ACDIS/AHIMA brief provides additional query guidance

New yes/no query options, rules for introducing new diagnoses, policy recommendations

It’s been more than 12 years since AHIMA published its first recommendations governing coder-physician interactions. Since “Developing a Physician Query Process,” published in 2001, much in the healthcare industry has changed—and much change is still to come.

Thus the impetus for the latest query practice brief, “Guidelines for Achieving a Compliant Query Practice,” published in the February Journal of AHIMA and produced in collaboration with ACDIS.

“Those not familiar with the physician query process may wonder why additional guidance is necessary,” says Kathryn DeVault, RHIA, CCS, CCS-P, senior director of HIM Practice Excellence at the Chicago-based AHIMA, one of the brief’s contributors.

“However, those of us involved in the process know it’s hard. It’s difficult to write a compliant query to convey the appropriate information to the provider without leading them to a particular diagnosis.”

Guidance for all

Query confusion in the industry is related to what and how a coder or CDI specialist can question about the contents of the medical record, says Rose T. Dunn, MBA, RHIA, CPA, FACHE, chief operating officer of First Class Solutions, Inc., in Maryland Heights, Mo. Such confusion may have been driven, in part, by the specialists’ credentials, she says.

Previously, those who worked in the CDI field fell somewhere between the nursing and coding ranks. These individuals often questioned which rules to follow, if they knew about AHIMA guidance at all. Some believed a CDI specialist should never pose a leading query, whereas others set forth that those with nursing backgrounds could approach a physician as...
a fellow clinician, have a clinical discussion, and bring that information back to the medical record. Conversely, coders, who theoretically assign codes for reimbursement purposes and have little or no medical training, could not, the thinking went.

The latest guidance eliminates the confusion in part because of the collaborative nature of the brief, including as it does input from a wide swath of experts from various backgrounds. It states:

All professionals are encouraged to adhere to these compliant querying guidelines regardless of credential, role, title, or use of any technological tools involved in the query process.

The new brief also sets clear boundaries and definitions in areas that previously caused confusion, if not outright consternation, for those in field.

**Leading queries**

The question of crafting non-leading queries may well be a defining theme of the 2013 brief. Its opening lines state: 

*In court an attorney can’t “lead” a witness into a statement.*

In hospitals, coders and clinical documentation specialists can’t lead healthcare providers with queries. Therefore, appropriate etiquette must be followed when querying providers for additional health record information.

The simplest way to ensure that queries remain non-leading is to include evidence from the medical record and provide the opportunity for the treating physician to offer additional input through the use of multiple response

"The goal is to increase the transparency between the query and the medical record."

—Cheryl Ericson, RN, MS, CCDS, CDIP

While previous practice briefs contained somewhat nebulous definitions for the term “leading,” the 2013 brief defines a leading query as:

*[O]ne that is not supported by the clinical elements in the health record and/or directs a provider to a specific diagnosis or procedure.*

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options.

“The goal is to increase the transparency between the query and the medical record. [That’s why] over and over again within the latest query practice brief the importance of the clinical indicator, or indicators, is emphasized,” says Cheryl Ericson, RN, MS, CCDS, CDIP, CDI education director for HCPro, Inc., in Danvers, Mass.

According to “Guidelines for Achieving a Compliant Query Practice”:

All queries must be accompanied by the relevant clinical indicator(s) that show why a more complete or accurate diagnosis or procedure is requested.

The 2013 brief provides examples of both leading and non-leading query versions and illustrates how clinical indicators should be integrated into the queries. (Read the complete practice brief on p. 7.)

“Because of the increasing scrutiny of queries by external reviewers, it is more important than ever to toe the line and to ensure that ‘leading’ does not occur,” says Dunn.

“A query is not a fishing expedition,” says William E. Haik, MD, FCCP, CDIP, director DRG Review, Inc., in Fort Walton Beach, Fla., who spoke with Ericson during the March 4 webcast, “Physician Queries: Comply with new ACDIS/AHIMA guidance.”

Yes/no queries

Previous 2008 AHIMA guidance “Managing an Effective Query Process” limited yes/no queries to those related to present-on-admission conditions. The 2013 guidance, however, opens yes/no queries to use in three new possible situations, including:

1. Substantiating or further specifying “a diagnosis that is already present in the health record”
2. Establishing a cause-and-effect relationship between documented conditions such as manifestation/etiology, complications and conditions/diagnostic findings
3. To resolve conflicting practitioner documentation

“This is a big change,” says Haik. “It is no longer your daddy’s Buick as the saying goes.”

In short, if one doctor mentions a diagnosis, you can ask the attending physician verbally whether he or she agrees with this diagnosis. However, yes/no queries may not introduce new diagnoses and they cannot be used when only clinical indicators of a condition are present and the condition/diagnosis has yet to be documented in the health record.

Even when the information is in the record, the new brief encourages yes/no queries to also include other

Query process considerations

The reasons for submitting a query to a physician have been addressed in previous practice briefs, coding regulations, and other venues. The latest 2013 ACDIS/AHIMA guidance reiterates that queries should be generated when:

» The documentation is not clear enough to support the rationale for tests that were performed
» An extended length of stay due to conditions is documented by other patient caregivers
» A response is needed for a condition identified by another clinician
» Added specificity is needed for the codes being applied

With the advancement of Recovery Auditors, ICD-10-CM/PCS implementation, value-based purchasing, and other initiatives affecting documentation and coding specialists, Kathryn DeVault, RHIA, CCS, CCS-P, senior director of HIM Practice Excellence at the Chicago-based AHIMA, says organizations should also bear in mind:

» Severity of illness. The health record documentation should reflect the severity of the patient’s condition and specific treatment provided. Thorough documentation provides consistency in continuity of care and establishes the severity of a given patient’s illness.

» Complete documentation and appropriate reimbursement. A complete health record with thorough documentation results in a correctly coded account, which ultimately leads to appropriate reimbursement.

» Recovery Auditors and other reviewers. Documentation in the health record should be consistent and appear in the correct context. Diagnoses that are a result of a query should be supported by the appropriate clinical indicators.
options such as:
» i.e.
» Other
» Clinically undetermined
» Not clinically significant
» Integral to

“It’s not like you’re pulling a diagnosis out of thin air,” says ACDIS Director Brian D. Murphy, CPC, who worked with the committee. “It just makes it easier to have the conversation.”

This new guidance may help CDI specialists query physicians more effectively once ICD-10-CM/PCS implementation takes place, says Ericson, since so many codes depend on capturing the etiology, manifestation, and cause-and-effect relationship between the diagnoses.

**Multiple-choice queries**

Similarly, the brief indicates that “multiple choice query formats should include clinically significant and reasonable options as supported by clinical indicators in the health record.”

Unlike yes/no queries, however, CDI specialists can include a new diagnosis in a multiple-choice query. Although past query briefs have permitted use of multiple-choice queries, many coders and CDI specialists believed that providing a new diagnosis—a diagnosis not otherwise specified within the medical record—was “leading.” The latest ACDIS/AHIMA brief removes that limitation. It states that:

> Providing a new diagnosis as an option in a multiple choice list—as supported and substantiated by referenced clinical indicators from the health record—is not introducing new information.

“The concept of new information has been confusing regarding the use of a diagnosis not previously documented,” says Haik. “This guidance states that you may introduce new information not included in the record as long as it is not in the stem of the question or in the title of the query form.”

Further, multiple-choice query formats should include additional options such as “clinically undetermined” and “other” that would allow the provider to add free text, according to the brief. “Not clinically significant” and “integral to” may also be included on the query form if appropriate.

Many in the CDI industry were concerned about the use of multiple-choice queries when the reasonable choices were limited, writes Marion Kruse, MBA, RN, a healthcare consultant based in Columbus, Ohio, and author of the forthcoming *Physician Queries Handbook, Second Edition.*

By listing only one diagnosis, they could be accused of leading the physician, even if “other” and “clinically undetermined” were used. So they may have added clinically unreasonable options just to make the query form itself appear compliant. The latest guidance eliminates those efforts and, essentially, eliminates potential confusion for the physician, Kruse writes.

**Policy recommendations**

The latest guidance avoids “reinventing the wheel,” Murphy says, drawing on previous rules governing query basics such as when to query the provider. It also readdresses the need for policies and procedures governing the query process.

It suggests that both verbal and written queries should be documented and tracked for effectiveness and to “allow reviewers to account for the presence of documentation that might otherwise appear out of context.”

DeVault admits it’s a struggle to document verbal queries.

> “How do you document a conversation that results in a diagnosis?” she says.

Nevertheless, says Ericson, “for verbal queries there has to be a record or memorialization of that interaction [between the CDI specialist and the physician] within the record.”

Physicians really like the verbal query format, she says, because it saves both the physician and the CDI specialist time writing and responding to multiple-part queries, and allows for immediate feedback.

Verbal queries are not without risk, however. They need to include the same clinical indicators and follow the same format and structure as their written counterparts, according to the 2013 brief. This will help “ensure compliance and consistency in policy and process,” the brief states.
Documentation of the verbal query should identify the:
» Clinical indicators that support the query
» Actual question posed to the practitioner
» Time of the discussion

The 2013 guidance also recommends facilities establish policies regarding query permanence, and whether queries will be retained as a part of the medical record. It states:

Organizations that opt to not maintain queries as part of the permanent health record are encouraged to maintain copies as part of the administrative, business record. If the practitioner documents his or her response only on the query form, then the query form should become part of the permanent health record.

When queries are not part of the health record, policies governing permanence should identify how long queries will be kept, how they will be identified and tracked, and where they will be retained.

Auditors increasingly have begun to request query forms as part of their medical record reviews, and regular internal audits of the query forms as part of process improvement measures will require access to those forms.

Spurred by recent Recovery Auditor activities, the 2013 brief addresses concerns of clinical validity of diagnoses and suggests possible procedures for query escalation, too.

Questioning the clinical validity of a diagnosis, however, is tricky business, says Ericson. After all, it is the physician’s job to diagnosis and treat the patient. CDI specialists who submit these types of queries may jeopardize their working relationship with that physician.

“Recovery Auditors have changed the game in terms of how auditors are looking at these records,” says Murphy. “Physicians may have documented a diagnosis, but if there is no clinical support for that diagnosis, auditors will deny the claim. It puts coders in a tough spot.”

Therefore, the 2013 brief recommends that facilities follow “their internal escalation policy rather than requiring the CDI specialist/coder to query the practitioner.”

“Auditors don’t want to see a diagnosis that appears out of context without supporting documentation,” DeVault says. “It’s a new normal for documentation. It’s not just asking for a diagnosis, but also the clinical validation of the diagnosis.”

Applying rules to practice

Like previous briefs, the latest is not binding governmental law but rather industry standards. As AHIMA is one of the four Cooperating Parties responsible for code assignment, its opinion carries some weight and is often invoked by auditors.

It’s been wonderful to see the compromising and the evolution of the query practice through these various guidances. I think it’s great that the industry as a whole is open-minded enough to realize that we have to continually revise and adjust to improve our processes.

—Cheryl Ericson

Ultimately, the onus is on HIM and CDI professionals to review the recent guidelines and assess them in relationship to earlier guidance, standards of procedure and ethics, and adopt them to their existing query processes, says Murphy.

Murphy recommends that CDI and HIM directors:
» Update their query forms and policies to conform with the new query practice brief
» Explain to CDI/HIM staff that yes/no queries are permitted when a diagnosis already appears in the record (review relevant clinical examples from the brief)
» Remind CDI/HIM staff that it is incumbent on them to query a physician to provide clinical support for a diagnosis if none exists, or to address the situation through their hospital’s escalation policy

“It’s been wonderful to see the compromising and the evolution of the query practice through these various guidances,” says Ericson. “I think it’s great that the industry as a whole is open-minded enough to realize that we have to continually revise and adjust to improve our processes. I think that’s the goal of it—to always keep in mind what we are here for, to make sure that we have an accurate medical record that reflects the physician’s intent and care provided to the patient.”

Access the brief at http://tinyurl.com/agjsjoj.