Query metrics and technology

As part of the fourteenth annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. Lynette A. Byerly, BSN, RN, CCDS, CCS, CDIS auditor/educator at University of Colorado Health, and and **Mariclare Hoffmann, RN, BSN, CCDS**, director of CDI at University of Colorado Health, answered these questions. Byerly is a member of the ACDIS Furthering Education Committee and co-leader of the ACDIS Colorado local chapter. For questions about the committee or the Q&A, contact ACDIS Editor Jess Fluegel (*jess.fluegel@hcpro.com*).

Q: The majority of respondents reported they have a 91%–100% physician query response rate within their facility's required time frame (69.44%), according to CDI Week industry data. What is your response rate, and what tactics has your CDI program found successful over the years to improve and/or maintain a good response rate?

A: Our overall provider response rate is 96%. Some of our regions have implemented incentive bonuses for response rates above 90%. Our business intelligence analysts have also created an "open query report" through an interactive data visualization software, which is distributed to executive leadership and service line leads three times a week to keep them informed of queries that have not been answered for 48 hours. Individual providers can also subscribe to this software if they want to monitor themselves.

Q: Of respondents whose organization tracks physician query agree rate, the results were a bit more varied: 48.76% reported a 91%–100% agree rate, 39.75% reported an 81%–90% agree rate, and 6.36% reported a 71%–80% agree rate. When providers do respond to a query, about 34.21% of respondents reported that the provider said "clinically indeterminable" (or a similar option). What efforts has your CDI program made, if any, to have a higher physician query agree rate? Do you have any advice on query wording, organization, policies, etc., to help CDI professionals construct effective queries?

A: Our organization has many diagnosis query templates. For the query "out" option, we have removed "clinically unable to determine" or "unable to determine" as a choice. Rather, we give the providers the option of "Other, please specify" or "Another diagnosis (please specify)."

For organizations that have set criteria or guidelines for specific diagnoses, we recommend you include that information at the bottom of your query. Within the query, be specific about what is needed, such as acuity and specific terminology. Educate through the queries without leading. For example, when the documentation states the patient has encephalopathy, open the query with an opener:

> Encephalopathy is documented within the medical record which requires further clarification.
>
> Based on the clinical data below, please further clarify the encephalopathy, such as:

- Metabolic encephalopathy due to hyponatremia
- Toxic encephalopathy due to fentanyl
- Other encephalopathy (please specify)

This gives the provider insight to exactly what the query is seeking to clarify.

We have found that asking the question first, then having clinical data that supports the documentation and treatment below, is helpful for the providers to get to the point. Then, if they need the data, it is within the query below the question.

We recommend CDI professionals draft queries as if they are the only place within the medical record where the diagnosis is supported. Include the monitoring, treatment, evaluation, assessments, documentation, labs, etc., to support the diagnosis in full.

Q: When asked if their organization has an escalation policy or other policy requiring physicians to respond to queries/CDI clarifications, 87.72% of respondents said they do, but many open-ended responses added that they are in the midst of creating one or that their current policy is ineffective. Does your CDI program have a query escalation policy, and if so, what have been your struggles and successes while using it? What advice would you give a CDI program wanting to improve or create such a policy?

A: We do not have an escalation policy. If the CDI team has any issues or concerns, we have the ability to collaborate with our physician advisors for assistance either through our electronic health record software or via email.

Q: While most respondents report that an average inpatient CDI specialist completes 6–10 patient reviews per day, about 19% of respondents report that the average is 11–15 reviews, a notable increase from about 15% of respondents in 2023. Considering 56.58% of respondents reported the implementation of new technology has increased productivity, do you think that the number of organizations reviewing more per day will continue to rise? Have you noticed a correlation between new technology and productivity levels at your organization?

A: Our productivity expectations can fluctuate depending on the focus area being requested by executive leadership. Currently, our focus is CC/MCC capture, and our expectations are a minimum of 10 initial reviews and eight subsequent reviews per CDI specialist. If we were focusing on quality reviews and/or DRG-specific risk model variable reviews, our expectations would be lower. Our leadership is comfortable with the current software as it does a good job at identifying CC/MCC opportunities and can streamline workflows, but software has a way to go for capture of risk model variables.

Q: When asked how technology has impacted the role of CDI professionals and the work they perform, most respondents agreed that it's allowed them to perform work more remotely (63.60%). In your experience, how has remote work impacted CDI reviews and the querying process, both for better and for worse? What role has technology played in these changes, and how would you recommend utilizing it to help with querying?

A: Our program has been remote for nearly a decade. Recent technology advancements have made integrating team operations and connections more efficient. Working remotely has allowed us to cover more patients for our large health system, and we leverage remote technology to help us streamline work, such as central location for workflows and query templates that can be updated instantaneously. It has also allowed us to hire out-of-state CDI team members.

Q: This year, the spot for the most-used CDI software solution by respondents was nearly tied between computer-assisted coding (77.93%) and electronic querying (77.49%), followed by electronic grouper software (76.61%) and chart prioritization (75.88%). What kinds of software solutions would you say have become common practice to use by CDI departments, and what types have you found helpful for your own team? Which solutions, if any, have you noticed becoming more popular over the last few years in the CDI profession?

A: Our organization's leadership believes utilizing computer-assisted coding, electronic grouper software, and electronic querying is very common practice at this point, especially for large health systems. Prioritization software has experienced rapid evolution and popularity more recently. We went live

with advanced prioritization about 18 months ago and it has been very effective..

Q: As the CDI profession grows, more workflow tools and technology options are becoming available for CDI departments to choose from. While that is an exciting development, it can also be overwhelming. Do you have any advice for those choosing from various tools and/or software on how to decide what's best for their department?

A: Our best advice is to be tenacious when considering new software. Ask for as many demonstrations and information sessions as you need. The nature of sales is to highlight the best features and minimize the flaws, but as the consumer you have a right to all of the information needed to make an informed decision. After you contract and implement new software, be insistent about taking the time you need to validate functionality. ■