query on 11%–30% of the cases they review. (See Figure 35.) Physicians respond to between 71%–80% of those queries, in the case of 16% of respondents, followed by 15% who indicated the response rate to be between 86%–90%. (See Figure 36.) According to Figure 37, the most common physician query agreement rate is 86%–90%. Again, all the ranges were fairly well represented. This may reflect

*continued on p. 21*

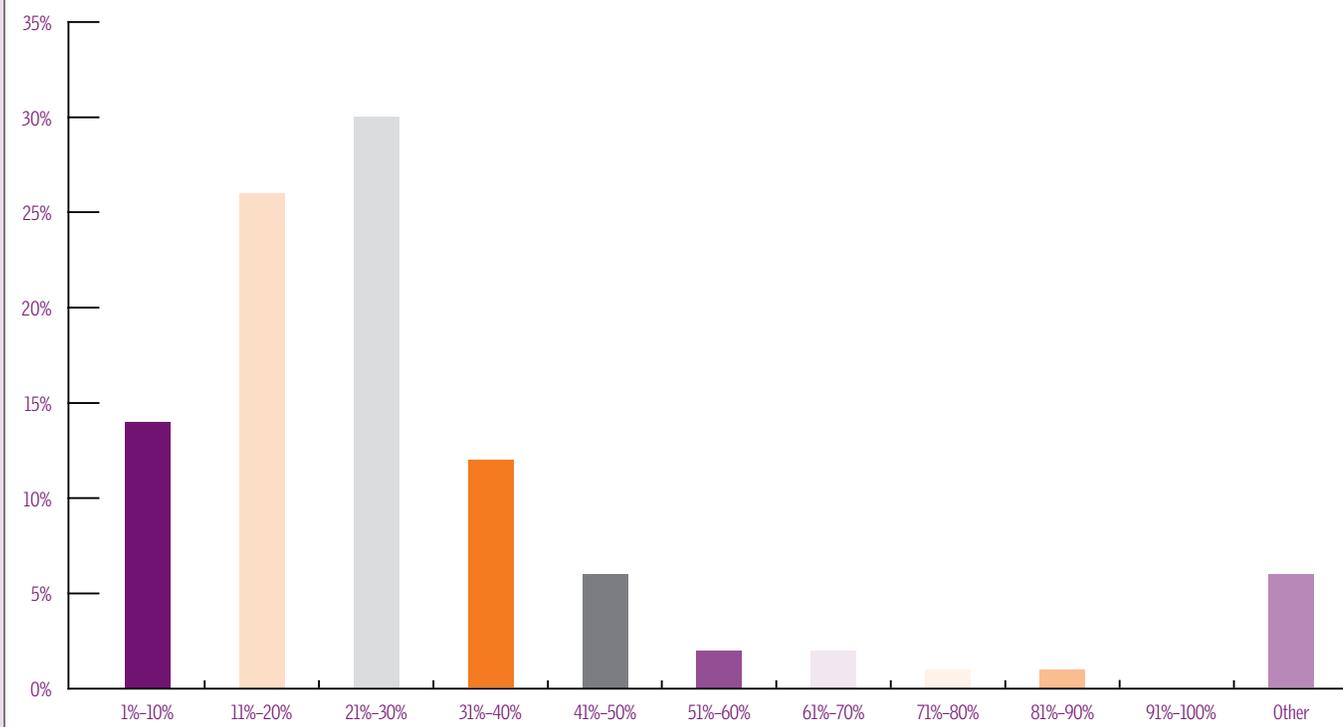
**Figure 34: What percentage of cases reviewed have more than one query left on the chart or posed to physicians?**



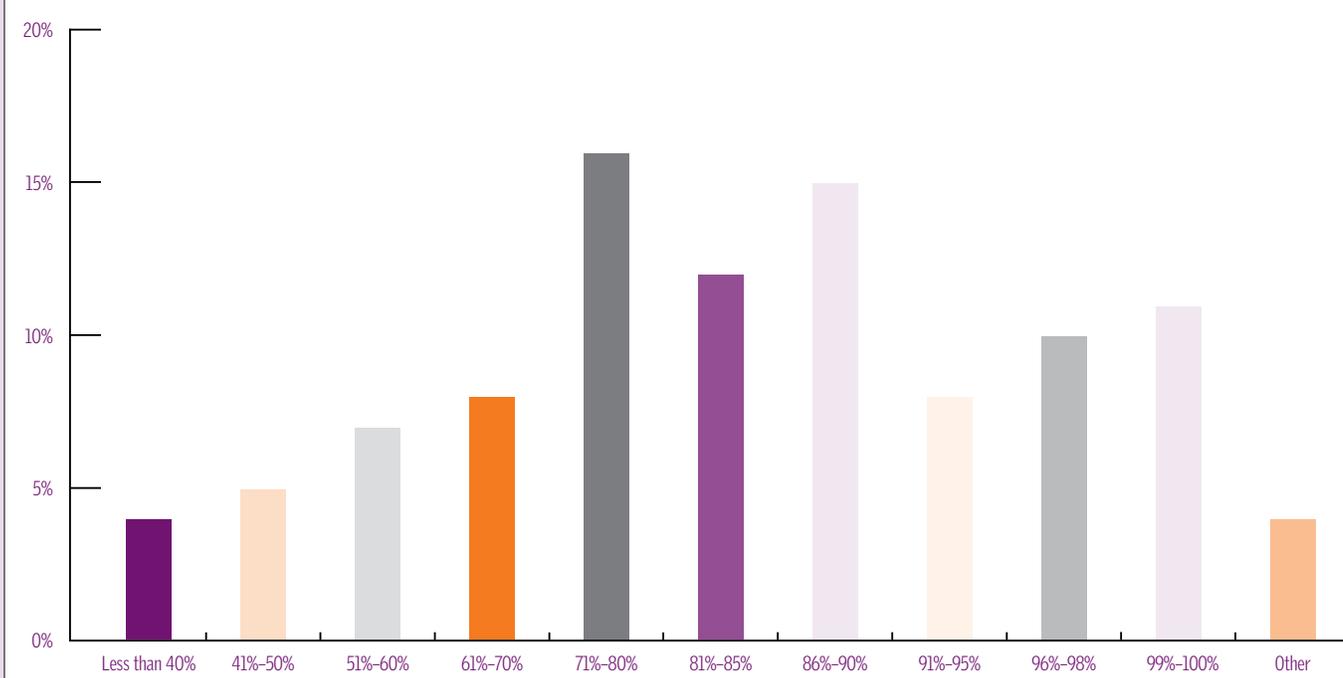
**Figure 33: How many rereviews (charts previously reviewed one or more times) does an average CDI specialist (one full-time staff member) follow up on per day?**



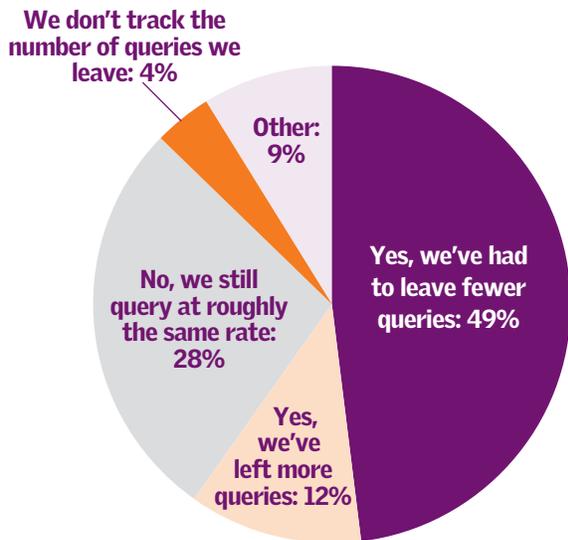
**Figure 35: What percentage of your chart reviews result in a query?**



**Figure 36: What is your percentage of physician response to queries?**



**Figure 38: As your CDI program has matured, have you seen a change in the number of queries posed to physicians?**



## Query survey

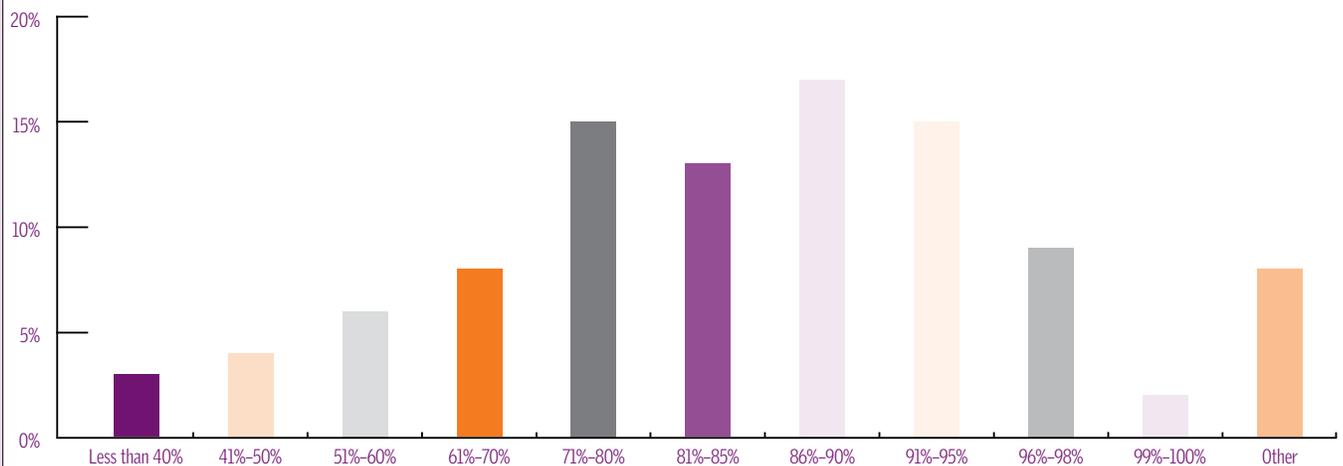
*continued from p. 19*

the various ages and experience levels of CDI programs across the country. However, 28% indicated their query rate has not changed since their program's inception, compared to 49% who suggested they haven't needed to leave as many queries as the years go by. (See Figure 38.)

"The number should change over time, not so much that you have a set number of queries that need to be submitted in any set number of records reviewed, but that you need to define if your group's productivity is where you would expect it to be given your unique set of circumstances," Butler says.

Bryant recommends that CDI staff use the results of the *2010 Physician Query Benchmarking Report* to evaluate their practices against industry norms. "This is interesting information to bring back to your program and discuss among the various people involved," she says. "It tells me that across America we do not have complete documentation from our physicians in the medical record." ■

**Figure 37: For those queries that receive a response, what is the physician's agreement rate?**



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