PHYSICIAN QUERIES

Physician queries 101: Debunking the myths

It’s been nearly two years since the American Health Information Management Association (AHIMA) joined ACDIS to offer the industry physician query instructions in Guidelines for Achieving a Compliant Query Practice, published in February 2013.

Nevertheless, “there are a lot of myths and misinformation about query practices out there,” says Cheryl Ericson, MS, RN, CCDS, CDI-P, AHIMA Approved ICD-10-CM/PCS Trainer, CDI education director for HCPro, a division of BLR, in Danvers, Massachusetts.

Myth 1:
All guidance is created equal

AHIMA, along with CMS, the AHA, and the National Center for Health Statistics, comprise the four Cooperating Parties in charge of ICD-9-CM (soon to be ICD-10-CM/PCS) code creation and updates. So any advice from these governing bodies bears additional regulatory weight. Similarly, as the only national association solely dedicated to CDI, ACDIS advice, in collaboration with AHIMA, should be regularly reviewed.

That said, “there is a hierarchy to follow in terms of coding and querying advice,” Ericson says.

The Official Guidelines for Coding and Reporting and AHA Coding Clinic for ICD-9-CM (now Coding Clinic for ICD-10-CM/PCS) each contain numerous recommendations for when to query physicians. (Read CDI Boot Camp instructor Sharme Brodie’s take on the latest Coding Clinic advice on p. 33.) For example, the Official Guidelines for Coding and Reporting states:

A joint effort between the healthcare provider and the coding professional is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized.

Refer to the Official Guidelines for Coding and Reporting first, then to Coding Clinic, for applicable recommendations regarding specific diagnoses and query advice. These two related publications often provide specific instances of when query submission and clarifications may be warranted. For example, the Official Guidelines for Coding and Reporting recommends querying to determine whether:

- A pressure ulcer is new or healing
- A condition such as sepsis or a potential hospital-acquired condition was present at the time of admission
- An abnormal finding should be added to the diagnostic statement and coded

Coding Clinic, too, offers many such recommendations. However, clinical information previously
published in Coding Clinic—whether for ICD-9-CM or ICD-10-CM/PCS—does not constitute clinical criteria for establishing a diagnosis, substitute for a provider’s clinical judgment, or eliminate the need for provider documentation regarding the clinical significance of the patient’s medical condition, according to Coding Clinic, First Quarter 2014.

That’s why many facilities work with their physician advisor or specialty staff collaboratively to develop standard clinical definitions and incorporate these into the CDI team’s query templates. Such efforts help improve physician buy-in for CDI efforts as well as ensure medical record accuracy.

“Coding Clinic is not an authoritative clinical source,” Ericson says. “It is trying to help non-providers become familiar with a given diagnosis, [however it is] not saying that its clinical information is the only information that should be used. Really the underlying point here is that it is not the role of the CDI or coding team to determine what clinical indicators the physician or facility uses but it is best to develop a consensus for both querying and audit defense efforts.”

Similarly, facilities should look first to CMS for advice on query construction and compliance and then to other industry leaders for additional direction.

When CMS rolled out MS-DRGs in 2007, the agency essentially gave facilities the green light to expand CDI efforts. The August 2007 Federal Register encourages facilities to better capture clinical documentation to improve coding opportunities. It states:

“We do not believe there is any-thing inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation in the medical record.

Additionally, CMS has said that queries are acceptable as long as they:

- Are not leading
- Do not introduce new information not otherwise contained in the medical record
- Provide clarification
- Are consistent with other medical record documentation

“That’s one of the nice things about the 2013 brief, that we finally have a definition of leading,” says Ericson, who points to CMS’ original statement regarding query creation.

“It says that the query is okay if it is consistent with other medical record documentation, and that’s what the latest practice brief says also.”

Similarly, the 2013 release builds on AHIMA’s previous publications

Myth 2: New rules same as the old rules (second verse same as the first)

While earlier practice briefs did much to outline when queries might be necessary (such as clarifying “conflicting,” “incomplete,” or “ambiguous” documentation, according to AHIMA’s 2008 Standards of Ethical Coding, or in situations such as “illegibility,” “incompleteness,” “lack of clarity,” “inconsistency,” or “imprecision,” according to AHIMA’s 2008 Managing an Effective Query Process), the definition of what constitutes a “leading” query remained ambiguous until 2013. The new brief finally addressed this concern directly by stating:

“A leading query is one that is not supported by the clinical elements in the health record and/or directs a provider to a specific diagnosis or procedure. The justification (i.e., inclusion of relevant clinical indicators) for the query is more important than the query format.”

– Cheryl Ericson, MS, RN, CCDS, CDI-P, AHIMA Approved ICD-10-CM/PCS Trainer

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and guidance. Yet some professionals adhere to earlier recommendations and neglect advice contained in the new brief.

For example, previous recommendations limited the use of yes/no queries (where the physician was allowed to answer either yes or no) to questions pertaining to whether a condition was present on admission or not. The new guidance allows such questions in additional specific circumstances with the addition of options for “other,” “clinically undetermined,” or “not clinically relevant,” Ericson says.

The guidance also outlines that yes/no queries should not be used if the physician hasn’t yet documented a diagnosis in the record; also, CDI specialists cannot use a yes/no query to obtain a new diagnosis.

Here is the exact language from the brief as to when a yes/no query can be used:

*In addition to present on admission (POA) determinations, yes/no queries may be utilized under the following circumstances:*

- **Substantiating or further specifying a diagnosis already present in the health record (i.e., findings in pathology, radiology, and other diagnostic reports) with interpretation by a physician.**
- **Establishing a cause and effect relationship between documented conditions such as manifestation/etiology, complications, and conditions/diagnostic findings (i.e., hypertension and congestive heart failure, diabetes mellitus and chronic kidney disease).**
- **Resolving conflicting documentation from multiple practitioners.**

"Many programs felt that introducing any new information in a physician query that wasn’t included in the medical record was leading the physician," Ericson says. “The 2013 brief clarifies that.”

The 2013 guidance highlights different query format options—open ended, multiple-choice, and yes/no—as well as differences between written and verbal queries with scenarios outlining each one’s appropriate use. The format choice needs to reflect the clinical scenario and information available—the context of the situation, Ericson says. “The first concern is the quality and construction of the query,” she says. “Does it contain appropriate information relevant to the question being asked? Secondly, is the query warranted at all? Are you on a fishing expedition trying to get the physician to document a certain diagnosis?”

**Myth 3: Those rules don’t apply to us**

It had been said that ACDIS recommendations don’t apply to HIM/coding professionals and that CDI professionals who hail from nursing backgrounds need not follow AHIMA guidance.

Yet ACDIS’ representatives have consistently been invited to join AHIMA workgroups in the creation of query guidance since 2008, culminating in the joint publication of the most recent 2013 physician query practice brief. And the 2013 practice brief specifically states that anyone involved in the query process must abide by the guidelines. 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.*

“Whether or not you are a member of AHIMA or ACDIS, you should follow these recommendations,” says Ericson. “It doesn’t matter what your professional affiliation is, it doesn’t matter whether you are a nurse or a coder or a physician.”

That’s because once an individual steps into the CDI role, his or her principal responsibility becomes the veracity of the medical record and the integrity of the information therein, says Mark LeBlanc, RN, MBA, CCDS, CDI director at The Wilshire Group in Sierra Madre, California.

While each type of professional background brings particular areas of expertise to query practice, each professional is bound by the limitations and expectations of the CDI role. Physicians performing the CDI function cannot document their opinions in the medical record if he or she is not a part of the treating medical team, nor can they prompt another physician to do so, Ericson says.

“Everyone involved in the query process needs to review the various industry recommendations and make sure their efforts reflect the latest information,” she says. 🌟

**Editor’s note:** Learn more from the on demand webinar “Physician Queries: Ensure Effective, Compliant, Regulatory-Based Clarifications.”

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**Unfortunately, CMS did not define what it considers ‘leading’ nor what is considered as ‘introducing new information,’ which has left much open to interpretation.”**

– Cheryl Ericson
QUERY PRACTICE
Find the right tool for the job

The 2013 ACDIS/AHIMA physician query practice brief Guidelines for Achieving a Compliant Query Practice outlines formats that may be presented either through written or oral means:

- Open-ended
- Multiple-choice
- Yes/no

The brief also outlines how each of these formats may be effectively and compliantly employed so as to not lead the physician to a particular diagnosis. The following examples offered by Cheryl Ericson, MS, RN, CCDS, CDI-P, AHIMA Approved ICD-10-CM/PCS Trainer, CDI education director for HCPro, a division of BLR, in Danvers, Massachusetts, and Mark LeBlanc, RN, MBA, CCDS, CDI director at The Wilshire Group in Sierra Madre, California, show how a particular query might be better composed in an alternative format.

Example 1: Cause and effect

The first example represents an open-ended query for the relationship between diabetes and peripheral neuropathy, which might have better been composed as a yes/no question.

Although there isn’t anything technically wrong with the open-ended version, it is a “bit clunky and may confuse the provider,” says LeBlanc. “We’re already struggling with providers who say they don’t understand what we’re asking them for, who complain that we’re wasting their time.”

The open-end query example demonstrates an over-inclusion of clinical information, which forces the provider to pore over redundant information to get to the point.

Additionally, says Ericson, query disclaimers such as the one included at the top of the open-ended example do nothing to protect the CDI staff from compliance concerns if the query itself is not appropriately worded and supported by information in the medical record.

While the closing information at the bottom of the form may serve as a helpful reminder to physicians, such information may be better delivered during one-on-one educational sessions or as part of larger educational efforts.

Open-ended (less effective):

By submitting this query, we are merely seeking further clarification of documentation to reflect the severity of illness of your patient. Please use your independent clinical judgment when addressing the question(s) below.

Dear Doctor,

The past medical history of patient [patient ID number] includes stage III chronic renal insufficiency, peripheral neuropathy, hypertension, degenerative joint disease, dyslipidemia, diabetes, history of hepatitis C, gout, anemia, vitamin D deficiency, and COPD who presents for evaluation of syncopal episode.

The medical record indicates that the patient uses a walker to ambulate and that his gait is worsened by his chronic gout as well as peripheral neuropathy. Can you please clarify the relationship, if any, between peripheral neuropathy and diabetes in the medical record?

*For coding purposes, the cause and effect relationship may not be assumed and must be documented by the provider. Note: Use of possible, probable, and likely are acceptable terms if documented in the discharge summary.

Yes/no (more effective):

Dear Doctor,

Is there a relationship between “peripheral neuropathy” and “diabetes” documented in the history and physical in this patient who “uses a walker to ambulate and his gait is worsened by his chronic gout as well as peripheral neuropathy”?

____Yes
____No
____Unable to determine
____Other: ____________
Example 2: Diagnosis introduction

It may seem subtle, but in the following open-ended query, the CDI specialist emphasizes the diagnosis of “severe protein calorie malnutrition.” Although it doesn’t introduce a new diagnosis, it could be construed as “leading” since it offers no other options for the physician, says LeBlanc. In this instance, a multiple-choice query could provide better clarity and direction to the physician.

Open-ended (could be construed as leading):

Dear Doctor,
Can the clinical findings below be further qualified as severe protein calorie malnutrition or would a different clinical descriptor be more appropriate?

Per 5/10/14 dietitian note: Evidence of malnutrition: Yes - Severe, protein calorie malnutrition in the context of chronic illness. Physical findings: subcutaneous fat and muscle loss [12/16/13 58.06 kg (128 lb) to 05/08/14 52.572 kg (115 lb 14.4 oz)].

If, in your clinical judgment, you concur with the above listed diagnosis, please add the diagnosis to your list of diagnoses and discuss in the body of the medical record and/or discharge summary. If not, please indicate what clinical diagnosis you were treating.

I disagree because (please add in the reason here): __________________

Multiple-choice (compliant choice):

Dear Doctor,
The dietitian note of 5/10/14 has a finding of severe protein calorie malnutrition in the context of chronic illness based on the physical findings: subcutaneous fat and muscle loss [12/16/13 58.06 kg (128 lb) to 05/08/14 52.572 kg (115 lb 14.4 oz)]. Can these findings be clarified as one of the following diagnoses?

____Mild protein calorie malnutrition
____Moderate protein calorie malnutrition
____Severe protein calorie malnutrition
____Finding without clinical significance
____Unable to determine
Other: __________________

MD signature: ______________
Date/time: ______________

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