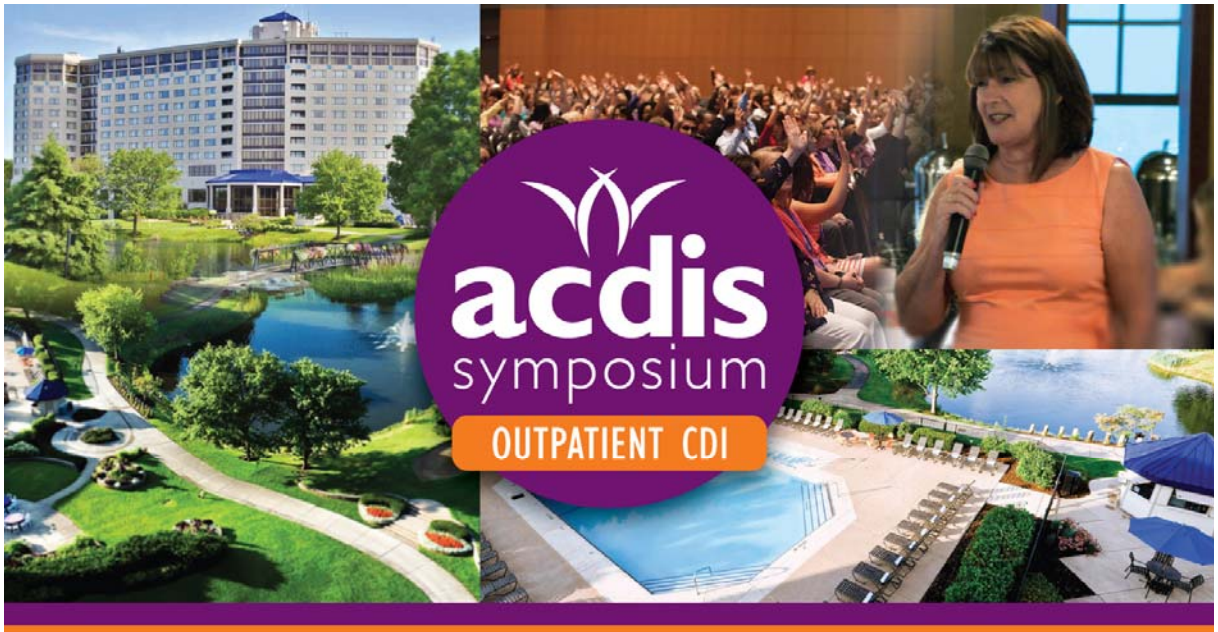

Outpatient Query Practices: Building Compliant Queries

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Program Notes for CDI Outpatient Workshop Series

acdis
Association of Clinical Documentation Improvement Specialists

- Workshop materials and recordings
  - Copies of the slides for all programs in this workshop series can be downloaded at the link below. The workshop recordings will be posted to the same location on a rolling basis within a few days of a program:
  - https://acdis.org/2017-outpatient-cdi-workshop
- Continuing education information
  - Please note: In order to receive your continuing education certificate(s) for this workshop series, you must complete the online evaluation, which can be found in the CE instructions file on the download page. The evaluation will open after the last event in the *entire* series on November 17, 2017.

Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Define an outpatient admission per UHDDS
  - Demonstrate knowledge of query process
  - Identify the challenges of the query process
  - Identify the appropriateness of a query
  - Understand the different types of queries
  - Demonstrate knowledge of AHIMA/ACDIS "Guidelines for Achieving a Compliant Query Practice"

Definition of Outpatient Services

- Outpatient services include:
  - Emergency department services
  - Observation services
  - Outpatient (ambulatory) surgery
  - Lab test, x-rays
  - Physician practice/clinic

Patient Care: Tick Tock

- The average time:
  - Inpatient length of stay is 4.5 days
  - Physician office visit is less than 15 minutes
  - ED providers expected to see 2–3 patients per hour

Because patient encounters within the outpatient setting are so compact, capturing quality documentation concurrently is key. CDI function in the outpatient setting must address issues related to documentation efficiently and timely. They must be active at the point of care.

Racing legend Mario Andretti famously said, "If everything seems under control, you're just not going fast enough."
https://www.brainyquote.com/quotes/authors/m/mario_andretti.html

Roni Caryn Rabin: You're on the Clock: Doctors Rush Patients Out the Door. Kaiser Health News, April 2014

Patient Care: Tick Tock

- Providers have limited time to complete the work at hand. They resent time spent in documentation.
- CDI efforts can interfere with provider-patient time. Query practices must be timely and respectful of provider time.
- Prioritize queries to match your identified mission or goals. Combine queries when appropriate.
- Learn the workflow and billing cycle related to the services you are reviewing.
- Work to eliminate need for query with 1:1 education, properly designed templates or EHR prompts, on-the-spot education, etc.

Patient Care: Turn Up the Volume

- For every 100 inpatient encounters, a hospital treats 850 outpatients
  - Chemotherapy
  - Radiology
  - Laboratory
  - Emergency
  - Observation
  - Rehab/physical therapy
  - Ambulatory surgery/procedures
  - Primary care/clinic

You can't review them all. Let your mission drive your priorities.

Yuen, Knauss. *First Steps in Outpatient CDI: Tips & Tools for Building a Program*. HCPro, an H3.Group division of Simplify Compliance, 2017.

Outpatient CDI Impact

- **<u>What is your CDI mission?</u>**
  - Pay for performance
    - Quality initiatives
    - MACRA, MIPS/APMs
  - Reimbursement appropriate for resource use
    - Provider E/M
    - Payment for services
  - Risk adjustment
    - Hierarchical Condition Categories
  - Medical necessity of care
    - LCDs, NCDs
  - Other

Your mission will determine what records you review and what types of queries you apply

Documentation Requirements Vary

- The volume and required elements vary greatly related to the services provided
- Observation records are very similar to inpatient records
- Laboratory/diagnostic testing require only an order by the provider with the identified reason for the testing
- Physician practice/clinic documentation requires documentation of the patient's condition(s), assessment, and treatment plan

CDI professionals need to adjust their review and query practice to the setting type and the reimbursement rules related to code assignment for that setting.

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."

https://www.cdc.gov/nchs/data/icd/10cmguidelines_2017_final.pdf

Advice on Query Practice

- *Federal Register* (2007) directed hospitals to make attempts to improve all aspects of clinical documentation
  - *We do not believe there is anything 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.*
- For this reason, queries are often used for the purpose of capturing those diagnoses, allowing for accurate reimbursement, clarity of quality measures, accuracy of SOI/ROM measures, etc.

Query Practice

A Matter of Compliance

What Is a Query?

- A routine communication and education tool used to advocate for complete and compliant documentation
- A method to request additional documentation to accurately reflect the condition(s) that were managed during an episode of care
- Clinical documentation improvement (CDI) programs may use different names for this process, but regardless of what the communication is called, the query should adhere to the guidance outlined in the AHIMA/ACDIS practice brief "Guidelines for Achieving a Compliant Query Practice"

What Is a Query?

- Queries are not intended to challenge the physician's clinical diagnosis or management of a patient

Quality of documentation, *not* quality of care

Code of Ethics

- AHIMA's standards of "ethical coding" state that coding professionals are expected to consult the physician for clarification and additional documentation prior to code assignment when there is conflicting or ambiguous data in the medical record

ACDIS Code of Ethics states: Clinical documentation specialists shall facilitate interdisciplinary collaboration in situations supporting clinical documentation improvement practice and avoid participation in, condone, or be associated with dishonesty, fraud, abuse, or deception.

When to Query

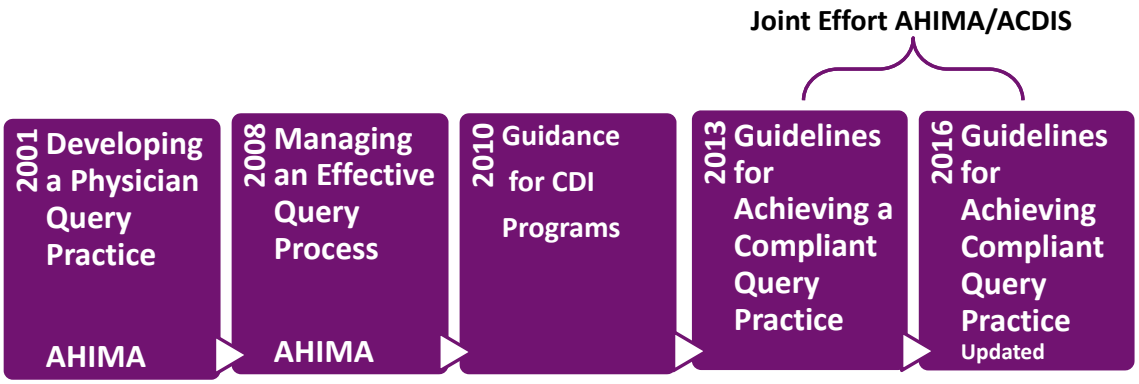
- When there is conflicting, incomplete, or ambiguous information in the health record regarding a significant reportable diagnosis or procedure

When to Query

Your designated focus or mission will direct the queries that you need to apply. Reasons to query include:

- To capture all appropriate diagnoses to support patient severity or risk adjustment
- To capture further specificity of already documented diagnoses
- To support medical necessity of care provided
- To support quality measures, MACRA, meaningful use
- To identify clinical indicators to support a documented diagnosis
- Other identified focus

History of Standards for Queries



"The guidance is relevant to all CDI professionals and those who manage the CDI function, regardless of the healthcare setting in which they work or whether they are AHIMA members."

AHIMA. "Guidance for Clinical Documentation Improvement Programs." *Journal of AHIMA* 81, no.5 (May 2010): 45-50.

Query Guidance Based on Patient Status

- **Is there a different set of guidelines and/or rules that govern the query process in the outpatient setting?**
  - AHIMA has issued numerous practice briefs (including 2013/2016 that is coauthored with ACDIS) setting professional standards for querying
  - Because ICD-10 guidelines apply to both the inpatient and outpatient settings with some variation per setting noted, the AHIMA query guidance implicitly applies to both settings as the ethics of coding should be the same regardless of setting

CMS Position on Querying

- A query form is acceptable as long as it is:
  1. Not leading
  2. Does not introduce new information not otherwise in the medical record
  3. Provides clarification
- CMS does not define "**leading**" nor what is considered as "**introducing new information**," which leads to an issue regarding different interpretations

Queries: Written & Verbal

- Traditionally queries were in a written format. With concurrent record review, inpatient CDI specialists have become quite comfortable with verbal query practices.
- The condensed timeline related to outpatient record review lends to the flexibility and "just in time" approach of verbal queries.
- Verbal interaction works well in the office and ED. The CDI specialist must first and always be respectful of patient flow and provider time.

Verbal Queries

- Documentation of the verbal query must reflect the stated information, but should identify the clinical indicators that support the query as well as the actual question posed to the practitioner
- Verbal queries should be documented at the time of the discussion or immediately following

Verbal query = written query

Query Formats

- **Open-ended**
  - Cited by AHIMA as being the preferred query format. The most difficult to construct to elicit a desired provider response.
- **Multiple-choice**
  - Easier to construct and easier to understand
- **Yes/no**
  - Had limitations regarding usage prior to the 2013 Practice Query Brief
- **Verbal**
  - Often preferred when addressing complex issues, or regarding simple documentation issues

Open-Ended Query

- An open-ended query should introduce the clinical indicators that have spurred the need for query followed by the question.

ED Doctor, your documentation describes this patient be placed in observation status for fluid overload. Diagnostics indicate a BNP 450, with audible rales in the lower lobes. Patient states on arrival she has not taken her "fluid pills" for three days as she is on vacation and "road tripping." Medications include Tenormin and insulin. Please clarify the condition you are treating related to the fluid overload.

These queries can be easily asked both verbally and in written format.

Multiple-Choice Format Construction

- Multiple-choice query format should include
  - Clinically significant options
  - And reasonable options
  - That are supported by the clinical indicators in the medical record
  - Additional options such as "clinically undetermined" or "other"
- There should be no consideration as to how the answers affect reimbursement
- Providing a new diagnosis as an option in a multiple-choice query that is supported and substantiated by the referenced clinical indicators within the medical record is not introducing new information

AHIMA. "Guidelines for Achieving a Compliant Query Practice." *Journal of AHIMA* 84, no.2 (February 2013): 50–53.

Provider Responses

- Providers should always be presented with a way to respond to a query without having to agree to the query
- The phrases "clinically undetermined" or "unable to determine" allow providers to disagree with other choices given
- The phrase "other: ____" with an option for a provider to give a response allows providers to document an alternative to the options provided
- The phrase "not clinically significant" or "integral to" allows providers to note the diagnosis is accurate but not significant or not reportable

Example Multiple-Choice Query Office Setting, Retrospective

- Dr. Smith, your office note dated 8-15-17 for Mr. Green indicates a referral to Dr. Aveoli (Pulmonologist) related to her medication management. Medication history includes Advair. Chief complaint identified as shortness of breath with exertion, wheezing, with some relief received from inhalers. You write "*nighttime symptoms are increasing*." Please clarify the condition you are monitoring and treating.
  - A. Asthma (Please further specify to classification as appropriate)
  - B. COPD (Please further specify severity as appropriate)
  - C. Other
  - D. Unable to determine

Determining Significant Diagnoses

- Documentation of diagnoses should include at least one aspect of **MEAT**:
  - **M**onitoring: signs, symptoms, status
  - **E**valuating: test results, medication effectiveness
  - **A**ssessing/addressing: ordered tests, discussion, counseling
  - **T**reatment: medications, therapies provided

Yes/No Query Guidance

- Yes/no queries can be used to:
  - Substantiate or further specify a diagnosis that is already present in the health record
  - Establish a cause-and-effect relationship between documented conditions such as etiology/manifestation pairs, complications, and conditions/diagnostic findings
  - Resolve conflicting documentation from multiple practitioners

AHIMA. "Guidelines for Achieving a Compliant Query Practice." 2016 Update. http://bok.ahima.org/doc?oid=301357

Yes/No Query Guidance

- Yes/no queries may **not** be used in circumstances in which only clinical indicators of a condition are present and the condition/diagnosis has yet to be documented in the health record
- **New diagnoses cannot be derived from a yes/no query**
  - Open-ended queries, or multiple-choice query formats, must be used under these circumstances. It is not considered leading to include a new diagnosis as part of a multiple-choice format when supported by clinical indicators.

Examples of compliance issues:

- **CDI specialist updating the problem list and asking provider to agree or disagree with diagnoses**
- **Asking the provider if the patient has "malnutrition," yes or no? (verbal/written)**

AHIMA. "Guidelines for Achieving a Compliant Query Practice." 2016 Update. http://bok.ahima.org/doc?oid=301357

Query Practice

Considerations by Setting of Care

Query Practice in the Office or Clinic

- Depending upon the setting and provider preference, queries may be placed in the record prospectively, concurrently, or retrospectively.
- EHRs allow for ease in pulling information from other encounters, and most organizations feel comfortable pulling clinical indicators from previous encounters to support queries. There is presently no definitive guidance related to this practice.
- We suggest you work to develop policies related to this practice to allow for consistency in when and what information can be used to support a query.

Query Practice in the Office or Clinic

- Prospective query:
  Which if any is the compliant query?
  - **Query 1:** Please ensure you document malnutrition in encounter documentation today as this has been addressed in the past and the patient's BMI still remains low.
  - **Query 2:** Prior visit six months ago included a plan to address "mild malnutrition" per your documentation. Mrs. Smith returns today with complaints related to antihypertensive medication. Please clarify if the malnutrition remains as a significant issue or has resolved.

Query Practice in the Office or Clinic
The Challenge of the EHR

- Most EHR platforms allow providers to assign within the record as they document. Most of these encounters are billed based on the provider's code selection. The drop-down lists provide a listing of all diagnoses from a specific code grouping. These systems are designed to assist providers in ease of documentation and billing, but they don't easily recognize the importance of the specificity needed for specific codes. There is opportunity here for provider education, and concurrent querying may be very useful to assist in these efforts.

When concurrently working with a provider, focusing on a specific patient and documentation need, compliance must always be an influencing factor in these discussions. We cannot lead, nor can we indicate which answer would positively influence reimbursement, risk adjustment, or quality measures.

Query Practice: Diagnostic Testing

- The specific patient history, complaints, or diagnoses support the medical necessity of the testing service provided (for example, the symptom of syncope and headache to establish medical need for a head CT)
- If this information is missing, reimbursement for the test may be denied
- Providers often must be queried to obtain the specifics as defined in the associated local or national coverage determination prior to the test being completed

Query Practice: Diagnostic Testing Example

- Orders read for head CT related to trauma to the head experienced 24 hours prior. Documentation does not indicate any acute symptoms to precipitate need for CT. Medication list includes antiemetic.
- Which query is the compliant one?
  - **Query 1:** Doctor, please identify the patient is experiencing headache and vomiting in your assessment so that the head CT can be approved.
  - **Query 2:** Patient experienced trauma to the head, prescribed antiemetic medication and CT of the head ordered. Please clarify the symptoms or complaints necessitating the CT assessment.

Query Practice: Observation Stay

- These encounters are abbreviated, usually less than 48 hours or 2 midnights. There is a limited window to address issues within the record.
- Documentation is similar to inpatient records, and likely the query process would mirror inpatient reviews.
- CDI reviews are usually aimed to address issues of status and medical necessity. Identifying needed specificity to support:
  - Converting to inpatient admission if appropriate
  - Medical necessity of ordered tests/treatments

Query Practice in the Emergency Department

- Reviews in the ED can occur for a number of reasons, including:
  - Capture specificity and comorbidities to support inpatient admission and severity of illness
  - Capture of patient conditions to support medical necessity related to outpatient tests/treatments
  - Provider E/M reimbursement
  - Documentation needed to reflect specific quality measures
  - Other identified focuses

Query Practice in the Emergency Department

- The ED encounter by nature is very condensed, likely over a 1–2 hour time frame
- Reviews may be performed concurrently or retrospectively
- Queries likely would be verbal and face-to-face due to the setting
- Depending upon the given objective of the CDI review, specific records or patient populations would be targeted

Timing/Compliance of Queries

- Queries can be applied concurrently, pre-bill or post-bill process.
- Organizations should employ compliant query practices regardless of which department issues the query. The procedures may be slightly different, but the concepts of compliance should be consistent.
- CMS states that any information that affects the billed services and is acquired after physician documentation is complete should be added to the existing documentation in accordance with the accepted standards for amending the medical record.

Who Should Be Queried

- Any physician or other qualified healthcare practitioner who is legally accountable for establishing a patient's diagnosis
- The provider must be licensed by his or her state and credentialed by the facility to diagnose and treat patients
- This can include attending physicians, consultants, specialists, emergency physicians, anesthesiologists, certified registered nurse anesthetists (CRNA), residents, fellows, physician assistants (PA), and nurse practitioners (NP)

Determining Compliance

- Query compliance is very subjective
- CDI "experts" and coding "experts" may disagree on when a query is compliant
- Organizations each need to determine their own threshold regarding query compliance
- Good advice: you should always trust your "gut" and not participate in query practices that may compromise integrity, but be sure your views are supported with recognized guidance (i.e., AHIMA Practice Briefs)

Query Retention Guidance

- Varies across organizations
  - It is recommended, if documentation occurs directly on the query, that the query be retained as part of the medical record
  - Organizations should seek advice from their legal and compliance department as to the retention of queries
  - Regardless of how the query is created, the organization should determine:
    - Where the query is to be placed
    - Whether the query will be part of the legal health record
    - Whether copies of the queries will be provided to auditors

Query Retention Guidance

- The 2016 AHIMA/ACDIS Query Practice Brief states:
  - Organizations who opt not to maintain queries as part of the permanent health record are encouraged to maintain a copy as part of the administrative business record
  - If the practitioner documents their response on the query form itself, then the query should become part of the permanent health record
  - Queries will need to be properly authenticated, signed with time and date

Query Summary

- Queries should be unique to the patient
- Include the source of the clinical indicators along with the dates of findings
- Include a contact for the provider if needed
- Include directions on how and when to answer
- Keep queries short, sweet, and to the point
- Verbal queries should be recorded

Outpatient CDI: Future Challenges

- Just as compliant query practice adjusted to the addition of concurrent record review and CDI intervention within the inpatient setting, the practice of provider query in the outpatient setting will evolve as well
- Compliant practice needs to be your focus—continue to follow industry guidance and work with your organization compliance department to ensure your query policies, templates, and activities remain within the lines of compliance
- Re-evaluate your query practice as new guidance is published
- Query practice should also be audited to ensure compliance

Query Example

Dear Doctor,

The following discrepancy in patient chart (*identify patient*) was found in the (*area of chart*) (*describe the discrepancy*).

Please update the (*area of chart*) with the information that is related to the patient as an addendum.

Pre-Visit Query Example

Dear Doctor,

(*Patient name*) has an annual wellness visit scheduled with you on (*date provided*). According to their medical record, the patient has a documented ejection fraction of 28% (*date of finding*) with a documented BNP of 2000 (*date of service*). Medication list includes carvedilol and Lasix.

If you feel these findings are significant and need to be further evaluated during upcoming appointment, please include the diagnosis and treatment plan in the visit note and update problem list.

Post-Visit Query Example

Dear Doctor,

(*Patient*) was seen on (*date of service*). The following diagnosis was documented in the visit note, with a treatment plan of (*identify treatment*) but does not appear on the patient's problem list:

(*Describe the diagnosis*)

If you feel this condition is significant to the patient, please update the problem list.

Post-Visit Query Example
Clinical Validation

Dear Doctor,

According to the progress note on (*date*) the following diagnosis has been documented: (*documented diagnosis*).

Could you please identify the supporting information used to diagnose the condition and its significance to this patient visit as related to the plan of care?

Monitored = signs, symptoms, status
Evaluated = test results, medication effectiveness
Assessed = order tests, discuss, counseling
Treated = medication, therapies

Thank you. Questions?

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To submit a question, go to the questions window located on the right side of your screen. Type your question into the box at the bottom then click the "Send" button.

Conclusion

- Workshop materials and recordings
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Thank You!

The next program in the
Outpatient CDI Workshop series,

Beyond the Walls: Building an Ambulatory Outpatient CDI Program,

will be broadcast live on
Friday, October 27 at 1 p.m. ET.