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BONUS: Obtain one (1) CEU for reading this Journal
ACDIS members are entitled to one continuing education credit for reading the CDI Journal and taking this 20-question quiz.

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Back to basics: Query practice resources

by Linnea Archibald

Regardless of their setting or length of time in their role, CDI professionals can’t escape the query process in their everyday work. It’s often one of the first things a new CDI specialist learns about, and a well-written query is one of the main indicators that a developing staffer is self-sufficient and capable of removing the proverbial training wheels.

Despite its centrality, it’s easy to become complacent when it comes to query practices. Because it’s a “CDI basic,” brushing up on best practices and procedures may take a back seat to flashier pursuits—such as denials management and appeals, clinical validation reviews, quality measures, expansion into new settings, and the like. Yet, a careless query practice may be the biggest compliance risk CDI professionals encounter in their day-to-day work.

That’s why we’ve dedicated this edition of the CDI Journal to querying best practices, giving space to this modest but essential skill.

Each year, no matter how many headaches sepsis, malnutrition, and denials cause, the most searched-for items on the ACDIS website are related to queries. Search terms range from clinical validation to queries for specific diagnoses, best practice advice, and formatting concerns. Our hope is that this edition helps put the most up-to-date query information at the top of your search.

While this issue’s readers will gain a glimpse into many aspects of query practice, I encourage you to also take a deep dive into the well of information already available on the ACDIS website—it’s sure to strengthen your knowledge of all aspects of the query process.

Start with the basics and review the 2019 ACDIS/AHIMA “Guidelines for Achieving a Compliant Query Practice,” found in the “Position Papers” section of the website. For a glimpse at how organizations ensure their queries align with this guidance, turn to p. 36 and read our article on query audit practices. Additionally, in his Physician Advisor Corner on p. 45, Trey La Charité, MD, FACP, SFHM, CCS, CCDS, walks readers through the process for weeding out noncompliant queries.

Next, take a step further and review ACDIS’ overview of compliant clinical validation processes in the “White Papers” section of the
website. While these reviews were once an example of CDI expansion, according to the 2019 CDI Week Industry Survey, more than 91% of CDI professionals now send clinical validation queries regularly. As ubiquitous as they are, clinical validation reviews can pose compliance headaches. To help you even further, you’ll find an article on the topic on p. 21.

Those reviewing outpatient records should also make time to review ACDIS’ position paper on compliant outpatient query practice. The first of its kind, this paper builds on the ACDIS/AHIMA practice brief and gives specific guidance for the unique circumstances of outpatient reviews. To see what a compliant outpatient query practice looks like in practice, make sure to read the case study on p. 39. This edition of the Journal also features an article by guest contributor Jessica Vaughn, MSN, RN, CCDS, CCDS-O, CRC, about the evolution of outpatient query practice—for that, turn to p. 34.

CDI leaders should brush up on the best-practice advice for setting staff productivity standards and query rates. According to the ACDIS white paper “Set CDI productivity expectations, but don’t look for a national standard,” these performance indicators may be helpful, but only when set with careful attention toward organizational specifics. To take the current pulse of query productivity and compliance, this edition also includes a report on a 16-question survey, which you can find on p. 9.

Throughout the ACDIS website, you’ll find Q&As with our team of expert instructors on a variety of topics, but query practice remains one of the most frequent sources of questions. Whether it be clinical validation conundrums or template use, the Boot Camp instructors are adept at navigating even the toughest scenarios. For information on query retention policies and whether queries should be part of the permanent medical record, turn to p. 39 to read advice from CDI Education Director Laurie Prescott, RN, MSN, CCDS, CCDS-O, CDIP, CRC.

While the query process takes center stage in this edition, it’s supported by a cast of articles surrounding other aspects of CDI professionals’ varied roles. Turn to p. 21 for advice on physician education, p. 25 for a sneak peek at the national ACDIS conference from Associate Director Melissa Varnavas, and p. 47 for advice from one of our ACDIS members.

We hope you enjoy this edition and find answers to some of your everyday conundrums.

Linnea Archibald
Florida event kicks off 2020 ACDIS Road Show

by Melissa Varnavas

While the ACDIS conference each May offers premier CDI education and networking, local chapters and topic-focused networking groups offer a variety of amazing events throughout the year. This year, ACDIS staff are hitting the road to attend a number of these events in person for an ACDIS Road Show. I was blessed to attend the California ACDIS chapter meeting back in October 2019, and on February 1 this year, I had the additional privilege of attending a meeting held by ACDIS’ Florida chapter.

These local events offer value not only from the educational sessions presented, but also in seeing how each chapter runs their meetings and how the leadership and volunteers work together to ensure the best outcomes for everyone—attendees, speakers, vendors, and the volunteer staff themselves. All these lessons can be brought back for other chapter leaders to hear and learn from.

At a table outside the conference room on that rainy Florida Saturday morning, Deborah Hilliard White sat welcoming chapter members to the Mayo Clinic in Jacksonville. As attendees identified themselves, White, the chapter secretary, checked off their names.

“It’s a nice task to be assigned,” she said. “It’s good to be able to put faces to names, and this is the first place anyone gets to do so.”

Inside, roughly 10 tables wore a rainbow of brightly colored cloths. More than a dozen donated raffles boarded one side of the room, including baskets of chocolate, gift certificates, glassware, facials, and more. Some were donated by vendors, while others were gifted by attendees. A breakfast buffet of bacon and eggs, croissants and muffins, coffee, tea, and juice boarded another side, sponsored by TrustHCS. Later, attendees enjoyed a buffet taco lunch with pulled pork and ground turkey.

Chapter President Edna I. Betances-Harold floated around the room greeting participants, ensuring vendors had everything they needed, and checking in with speakers. Event host Candace Blankenship and her colleagues made sure the day’s slides were set and audio/video worked, collaborated with Harold, and served as backup to the chapter leaders. At a table near the room’s entrance, chapter treasurer Karen Williams sold raffle tickets and renewed chapter memberships.

Volunteers handed out folders with an array of information. On the back of my folder read “G71.0 Muscular Dystrophy.” Later, speaker Peggy Hickman, MS, CCDS, CCS, CCRC, would explain the importance of the Hierarchical Condition Category (HCC) system and ask the audience to play a game with her. “Stand up,” she said, “if you think your code qualifies as an HCC.” About a dozen individuals stood. “I’ll give you just a few more moments to think about it,” Hickman told everyone as a few more people stood, then a few more joined them. “Give up?” she asked everyone before revealing that, in fact, every folder’s code qualified as an HCC.

The folders also contained the day’s agenda and an evaluation form. Attendees would need to complete the
evaluation at the end of the day in order to receive continuing education (CE) credit for the Certified Clinical Documentation Specialist (CCDS) credential. The Florida team also secured CEs for nursing, with associated sign-in sheets at each table. The folders included a flyer for the chapter’s upcoming event on May 16 in Fort Lauderdale and a flyer seeking leadership volunteers who will be voted on during that May meeting.

Also in the folders were marketing sheets from each vendor and a card titled “Fun With Networking” that featured 13 questions such as “What is Corey’s favorite hobby?” and “Who works at Orange Park Medical Center?” Participants needed to circulate around the room and visit the vendors to gather the right responses and then submit their card for a raffle prize. There were over half a dozen vendors, including TrustHCS, AMN Healthcare, Artifact Health, Medovent, Harmony Healthcare, DVS Dolbey, and ACDIS’ parent company HCPro.

The educational sessions began at 8:15 a.m., with my own discussion of the state of the industry and a review of important releases from ACDIS within the past year, such as the position paper “CDI yesterday, today, and tomorrow: Staying relevant in changing times,” and the “Guidelines for Achieving a Compliant Query Practice—2019 update,” with an eye toward 2020’s focus on physician engagement.

Next came James Manz, MD, CCDS, CCDS-O, co-author of the ACDIS 2020 Pocket Guide, and Hickman who spoke about Mayo’s efforts in building an outpatient CDI program. Manz outlined the impetus for the team’s efforts, explaining how they found significant financial impact related to a single Health and Human Services (HHS) model plan that affected two regions in one state. Essentially, an external consultant identified where Mayo underperformed compared to the rest of the state, and then the team built a pilot program to address these concerns in mid-2017, according to Manz. With the success of that pilot, the team expanded to include all five of Mayo’s Midwest regions.

Mayo’s Revenue Cycle Denial Management Director Karen O’Lessker, MBA, RHIA, spoke next, offering a view of the healthcare system’s CDI and coding reconciliation and collaboration efforts. The first step, according to O’Lessker, was to take a broad view and redefine roles and responsibilities. “Developing roles and responsibilities for staff is just so important because if your staff doesn’t know what they’re supposed to do, you can’t begin to develop standardized processes and begin to improve,” O’Lessker said. Next, Mayo created a new position of DRG reviewer to provide timely CDI turnaround and lead the reconciliation efforts.

Various members of the Mayo CDI team, including Dana Hasten, MSN, C-FNP, CDIP, CCS, CRC, CPCP, COC, CHC, system director of enterprise CDI, spoke
about the interconnected nature of the system’s CDI efforts with analytics, coding, denials management, and medical staff all playing a role. Since coalescing the CDI teams under one corporate management structure, Hasten has been able to grow the staff by nearly 50% in three years. She’s also rolled out a series of standardized educational offerings through PropelCDI and on-site education for both coders and CDI staff to streamline learning and create a collaborative culture for both teams.

Mayo’s physician advisor Razvan Chirila, MD, CCDS, presented “How We ‘Action’ Analytics.” During the presentation, Chirila explained how Mayo mines for data related to key performance indicators for all DRG payers. They look at observed to expected mortality ratios, service line CC/MCC capture rates, and rates of clinical validation denials. Mayo found that one of their most frequent queries was for malnutrition, so they dug into the data for more information, which led to several interventions by both CDI and nutrition services. They removed the phrase “well nourished” from templates and added a smart phrase, “malnutrition1,” that imports the dietitian’s assessment into the medical record. Nutritional services transitioned to using the ASPEN criteria and assigned a dietitian to screen all inpatients for possible referral. The quality assurance team also began to review CDI efforts on roughly 10 charts per quarter related to malnutrition. (To read about a similar malnutrition documentation project, read the article on p. 19.)

Finally, one of the day’s highlights was a visit from Mayo’s on-site tai chi teachers, who gave attendees a crash course in an ancient art.

“There’s no amount of money that can replace the value of face-to-face meetings,” Hasten said during her presentation. And while her comments were describing the education provided to her coding and CDI teams, it’s certainly true of the importance of local networking.

The Florida ACDIS chapter was one of the first local volunteer groups to get started, predated by only the Illinois and New England groups. I remember being on the phone for its very first meeting, and this February I was a voyeur as the leaders introduced speakers and the audience asked their questions, chatted, and laughed. It was so gratifying to be able to join them in person and to see how far the group has come. The team and I are looking forward to visiting more local events throughout 2020 and hope to see you soon. So, keep an eye out for us—you never know where we’ll pop up next! 🌟

Editor’s note: Varnavas is the associate editorial director for events at ACDIS. Contact her at mvarnvas@acdis.org.
It’s been nearly three years since ACDIS’ last survey dedicated to query practices. Since querying is a constant and continuous aspect of CDI work, ACDIS recently issued a focused 16-question survey on physician queries. Because of the survey’s limited length, it concentrated primarily on productivity and compliance concerns.

The 2020 Physician Query Survey garnered 333 respondents. Though the number of respondents stayed roughly the same since our last survey (361 respondents in 2017), the distribution of professional titles shifted slightly. In 2017, 67.04% of the respondents identified as CDI specialists (whose primary role is record review); in 2020, only 56.16% identified as CDI specialists. The number of respondents in CDI manager/director roles was roughly 25% averaged across both surveys, making these two categories combined the majority of respondents. The 10% drop in the CDI specialist bucket is likely due to the more specific occupational titles and job opportunities available to CDI professionals today. (See Figure 1.)

The 2017 survey only offered seven options to respondents for their title, where the 2020 survey offered 20 position options plus an “other” response allowing respondents to fill in their own title, which accounted for 3% of overall responses. New position options offered on the 2020 survey included:
- CDI auditor
- CDI educator
- CDI physician educator
- CDI-coding liaison
- CDI-quality specialist

All above titles combined accounted for 6% of the responses. Most notably, the 2017 survey did not have a response option for educators, but in the recent survey educators made up 3.3% of the total respondents. (To learn more about CDI educator roles, read this article from the July/August 2017 edition of the CDI Journal.)

When it comes to the settings in which respondents work, nearly all reported working in acute care hospitals (88.89%), with more than half of those respondents (61.26%) being part of a larger healthcare system. (See Figure 2.) This trend reflects the general trajectory of healthcare as a whole. The American Hospital Association’s annual
hospital survey found that of the 5,198 United States community hospitals, 3,491 were part of a system as of 2018.

Echoing previous ACDIS productivity surveys, the survey results show that, though the general pool of respondents work in similar settings and hold similar titles, their query processes, productivity, and departmental policies differ widely.

**Productivity**

Most respondents (34.23%) said they review six to 10 charts each day, followed closely by respondents who review 11–15 charts per day (24.02%). When it comes to re-reviews (or subsequent reviews), 29.43% said they get through six to 10 charts each day, with an additional 22.82% re-reviewing 11–15 charts per day. With most respondents saying they review six to 10 charts each day, and re-review an additional six to 10 charts each day, this means the average respondent reviews 12–20 charts per day. (See Figure 3.)

“That’s low in my opinion; 20 is the sweet spot for most places,” says Chinedum Mogbo, MBBS, MsHIM, RHIA, CDIP, CCDS, CCS, manager of CDI at Tenet Healthcare in Dallas. If CDI specialists are expected to be doing other tasks during the day aside from chart reviews, however, then their number of chart reviews per day will be lower. Mogbo suggests that leaders should consider this when setting productivity expectations.

Though more than 18% of respondents said their facility expects them to query on 21%–25% of their reviewed charts and another 10.2% said they’re expected to query on 16%–20% of their charts, the largest portion (27.63%) reported having no query quota at all. (See Figure 4.) For those who do have a percentage quota, 29.21% of respondents reported that they query on 21%–30% of their charts, with a close 24.75% saying 11%–20% of chart reviews result in queries. (See Figure 5.)

**Query practice, focus**

Unsurprisingly given that most respondents work in the acute care setting, a whopping 95.20% said that their CDI team queries providers concurrently while the patient is still admitted. Additionally, 57.96% said they query retrospectively before the bill is dropped, 22.82% query retrospectively post-bill, and only 3.9% query prospectively before the patient arrives for the appointment. Of those respondents who said they query concurrently, 59.31% also query retrospectively pre-bill, and 22.71% query post-bill. (See Figure 6.)

Despite an increasing focus on quality and the overall integrity of the patient record, when asked to rank which type of queries their CDI program prioritizes, most respondents (79.50%) listed DRG shifts and CC/MCC capture for financial impact as their organization’s top priority. (See Figure 7.) Other top priorities included:

- Clinical validation (32.15%)
- Severity of illness/risk of mortality (29.34%)
- Quality or core measures (15.31%)
- ICD-10 or other code specificity (14.38%)
- Hierarchical Condition Category capture/Risk adjustment (10.60%)

The financial impact issue is “the big elephant in the room,” says Mogbo. “Most organizations will push CDI specialists to do this, so it will take a while to wean people off being financially driven.”

That way of thinking, she says, is tied to the old model based on DRGs and limits the scope of CDI’s influence significantly. The industry, however, is shifting toward a more holistic record review approach, Mogbo says, as evidenced in associations such as ACDIS moving away from terms like “improvement” (which are often linked to financial improvement) and embracing terms such as “integrity” in their stead.

Despite the shift, Mogbo says she does not see the financial aspect going away completely as long as organizations are paid based on documentation and coding. She does, however, see the quality aspect of reviews gaining traction and facilities beginning to recognize that when they provide better care to their patients, they’ll be paid accordingly and receive better quality ratings.
Template use

According to the survey results, 92.49% of respondents use query templates at their organization. Of those respondents who use templates, 96.44% said their templates have a space to include specific clinical data from the patient’s medical record, 84.79% have templates that provide open-ended options (such as “other” or “cannot determine”), and 70.23% of respondents said their templates contain specific diagnosis phrase options. (See Figure 8.)

“There is a large benefit to using templates,” says Mogbo, because “it brings standardization.”

Even when an organization uses templates, Mogbo reminds CDI professionals that they need to customize the information included on the template for each individual situation. “You can give multiple-choice options and add or remove items, so it keeps with the standardization,” she says. Template standardization with customizability helps ensure queries stay compliant. Without templates, Mogbo says, it’s easier to slip into leading tendencies.

Despite the obvious compliance risk of doing so, 1.94% of respondents said their templates include pre- and post-query DRGs, and 0.65% include DRG relative weights. Physicians need to have the freedom to answer queries while only considering their patient’s condition and their own medical judgment, not the financial implications. Putting that information in front of them in a query, Mogbo says, is influencing their response.

“That’s a big no-no,” she says. “Integrity is doing the right thing regardless of if you feel good about it or not. […] [Physicians] might answer the way you want just to get you off their back, so it’s not the truth.”

If DRG/financial information is written on queries, we have that focal bias, according to Mogbo. A CDI specialist who includes this information risks losing integrity and risks physician engagement as well, she adds, because the physicians will then have every right to see CDI’s work as all about the money.

“CDI should present the facts,” says Mogbo.

Tracking, auditing

When it comes to tracking and trending query dissemination/physician responses, the most popular metrics were physician agree rate (88.29%) and the name of the physician queried (85.89%). (See Figure 9.)

Less than 25% of respondents track paraphrases of verbal queries (24.32% track a paraphrase of the question asked, and 23.12% tracked a paraphrase of the response). Of those tracking verbal queries posed, only 69.14% also track the responses. Likewise, of those tracking paraphrases of verbal query responses, only 72.73% also track the query asked. This means that of the respondents who track paraphrases of verbal queries at all, about one-quarter of those are only tracking one component—either the question or the answer—of the verbal query.

“That’s a sticky point because no one really knows what is being said and how it’s being taken,” says Mogbo. For best practice, she suggests CDI specialists track verbal queries and their answers exactly as they occurred. “Make a note of how you posed the question to the physician and how they responded,” she says. “The physician has to be able to take credit for that response.”

Physician response, engagement

The majority of respondents (64.57%) said their physician response rate is 91%–100%, which is up slightly from 2017 when 62.03% of respondents fell into the same category. While 8.71% of respondents said they don’t know what their response rate is, the general trend showed that the lower the response rate was, the fewer respondents chose it as their answer. (See Figure 10.)

Yet response rate is only part of the equation, Mogbo says. Consider the type of responses as well—are they helpful? If not, that high response rate isn’t as glamorous as it seems. Physicians may be responding to queries simply to give an answer and avoid an escalation policy. To combat this, Mogbo suggests providing more physician education on CDI’s importance and why in-depth query responses are necessary, as well as administrative
and physician advisor support. “It’s a lot of moving parts,” she says.

Just over half of respondents (51.06%) said their physician agree rate was 81%–95%, with an additional 16.81% saying their agree rate was 96%–100%. Since 18.31% of respondents either didn’t know their agree rate or didn’t track it, this means that of those who were aware of physician agree rates, 83.08% had an agree rate of over 80%. (See Figure 11.)

Respondents who said their physician agree rate was 81%–85% on average also had lower physician response rates than those who said their agree rate was above 95%. The majority of respondents with a physician agree rate between 81% and 85% (54.47%) had a physician response rate of between 81% and 95%. Meanwhile, 80.95% of those with agree rates above 95% had response rates between 96% and 100%, meaning that (in general) a higher response rate is associated with a higher agree rate. (See Figure 11.)

Note that the above respondent data represents the percentages of those who answered they have physician response and agree rates between 0% and 100% and does not include those who answered “I don’t know,” “We don’t measure/track this,” or “other.” Figure 11 does include these responses, and as such specific data listed above might not directly be reflected in Figure 11.

Respondents who queried on 20% or less of their reviews were more likely to have lower physician response rates. While 9.19% of respondents querying on less than 20% of reviews had a response rate of 70% or less, only 0.59% of those querying on 31%–50% of their charts had a response rate of less than 70%. Most respondents reported high response rates, but it appears that querying less is more likely to result in a lower physician response rate. (See Figure 12.)

Although response rates between those querying more and less varied, the physician agree rates stayed statistically the same. Nearly 9% of respondents who queried on less than 20% of reviews had agree rates below 70%. Of those querying on more than 20% of their reviews, 7.14% also had agree rates below 70%. This 1% difference between querying more or less is negligible, showing that querying less frequently does not result in lower agree rates. (See Figure 12.)

On the other side, 47.5% of those who queried less than 20% of their reviews had physician agree rates above 90%. More than 37% of those who queried more frequently had physician agree rates above 90%. Based on this data, those who queried less were actually 10% more likely to receive higher agree rates. Therefore, although querying less or more frequently does not seem to lower agree rates, querying less frequently does slightly improve the chances for a higher physician agree rate.

**Departmental growth**

As a CDI program matures, one might assume query rates would decrease because physicians have (hopefully) heeded the CDI team’s education and improved their documentation.

According to 29.43% of survey respondents, this is exactly what’s happened: Their query rates have decreased with program maturation. However, 22.22% said they have had to leave more queries, and the largest group of respondents (36.04%) said that their query rates have not changed. (See Figure 13.)

“It’s not surprising, really,” says Mogbo. While it might be frustrating to query on the same things over and over again, she says, this likely has to do with physician behavior patterns. While documentation habits may improve for a period of time, “if it is not something they are using often, physicians will forget,” she says.

Remember that there could also be instances where query rates skyrocket, such as times when clinical or coding guidelines are going through significant change or new physician staff join the team. But don’t get discouraged, Mogbo says—think of it like job security. “There will always be new physicians to educate” 🌟
### FIGURE 1 — CDI job titles: Year comparison

<table>
<thead>
<tr>
<th>CDI position</th>
<th>2017</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDI specialist (primary role is chart review)</td>
<td>67.04%</td>
<td>56.15%</td>
</tr>
<tr>
<td>CDI second level reviewer</td>
<td>N/A</td>
<td>1.20%</td>
</tr>
<tr>
<td>CDI team lead</td>
<td>N/A</td>
<td>5.71%</td>
</tr>
<tr>
<td>CDI supervisor</td>
<td>N/A</td>
<td>4.50%</td>
</tr>
<tr>
<td><strong>CDI manager</strong> (Note: The 2017 survey combined all managers, directors, and supervisors into one category)</td>
<td>29.09%</td>
<td>12.31%</td>
</tr>
<tr>
<td>CDI director</td>
<td>N/A</td>
<td>8.41%</td>
</tr>
<tr>
<td>CDI auditor</td>
<td>N/A</td>
<td>0.60%</td>
</tr>
<tr>
<td>CDI educator</td>
<td>N/A</td>
<td>2.40%</td>
</tr>
<tr>
<td>CDI physician educator</td>
<td>N/A</td>
<td>0.90%</td>
</tr>
<tr>
<td>CDI-coding liaison</td>
<td>N/A</td>
<td>0.60%</td>
</tr>
<tr>
<td>CDI quality specialist</td>
<td>N/A</td>
<td>1.50%</td>
</tr>
<tr>
<td>HIM/coding director</td>
<td>1.66%</td>
<td>0.60%</td>
</tr>
<tr>
<td>HIM/coding professional</td>
<td>0.83%</td>
<td>0.30%</td>
</tr>
<tr>
<td>Physician advisor/champion</td>
<td>0.55%</td>
<td>0.90%</td>
</tr>
<tr>
<td>Hospital executive</td>
<td>0.55%</td>
<td>0.30%</td>
</tr>
<tr>
<td>Consultant</td>
<td>0.28%</td>
<td>0.60%</td>
</tr>
<tr>
<td>Other</td>
<td>N/A</td>
<td>3.00%</td>
</tr>
</tbody>
</table>

### FIGURE 2 — Organization type

<table>
<thead>
<tr>
<th>Organization type</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care hospital (not part of a health system)</td>
<td>27.63%</td>
</tr>
<tr>
<td>Acute care hospital (part of a larger system)</td>
<td>61.26%</td>
</tr>
<tr>
<td>Critical access hospital</td>
<td>1.50%</td>
</tr>
<tr>
<td>Consulting firm</td>
<td>3.60%</td>
</tr>
<tr>
<td>Inpatient rehab facility</td>
<td>0.30%</td>
</tr>
<tr>
<td>Pediatric/Children's hospital</td>
<td>1.20%</td>
</tr>
<tr>
<td>Physician practice office setting</td>
<td>0.90%</td>
</tr>
<tr>
<td>Other</td>
<td>3.60%</td>
</tr>
</tbody>
</table>
### FIGURE 3 — Daily chart reviews: Reviews and re-reviews

<table>
<thead>
<tr>
<th></th>
<th>Reviews</th>
<th>Re-reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>7.81%</td>
<td>12.01%</td>
</tr>
<tr>
<td>6-10</td>
<td>34.23%</td>
<td>29.43%</td>
</tr>
<tr>
<td>11-15</td>
<td>24.02%</td>
<td>22.82%</td>
</tr>
<tr>
<td>16-20</td>
<td>7.21%</td>
<td>9.31%</td>
</tr>
<tr>
<td>21-25</td>
<td>5.41%</td>
<td>5.41%</td>
</tr>
<tr>
<td>26-30</td>
<td>1.80%</td>
<td>0.60%</td>
</tr>
<tr>
<td>31-35</td>
<td>0.30%</td>
<td>0.00%</td>
</tr>
<tr>
<td>36-40</td>
<td>0.30%</td>
<td>0.30%</td>
</tr>
<tr>
<td>41-45</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>46-50</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>More than 50</td>
<td>0.00%</td>
<td>0.30%</td>
</tr>
<tr>
<td>N/A: I don’t review records</td>
<td>18.92%</td>
<td>19.82%</td>
</tr>
</tbody>
</table>

### FIGURE 4 — Expected query percentages

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5% of charts</td>
<td>1.20%</td>
</tr>
<tr>
<td>6-10% of charts</td>
<td>1.50%</td>
</tr>
<tr>
<td>11-15% of charts</td>
<td>5.71%</td>
</tr>
<tr>
<td>16-20% of charts</td>
<td>10.20%</td>
</tr>
<tr>
<td>20-25% of charts</td>
<td>18.02%</td>
</tr>
<tr>
<td>26-30% of charts</td>
<td>7.51%</td>
</tr>
<tr>
<td>31-35% of charts</td>
<td>4.80%</td>
</tr>
<tr>
<td>36-40% of charts</td>
<td>5.41%</td>
</tr>
<tr>
<td>41-45% of charts</td>
<td>0.60%</td>
</tr>
<tr>
<td>46-50% of charts</td>
<td>0.00%</td>
</tr>
<tr>
<td>Greater than 50% of charts</td>
<td>5.71%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>5.41%</td>
</tr>
<tr>
<td>We don’t have a query quota</td>
<td>27.63%</td>
</tr>
<tr>
<td>Other</td>
<td>6.31%</td>
</tr>
</tbody>
</table>
**FIGURE 5 — Actual query percentages for those with a known quota**

<table>
<thead>
<tr>
<th>Percentage Range</th>
<th>Query Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-10% of charts</td>
<td>8.91%</td>
</tr>
<tr>
<td>11-20% of charts</td>
<td>24.75%</td>
</tr>
<tr>
<td>21-30% of charts</td>
<td>29.21%</td>
</tr>
<tr>
<td>31-40% of charts</td>
<td>17.33%</td>
</tr>
<tr>
<td>41-50% of charts</td>
<td>3.47%</td>
</tr>
<tr>
<td>51-60% of charts</td>
<td>1.49%</td>
</tr>
<tr>
<td>61-70% of charts</td>
<td>0.99%</td>
</tr>
<tr>
<td>71-80% of charts</td>
<td>1.49%</td>
</tr>
<tr>
<td>81-90% of charts</td>
<td>1.49%</td>
</tr>
<tr>
<td>91-100% of charts</td>
<td>0.00%</td>
</tr>
<tr>
<td>I don't know</td>
<td>4.95%</td>
</tr>
<tr>
<td>We don't track this metric</td>
<td>4.46%</td>
</tr>
<tr>
<td>Other</td>
<td>1.49%</td>
</tr>
</tbody>
</table>

**FIGURE 6 — Respondents querying concurrently: Additional query timing**

- Also query prospectively (before the patient arrives at the facility): 2.52%
- Also query retrospectively pre-bill (after the patient has left/been discharged, before the bill drops): 59.31%
- Also query retrospectively post-bill (after the patient has left/been discharged, after the bill drops): 22.71%
- Other: 1.89%

**FIGURE 7 Query focus prioritization**

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>1 (Top)</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7 (Lowest priority)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG shift/CC/MCC capture for financial impact</td>
<td>79.50%</td>
<td>12.62%</td>
<td>4.73%</td>
<td>0.95%</td>
<td>0.32%</td>
<td>1.26%</td>
<td>0.63%</td>
</tr>
<tr>
<td>Any documentation that requires clarification, regardless of impact</td>
<td>32.20%</td>
<td>14.24%</td>
<td>12.07%</td>
<td>9.60%</td>
<td>7.43%</td>
<td>8.05%</td>
<td>16.41%</td>
</tr>
<tr>
<td>Clinical validation</td>
<td>32.15%</td>
<td>28.62%</td>
<td>15.76%</td>
<td>7.40%</td>
<td>8.36%</td>
<td>4.50%</td>
<td>3.22%</td>
</tr>
<tr>
<td>Severity of illness/risk of mortality</td>
<td>29.34%</td>
<td>41.01%</td>
<td>17.35%</td>
<td>5.36%</td>
<td>2.84%</td>
<td>1.89%</td>
<td>2.21%</td>
</tr>
<tr>
<td>Quality or core measures</td>
<td>15.31%</td>
<td>19.87%</td>
<td>21.82%</td>
<td>12.05%</td>
<td>11.40%</td>
<td>7.82%</td>
<td>11.73%</td>
</tr>
<tr>
<td>ICD-10 or other code specificity</td>
<td>14.38%</td>
<td>19.06%</td>
<td>18.73%</td>
<td>12.71%</td>
<td>13.38%</td>
<td>10.70%</td>
<td>11.04%</td>
</tr>
<tr>
<td>Hierarchical condition category capture/Risk adjustment</td>
<td>10.60%</td>
<td>12.58%</td>
<td>17.22%</td>
<td>15.23%</td>
<td>10.60%</td>
<td>12.91%</td>
<td>20.86%</td>
</tr>
</tbody>
</table>

**Selected Comments:**
- Vizient risk adjustment/quality Vizient reviews
- Clarifying/most appropriate principal diagnosis
### FIGURE 8 — Query template elements

<table>
<thead>
<tr>
<th>Element</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Space to include specific clinical data from the patient’s medical record</td>
<td>96.44%</td>
</tr>
<tr>
<td>Open ended options (other, cannot determine, etc.)</td>
<td>84.79%</td>
</tr>
<tr>
<td>Specific diagnosis phrase(s) options</td>
<td>70.23%</td>
</tr>
<tr>
<td>Organizational or industry standard definitions for common diagnoses</td>
<td>30.74%</td>
</tr>
<tr>
<td>Relevant coding references</td>
<td>12.30%</td>
</tr>
<tr>
<td>Severity of illness/Risk of mortality information</td>
<td>4.53%</td>
</tr>
<tr>
<td>Pre- and post-query DRG</td>
<td>1.94%</td>
</tr>
<tr>
<td>DRG relative weights</td>
<td>0.65%</td>
</tr>
</tbody>
</table>

### FIGURE 9 — Query dissemination and physician response metrics

<table>
<thead>
<tr>
<th>Metric</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Origin of inquiry (i.e., CDI specialist or coding staff member)</td>
<td>57.96%</td>
</tr>
<tr>
<td>Name of person issuing query</td>
<td>75.68%</td>
</tr>
<tr>
<td>Name of the physician queried</td>
<td>85.89%</td>
</tr>
<tr>
<td>Method of query (i.e., written or verbal)</td>
<td>51.56%</td>
</tr>
<tr>
<td>Paraphrase of the question asked (if verbal query was presented)</td>
<td>24.32%</td>
</tr>
<tr>
<td>Focus of query (CC/MCC, primary diagnosis, procedure, SOI/ROM, etc.)</td>
<td>70.57%</td>
</tr>
<tr>
<td>Paraphrase of physician response (if verbal query was presented)</td>
<td>23.12%</td>
</tr>
<tr>
<td>Physician agreement</td>
<td>88.29%</td>
</tr>
<tr>
<td>Other</td>
<td>11.00%</td>
</tr>
</tbody>
</table>

**Selected other responses:**

- Response time
- No response
- Disagree rate
<table>
<thead>
<tr>
<th>FIGURE 10 — Physician query response rate: Year-over-year</th>
<th>2017</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 50%</td>
<td>2.77%</td>
<td>2.10%</td>
</tr>
<tr>
<td>51-60%</td>
<td>1.54%</td>
<td>0.30%</td>
</tr>
<tr>
<td>61-70%</td>
<td>2.16%</td>
<td>1.50%</td>
</tr>
<tr>
<td>71-80%</td>
<td>4.01%</td>
<td>3.00%</td>
</tr>
<tr>
<td>81-85%</td>
<td>8.02%</td>
<td>6.31%</td>
</tr>
<tr>
<td>86-90%</td>
<td>12.04%</td>
<td>8.71%</td>
</tr>
<tr>
<td>91-95%</td>
<td>22.84%</td>
<td>18.62%</td>
</tr>
<tr>
<td>96-98%</td>
<td>21.91%</td>
<td>25.23%</td>
</tr>
<tr>
<td>99-100%</td>
<td>17.28%</td>
<td>20.72%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>4.94%</td>
<td>8.71%</td>
</tr>
<tr>
<td>We don’t measure/track this</td>
<td>0.93%</td>
<td>1.80%</td>
</tr>
<tr>
<td>Other</td>
<td>1.54%</td>
<td>3.00%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FIGURE 11 — Physician response versus agree rate</th>
<th>Response rate</th>
<th>Agree rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent selected physician response or agree rate</td>
<td>Response rate</td>
<td>Agree rate</td>
</tr>
<tr>
<td>0-25%</td>
<td>0.90%</td>
<td>1.20%</td>
</tr>
<tr>
<td>26-50%</td>
<td>1.20%</td>
<td>0.90%</td>
</tr>
<tr>
<td>51-60%</td>
<td>0.30%</td>
<td>0.90%</td>
</tr>
<tr>
<td>61-70%</td>
<td>1.50%</td>
<td>1.80%</td>
</tr>
<tr>
<td>71-80%</td>
<td>3.00%</td>
<td>6.31%</td>
</tr>
<tr>
<td>81-85%</td>
<td>6.31%</td>
<td>15.32%</td>
</tr>
<tr>
<td>86-90%</td>
<td>8.71%</td>
<td>18.02%</td>
</tr>
<tr>
<td>91-95%</td>
<td>18.62%</td>
<td>17.72%</td>
</tr>
<tr>
<td>96-98%</td>
<td>25.23%</td>
<td>12.61%</td>
</tr>
<tr>
<td>99-100%</td>
<td>20.72%</td>
<td>4.20%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>8.71%</td>
<td>14.11%</td>
</tr>
<tr>
<td>We don’t measure/track this</td>
<td>1.80%</td>
<td>4.20%</td>
</tr>
<tr>
<td>Other</td>
<td>3.00%</td>
<td>2.70%</td>
</tr>
</tbody>
</table>
FIGURE 12 — Query rates versus physician response/agree rates

<table>
<thead>
<tr>
<th>Respondent selected query rate</th>
<th>Less than 20% response rate</th>
<th>31-50% response rate</th>
<th>Less than 20% agree rate</th>
<th>31-50% agree rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-25%</td>
<td>2.30%</td>
<td>0.00%</td>
<td>2.50%</td>
<td>1.79%</td>
</tr>
<tr>
<td>26-50%</td>
<td>3.45%</td>
<td>1.69%</td>
<td>1.25%</td>
<td>1.79%</td>
</tr>
<tr>
<td>51-60%</td>
<td>1.15%</td>
<td>0.00%</td>
<td>2.50%</td>
<td>1.79%</td>
</tr>
<tr>
<td>61-70%</td>
<td>2.30%</td>
<td>0.00%</td>
<td>2.50%</td>
<td>1.79%</td>
</tr>
<tr>
<td>71-80%</td>
<td>5.75%</td>
<td>3.39%</td>
<td>7.50%</td>
<td>8.93%</td>
</tr>
<tr>
<td>81-85%</td>
<td>5.75%</td>
<td>8.48%</td>
<td>18.75%</td>
<td>23.20%</td>
</tr>
<tr>
<td>86-90%</td>
<td>6.90%</td>
<td>5.08%</td>
<td>17.50%</td>
<td>23.20%</td>
</tr>
<tr>
<td>91-95%</td>
<td>22.98%</td>
<td>22.03%</td>
<td>30.00%</td>
<td>14.29%</td>
</tr>
<tr>
<td>96-98%</td>
<td>25.28%</td>
<td>37.29%</td>
<td>8.75%</td>
<td>21.43%</td>
</tr>
<tr>
<td>99-100%</td>
<td>24.14%</td>
<td>22.03%</td>
<td>8.75%</td>
<td>1.79%</td>
</tr>
</tbody>
</table>

FIGURE 13 — Query rates with program maturity

<table>
<thead>
<tr>
<th>Feedback</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>We’ve had to leave fewer queries</td>
<td>29.43%</td>
</tr>
<tr>
<td>We’ve had to leave more queries</td>
<td>22.22%</td>
</tr>
<tr>
<td>We are still querying roughly the same rate</td>
<td>36.04%</td>
</tr>
<tr>
<td>We don’t track the number of queries we leave</td>
<td>3.00%</td>
</tr>
<tr>
<td>Other</td>
<td>9.31%</td>
</tr>
</tbody>
</table>

Selected other responses:

- Increase in queries related to increased scope since inception—clinical validity, HCC capture, etc.
- More clinical validation queries
- Varies with new versus existing providers
- Query the same because influx of new physicians
- Query less as we educate more
Celebrating CDI research

by Howard Rodenberg, MD, MPH, CCDS

I’m starting this missive the day after Super Bowl LIV, and my hometown Kansas City Chiefs have emerged from five decades of futility and brought home the win. So, it’s understandable that my Facebook feed is full of Chiefs-related content, including a picture of former teen idol Donny Osmond supporting his friend, Chiefs Coach Andy Reid.

(Original joke: What did Donny Osmond say to Coach Kyle Shanahan of the San Francisco 49ers? “Go Away, Little Girl.” You heard it here first.)

Donny Osmond has also been a game show host. Do you remember Pyramid? It’s the show where one contestant lists seemingly random items and the other tries to guess the category to which these items belong. So, let’s play!

- Two days of utilization management training
- Watching paint dry
- Jar-Jar Binks: Hero of the Republic
- Lindsey Lohan news
- Research

For most of you, the category might be “dull conversation starters.” I’d ask you, though, to reconsider research; it’s something we can’t do without. If you think about it, we do research every day—we ask questions and then look for information to help develop answers. What do you do when you need a new smartphone? You check out the brands and features, look for sales, ask your friends what they think, decide, and plunk down your cash. What we call “research” is nothing more than an organized, systematic way to present those thought processes we engage in every day.

And so, it’s with this idea in mind that I want to present this new section of the CDI Journal. In this recurring column, we’ll try to summarize pertinent research studies to advance the CDI profession. With any luck, these studies won’t just answer a question, but provide springboards for action and further investigation. We’ll get many of these studies from the ACDIS poster presentations featured each year at the national conference. So, if you want to see your name into the metaphorical lights, submitting a poster presentation to ACDIS is an easy way to do it.

Malnutrition capture study

Let’s kick the series off with a presentation I particularly appreciated. At last year’s ACDIS conference in Kissimmee, Florida, Stacey Gaona, RN, CCDS, led a team from the University of Texas Medical Branch in presenting “Malnutrition: A Focused Study on the Capture, Impact, and Documentation Opportunities Related to Malnutrition.”

I think no one is particularly keen at documenting the clinical presence of malnutrition. The use of outdated criteria such as body mass index (BMI), a mistaken reliance on albumin levels or other biochemical markers, limitations on the diagnostic scope of nutritional practice, fear of audits, and the sheer volume of work likely keep us from fully describing this spectrum of diseases. (I think many of us recall the excellent presentation at the 2018 ACDIS conference where our colleagues from North Carolina discussed their experience with a CMS malnutrition audit. Needless to say, it wasn’t a good experience.)

The introduction to Gaona’s study describes the effect of malnutrition on the hospitalized patient. Malnutrition adversely affects morbidity, mortality, readmission rates, and healthcare costs in innumerable ways. So, it makes sense that in our efforts to best describe the needs of the patient, malnutrition should be documented whenever it’s clinically appropriate to do so. Knowing that mild and moderate malnutrition are CCs and that severe malnutrition is an MCC further whets the appetite with a financial carrot.

The key is being able to find those patients, and that’s why the population health aficionado in me particularly
likes this study. The study’s methodology included evaluation and revision of a nutritional risk screening tool to improve the tool’s ability to identify patients at risk during the nursing admission screening. To me, targeting the population for intervention is the single most effective step in any CDI program. While there are a host of other interventions described within this work (data collection, peer comparisons, reporting workflows, provider education, and the like), it’s great to see a CDI effort that understands the fundamental need to look outside the coding and CDI world for success.

Targeting these patients is particularly important when it comes to resource management. If every patient could be evaluated by an unlimited number of dietitians using the broadest criteria, we could probably capture every malnourished patient in every hospital. But that’s simply not possible, so we need to know where to deploy our limited resources. Getting the screening questions right means the dietitians see the most at-risk patients, which means you increase the likelihood of a malnutrition diagnosis being captured. It’s really no different than a screening tests like pap smears or colonoscopies, where the indications for the test target the populations most at risk. We can use a similar strategy to support documentation, using resources like nursing screenings, which would usually be considered outside of CDI’s scope.

The results presented at the conference were modest. At the time of the poster’s creation, the program had only been in place for a few months, with an 11% increase in the rate of malnutrition diagnoses. I’m certain that an update would show even more progress as nurses become more familiar with their screening tools and clinicians become accustomed to the increased recognition of malnutrition.

I appreciated this study partially because we’ve been working on a similar project. Like the folks in Texas, we’ve addressed the issue on multiple fronts. We’ve adopted the malnutrition criteria from the American Society for Parenteral and Enteral Nutrition, educated nutritionists in physical diagnosis, and asked them to record nutritional diagnoses rather than simple assessments. We’ve developed a real-time mechanism for transmitting their findings to physicians as well as a feedback loop through the CDI department if the diagnosis doesn’t appear in the final record. We’ve developed institutional definitions and extensively educated our hospitalists.

The most impactful thing we’ve done, however, was changing the nursing nutrition intake screening questions to a validated malnutrition screening test. Now that we’re better able to focus our dietitians on assessing those patients identified as high risk, we’ve seen our rate of malnutrition diagnoses nearly double since the program was fully implemented.

It’s estimated that up to a third of hospitalized patients are malnourished to some degree, so it’s clear that we’re just scraping the surface of inpatient malnutrition. Efforts such as those of our friends in Texas will help us reach those patients. Thanks for sharing your work.

Editor’s note: Rodenberg is the adult physician advisor for CDI at Baptist Health in Jacksonville, Florida. Contact him at howard.rodenberg@bmcjax.com or follow his personal blog at writingwith-scissors.blogspot.com. Advice given is general. Readers should consult professional counsel for specific legal, ethical, clinical, or coding questions. Opinions expressed are that of the author and do not represent HCPro or ACDIS.
Clinical validation starts with physician education

In recent years, clinical validation has become a prevalent topic in the CDI field. According to Elizabeth Aguirre, MD, CCDS, CDI program physician lead at Baylor Scott and White Medical Center in Temple, Texas, the increased focus is at least partially the result of common problems CDI professionals uncover during their regular chart reviews.

"Many times, the issues we are seeing in our chart reviews are clinical validation issues," says Aguirre.

While part of the momentum begins as a natural progression of the record review process, according to Jera Van Damme, BSN, RN, CCDS, CCS, senior clinical documentation educator at Essentia Health in Duluth, Minnesota, the push may be also coming from payer and auditor pressure.

"I have a feeling insurance companies are probably becoming more keen to the fact that it’s a problem and hiring more people to look for these clinical indicators as diagnosis validation," she says.

Though outside scrutiny can feel like simply an effort to take back hospitals’ rightly earned reimbursement, Office of Inspector General (OIG) Assistant Regional Inspector Christopher G. Bresette, CPA, reminded attendees of the 2019 ACDIS Outpatient Symposium that the purpose of the OIG is not to take back as much money as possible. Instead, its goal is to make sure the payments are right. To achieve this, the OIG relies on clinical indicators to validate documented diagnoses.

Clinical validation reviews and queries ensure that the documented diagnoses and clinical indicators hold up to inspection. They aren’t likely to go away any time soon.

**Processes and templates**

Clinical validation is the process of making sure there are clinical indicators included on a patient chart to verify the concluded diagnosis. If the patient record has a diagnosis but no clinical indicators to back it up, it will likely be noted as null by payers and the hospital or facility will not receive reimbursement. CDI departments must make sure that patient charts have this clinical information to validate diagnosis. There
are many ways to perform a clinical validation review, and different methods will work better for different facilities.

“For us, one policy governs everything,” says Cathy Testerman, CCS, CCDS, manager of coding and CDI at Greater Baltimore (Maryland) Medical Center, explaining that the same guidelines for general queries are applied to clinical validation queries. “We start our reviews 48 hours after admission and query in real time. We’ll go in and review any documentation we have at that time, and then review every two days.”

For Aguirre’s facility, however, clinical validation queries were a bit of a struggle because the standard query templates did not fit the need for clinical validation queries. “We set up a query alignment team that includes coding, physicians, and CDI that looked at all the query templates. We wanted to make sure we were looking at the big picture.”

Elizabeth Aguirre, MD, CCDS

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This team analyzed every query template and created appropriate templates based off the trends and problems they were seeing. After the templates were created, the team shared them with the compliance department to ensure they were non-leading and otherwise compliant. During this process, a template for clinical validation was build which asked for both validation of the diagnosis and documentation of supporting diagnostic clinical indicators. “Now we have a clear and true clinical validity template for our team to use,” says Aguirre.

Those developing a query template for clinical validation reviews will need to determine the common scenarios for which the template will be employed, according to Van Damme. In most cases, you’ll be able to identify the common triggers that result in these queries and tailor the templates to them.

“Often when we query for clinical validation, it is because the diagnosis is in the chart but no indicators are present,” she says. The team at Essentia Health, according to Van Damme, queries physicians to either rule out a diagnosis or add supporting clinical indicators. Because the CDI team may need to send clinical validation queries for various diagnoses, Van Damme’s team kept their template simple and flexible so that CDI staff can edit the template to suit their particular needs. (To see a sample of Essentia’s clinical validation query template, click here.)

Though the template is flexible, Van Damme suggests that the organizational leadership come to an agreement on the definitions for diagnoses commonly leading to a clinical validation query. This not only makes the CDI specialists’ jobs easier, but it also gives the organization a leg to stand on when it comes to denials management and appeals.

With those definitions in place, “our CDI team can then write appropriate and accurate queries with the awareness of what the most supported and up to date diagnoses are,” she says.

Top queried diagnoses

The top diagnoses leading to clinical validation queries tend to follow a pattern, and it’s likely one that will come as no surprise to even newer CDI professionals. For Aguirre, Van Damme, and Testerman, sepsis takes a top slot.

“Part of the issue is when a condition might look like sepsis and then tests come back negative, but the diagnosis is never removed from the chart or clearly documented as being ruled out,” says Aguirre. “The other part is the lack of consensus regarding the use of Sepsis 2 versus Sepsis 3 diagnostic criteria across the medical community.” Just as at Essentia Health, Baylor Scott and White also has a team responsible for developing systemwide guidelines for sepsis diagnoses.

“Developing clinical definitions for these problem diagnoses has helped immensely,” says Van Damme. Her facility created the educator position to help physicians with these clinical definitions and validation queries.
“We’ll send a query and the physician sees the topic and thinks they’ve already documented for it, so they’ll ignore,” she says. “We’ve found the best thing to do is to get on the front end of this and educate them.”

In addition to sepsis, pediatric malnutrition, acute respiratory failure, and acute renal failure can also cause consternation.

“Any time there is a lack of consensus across the medical community, these diagnoses lead to clinical validation queries,” says Aguirre. “You have to give physicians more solid guidance with these issues. We’ve found it important to educate regarding the rationale for endorsing specific sepsis criteria and explain quality programs related to the diagnosis and what accurate documentation means for our quality reporting.”

“Education is the most important factor,” echoes Testerman. “We made a pocket guide for physicians, our educator does quarterly education on these topics during staff meetings, then we also do chart reviews and meet one-on-one with physicians as needed.”

Baylor Scott and White has physician education modules that are available via their intranet system, so they can run reports and see how many/which physicians are using the modules. They also track one-on-one education, and the Topics provided in educational huddles from month to month.

“As we move forward into this year, we’re going to start trending the denials related to physician documentation,” Aguirre says. The team will look at clinical indicators, conflicting documentation, incorrect problem lists, and coding errors, use their internal system to track these numbers.

“In turn, we can focus our education on those areas. [...] We are developing a process we didn’t have in place before; working with the physicians to provide education and providing education to our CDI team on query focus areas specific to denial trends.”

Physician response can be mixed when it comes to CDI efforts—particularly with clinical validation, which can often come across as the CDI team questioning their clinical judgment. Take the time to educate physicians and help them understand why they’re receiving these queries, Van Damme suggests. Employing some backup from organizational and physician leadership can’t hurt either.

“We haven’t had many issues with pushback from physicians,” says Van Damme. “I think it’s likely because of the support of our leaders and having an engaged physician advisor.”

Having that backing from the higher-ups opens doors to additional incentives, according to Aguirre. If, for example, you’re struggling to get physicians to participate in clinical validation education or read and use the new organization-wide clinical definitions, organizational leadership can back you up through use of system resources.

“Our system created online modules for our physicians to view when their schedule permits instead of limiting the education to a set time and location. Another incentive was the addition of CME/MOC credits,” Aguirre says.

Even with incentivizing learning modules, however, some physicians are bound to push back, Aguirre adds.

“The learning modules are not mandatory,” she says. “Physicians are so busy, so when something is optional, they are more likely to skip it.”

To avoid this, Aguirre suggests paying attention to how much resistance your facility might be getting.
from physicians and asking yourself why. Then, find ways to answer that question and make the ask more appealing.

**The future of clinical validation**

While the need for clinical validation queries will not go away or lessen in the near future, there are steps facilities can take toward streamlining the process.

Testerman recommends setting up a process with your coding department to ensure lackluster, unsupported diagnoses are flagged before they’re coded and sent out the door. The infamous “Guideline 19” from the *Official Guidelines for Coding and Reporting* says that:

The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

While this does mean that coding professionals reviewing a record cannot omit a diagnosis code simply because they feel the diagnostic criteria are lacking, other guidance from *Coding Clinic*, Fourth Quarter 2017, p. 110, does instruct that the provider should be queried in these instances.

Testerman suggests working with your coding department to ensure there’s a process in place for identifying query opportunities (which may mean using organizationwide clinical criteria, etc.). Encourage critical thinking about what could be missing from the record and set a process in place to clarify those issues on the front end.

Aguirre recommends basic educational sessions for CDI specialists on clinical validation topics. “We were surprised to find there were some CDI specialists who thought they knew what clinical validation was but were not entirely sure,” she says. “A very basic presentation on clinical validation can be extremely helpful.”

When educating and querying the physicians, make sure they know you aren’t just asking for a confirmation of a documented diagnosis, but rather a confirmation of the diagnosis and documentation of the supporting diagnostic clinical indicators. “Make this very clear,” she stresses.

Remember, whatever process you put in place may change over time, and that’s OK, Van Damme says. As your program matures and the CDI department collaborates with other departments, clinical definitions may shift, and the process may need adjustments.

“It can be a process, but it’s helpful for everyone, so our leaders stand behind it,” Van Damme says. “There is always room for improvement, but at least it’s a starting place.” 🍀
NOTE FROM THE ASSOCIATE EDITORIAL DIRECTOR

Engage with ACDIS 2020 vision at 13th annual conference

by Melissa Varnavas

Back when I served as the editor of my hometown newspaper, I was lucky enough to attend a special conference put on by the American Press Institute (API) on the challenges facing the journalism industry. The challenges were many—slumping sales of print editions, the advent of the internet and online media, consolidation of organizations, and the rise of the mass media market. How were we supposed to tackle these challenges and keep our little community newspaper alive? This API event didn’t sugarcoat the challenges we faced at the time. Instead, it laid them bare and showed us how to broaden our scope, expand our reach, and leverage our experiences and expertise to engage with our readers and our community.

This story illustrates the fact that every single profession at some time or another requires people to step away from their day-to-day routine work to explore the valuable opportunities that exist beyond that routine. At the time, I was overwhelmed with keeping up with hectic deadlines, managing a staff of reporters, and struggling to capture the most vital information on breaking news stories while digging deeper to find the stories of community embedded within them.

Stepping away showed me how to tap into the resources that were available throughout my community. Stepping away gave exposure to some of the most amazing experts in the field. Stepping away gave me creative inspiration and allowed me to return to my beloved hometown newspaper with fresh insight.

That conference changed my professional career. The newspaper that year won awards for its local election coverage and earned me editorial honors from the New England Press Association.

I can’t tell you how many times the ACDIS conference has had a similar effect on me. Those of you who’ve attended before can attest to this fact from your own experiences. Each and every individual you meet at the event has their own CDI story to share and is willing and excited to share it.

The 13th annual ACDIS conference focuses on all the ways CDI staff can engage with, and for, their profession. With nearly 2,000 peers, sponsors, speakers, and staff in attendance, every minute of this three-day event represents an opportunity to network, learn, and grow. This year’s conference includes more than 60 educational sessions across six focused tracks for a wide range of experience levels, from basic to advanced.

It’s why so many attendees come back year after year. We often joke that the event feels like a family reunion—people who only get an opportunity to talk via social media or email come together again, and those who’ve only met via online networking through ACDIS get an opportunity to meet for the first time and chat like old friends.

The ACDIS conference is all about engagement. That’s why the theme for this year’s event is Engage! Since our first conference in 2008, it’s been the best source of engagement for CDI professionals across the nation. It’s a place to engage your mind. It gets you out of your facility and into the company of the country’s best and brightest CDI professionals. It’s also why this year we’ve included a new track focused on physician engagement and denials management; we’re also bringing back several core conference focus areas such as management and professional development, and the quality and regulatory track.

Pulling the conference together is a massive endeavor. This year, I owe an enormous debt of gratitude to the volunteer conference committee who met weekly on top of additional duties they performed on their own time. Nearly 175 presentation proposals were submitted for this year’s event. The conference committee needed
to review each proposal on its merits and determine which sessions to put on the ACDIS stage.

I am thoroughly impressed by their dedication and commitment as well as their creativity. They were able to pull together similar sessions, uniting speakers in some instances, and create new session types including lightning rounds, panel discussions, and split sessions designed to provide increased sharing of individual experiences, on-the-ground challenges, and opportunities for growth.

We know that not everyone can come to the conference every year. For some, it’s because of personal constraints such as family obligations or health concerns. For others, there are budgetary restrictions.

While we all know how invaluable conference information can be, it can be challenging to quantify the impact of this event. What is the monetary value of a fresh idea for engaging your physicians? You can help one doctor see the importance of CDI efforts and start answering queries, but how can you measure the effects of that? Many of you do this data work and can speak to the details of how to answer this question.

Consider delving into that data to make the case to attend the conference with us this May. If you need some help, we have a sample letter you can adapt.

Additionally, you might want to keep in mind all the ways you can save on your conference registration such as:

1. Register before the early bird deadline. The deadline is March 27, so register soon.
2. Team up and register together. You can register five attendees for the price of four (a savings of $1,050!). Call customer service at 800-650-6787, Ext. 4111 to register your group and receive your discount.
3. Plan ahead for 2021. ACDIS will be in Dallas for its 14th annual event. Speakers receive complimentary admission to the conference.
4. Volunteer on the committee. Is it a lot of work to serve on the committee? Yes. But it’s also rewarding to get a behind-the-scenes peek at the sessions and be able to help craft an amazing experience for your peers. Committee members additionally receive a significant discount on registration.

There is so much I’m excited about as we head into the home stretch—too much to share here! So, take a look at the full conference brochure and see where this year’s conference might take you.

Editor’s note: Varnavas is the associate editorial director for events at ACDIS. Contact her at mvarnavas@acdis.org.
PULMONARY HYPERTENSION IN ADULTS AND CHILDREN

By Amy Sanderson, MD

Pulmonary hypertension (PH) is a complex, progressive disease that affects both children and adults, and leads to significant morbidity and mortality. PH has been defined as a mean pulmonary artery pressure ≥ 25 mmHg when the patient is at rest (see references 1 and 2 from the list on p. 28). The abnormally high resistance in the pulmonary vascular bed obstructs blood flow from the right ventricle (RV) to the lungs. This, in turn, increases blood volume and pressure in the RV, causing it to work harder. Over time, the RV dilates and thickens due to the extra work, and it may develop dysfunction or even fail.

In a PH crisis, the significantly increased RV pressure and volume cause the interventricular septum to shift to the left, impeding the left ventricle’s (LV) ability to fill with blood. This causes decreased cardiac output and systemic oxygen delivery. Hypoxia and metabolic acidois ensue, potentially leading to death. PH patients may present with one or more of these signs/symptoms:

- Dyspnea on exertion
- Fatigue
- Hypoxia
- Cough
- Chest pain
- Poold growth/malnutrition
- Peripheral edema
- Ascites
- Distended neck veins
- Exertional syncope (severe cases)

The causes of PH can be classified into five categories (see reference 3 on p. 28):

- Pulmonary arterial hypertension
- PH due to left heart disease
- PH due to lung disease and/or hypoxia
- Chronic thromboembolic PH
- PH with multifactorial mechanisms

See the table for examples of specific etiologies.

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<td>Idiopathic</td>
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<td>Heritable</td>
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<td>Persistent PH of the newborn</td>
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<td>Congenital diaphragmatic hernia</td>
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<td>Glycogen storage disease</td>
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<td>Connective tissue disease</td>
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<td>Chronic pulmonary embolism</td>
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<td>Ischemic left heart disease</td>
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<td>Cardiomyopathy</td>
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<td>Myocarditis</td>
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<td>Drug-induced (chemotherapy, cocaine)</td>
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<td>Hematologic disorders (chronic hemolytic anemia, myeloproliferative disorders, splenectomy)</td>
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<tr>
<td>Chronic renal failure</td>
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<td>Portal hypertension</td>
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Physicians may document terminology that describes the pathophysiology or sequelae of PH, but such terms will not allow coders to capture the specific PH diagnosis. These include elevated pulmonary artery (PA) pressure, elevated wedge pressure, RV strain, RV hypertrophy, RV dysfunction, and pulmonary vasoreactivity.

To look for further evidence of PH, CDI specialists can review the diagnostic results section of the chart (see references 1 and 2 on p. 28). An indwelling PA catheter will supply direct evidence of PH as it provides the clinician with measurements of PA pressures, cardiac
output, and pulmonary vascular resistance. These catheters, however, are invasive and risky, so their use is becoming rarer, especially in pediatric patients.

Echocardiography is a noninvasive diagnostic tool that can estimate the PA pressure as well as evaluate the systolic function of both ventricles. It can also clarify cardiac anatomy including ventricular chamber size, wall thickness, intracardiac shunts, and valvular function. Its use, however, may be limited in obese or agitated patients as there may be poor heart visualization.

Cardiac MRI and CT are other noninvasive modalities that provide helpful information regarding the presence of PH. CT is useful to evaluate the pulmonary system to detect pulmonary emboli, diseases of the lung parenchyma, and vascular abnormalities. Cardiac MRI can demonstrate ventricular function, lung perfusion, and characteristics of the myocardium. Cardiac catheterization is the gold standard for PH diagnosis. This involves accessing vessels, commonly in the groin, to thread a catheter into the heart. During this study, pulmonary vascular anatomy can be assessed as well as pulmonary hemodynamics and pulmonary vasoreactivity.

Looking at documented therapies can also provide clues to the diagnosis of PH (see references 1, 2, and 4 on p. 28). The goal of treatment is to mitigate physiologic derangements by treating underlying diseases such as obstructive sleep apnea and pulmonary emboli, stimulating pulmonary artery dilation, and providing support for the RV. Oxygen is a potent vasodilator and may be administered to patients with PH to correct or prevent hypoxia. Correcting a metabolic acidosis and treating pain/agitation are also important strategies to reduce elevated pulmonary artery pressures.

There are several medications that are used in PH management. Sildenafil, inhaled nitric oxide, bosentan, prostacyclin, epoprostenol, treprostinil, and iloprost are examples of medications that induce pulmonary vasodilation. Epinephrine, milrinone, dopamine, and dobutamine can increase cardiac contractility. Vasopressors such as norepinephrine, phenylephrine, and vasopressin may be used to increase systemic blood pressure. Diuretics, beta-blockers, and anticoagulation agents are other strategies for medical management.

One surgical therapy is atrial septostomy, which might be beneficial in patients with severe RV failure. In this procedure, a hole is created in the atrial septum to allow for blood shunting from the right to the left atrium, decompressing the RV and increasing LV filling. Patients with chronic pulmonary emboli might benefit from surgical removal of the emboli and/or angioplasty of the pulmonary vessels. Finally, patients with severe PH who fail other therapies may undergo evaluation for lung transplantation.

PH is a serious disease that affects both children and adults, and it’s important for clinicians to properly document this diagnosis to accurately reflect the true severity of illness in this patient population. Diagnostic test results and documented therapies can be especially helpful for CDI specialists to aid in the capture this potentially devastating diagnosis. 😧

**Editor’s note:** Sanderson is a pediatric intensivist and physician advisor at Boston Children’s Hospital. She is also an assistant professor in anaesthesia at Harvard Medical School. She was a contributor to the book *Pediatric CDI: Building Blocks for Success*. Opinions expressed do not necessarily represent those of ACDIS or its Advisory Board. Contact Sanderson at Amy.Sanderson@childrens.harvard.edu.

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**REFERENCES**

Here are a few PH references:


CASE STUDY

Outpatient CDI launch takes education and patience

“We wanted to do outpatient from early on,” says Cheree Lueck, RN, an outpatient CDI specialist at Denver (Colorado) Health. “I was always thinking, ‘Why aren’t we doing this in the clinic?’ ”

Lueck and a fellow CDI staff member began the outpatient CDI program at Denver Health just shy of three years ago. “There were a lot of growing pains,” Lueck says. “It’s been sort of my baby.”

As with any new department, much of the outpatient CDI program was developed through trial and error, including the query process and provider education on the importance of CDI.

Physician coding

At Denver Health, the primary care providers assign their own codes for diagnoses (as opposed to employing outpatient coding professionals). However, Lueck says that the CDI team still leverages the coding department’s expertise in order to ensure the chart is correct before it heads out the door.

“We might have to work with the coding department on occasion,” she says. “If the chart didn’t get coded correctly, we have to send it to a coder.”

Provider self-coding can create a whole slew of problems, Lueck says. In some cases, providers weren’t just coding incorrectly—they weren’t coding anything at all.

“Theyir notes would be full, but nothing would be coded, other than the type of visit and maybe one diagnosis,” says Lueck. “All of the information would be there, but just in the wrong section.”

Some providers were leaving this codable information in the notes section of the chart where it couldn’t be picked up for billing and reporting by their EHR system (Epic).

Lueck says this is because the providers were simply used to writing their notes a certain way. There are a variety of ways to do things in their EHR system, so it’s not surprising that each provider was using the system differently, Lueck says.
“We have to learn how they are using the tool, go to an Epic trainer, and say, ‘They are doing it this way; how do we teach them our standardized way?’ ” she says.

Lueck reminds us that providers did not choose their career to code charts; “they chose it to take care of patients,” she says. Providers often won’t know the correct way to code something or the importance of including clinical indicators in their charts unless they receive education on the topic. “It is important for us to educate them not only on why proper coding is important, but why supporting evidence for a certain diagnosis is necessary,” says Lueck.

Physician education

Lueck and her team track specific providers’ data and use the hard numbers to show providers what is and isn’t working. Some of the elements they track are:

- Unanswered queries
- Queries on particular diagnoses
- Diagnoses removed from records due to lack of clinical indicators

“When we first start working with a new clinic, we know it takes them a while to understand,” says Lueck. “Give them a good three months to see their data and review it; some might need six months.”

While providers may think they’re generally good documenters, after seeing their actual data and the effect it has downstream for reporting purposes, they’re much more likely to understand the importance of proper documentation. These changes in attitude and provider behavior will not happen overnight, Lueck says. Instead of focusing on immediate measurable results, educate to change the providers’ long-term habits.

“In the outpatient setting, you really have all year to get all HCCs [Hierarchical Condition Categories] on the record,” says Lueck, which puts less pressure on providers to fully and accurately code their charts without truly understanding the concept. “A lot of patients come in pretty often,” she adds, meaning providers have multiple occasions to document HCCs if they’re missed the first time around.

Now, Lueck says, they “have doctors that are rarely queried because they already know what to do; from our education, they update their problem list, use Epic features to help them remember to get the documentation in the record, and that is the sort of progress we are aiming to achieve.”

Even still, there are occasions where providers don’t catch on to the importance of CDI as quickly as they should, or where they simply resist cooperating.

“There are always some stubborn ones,” says Lueck, “but mostly everyone has gotten on board after seeing why it’s needed.”

From the start, the Denver Health team had the department heads on board with outpatient CDI efforts. Having that sort of support trickles down to the providers, making them more likely to be supportive as well. Not only do the individual providers see their own data, but the CDI team also sends the unanswered query data to the department heads. “That way everyone is in the loop and being held accountable,” Lueck says.

For those who still resist, Lueck suggests using the incentive of reduced queries to motivate change. “Make sure to reiterate to them that if they don’t like us querying, get all the information in to begin with so we don’t have to query you,” she says.

Even the most wayward documenters do sometimes deserve a little grace, she adds. “Sometimes it just takes people a while to learn why it matters. [...] I like to give them the benefit of the doubt.”

Query process

Since provider education and long-term change is the goal of the outpatient CDI team, they leverage their query process and data to that end as well.

When the CDI specialists review charts, they enter the records into an audit tool that tracks which HCCs were queried on. Then, they can take that information and develop education around the most often-queried diagnoses.

“Instead of sending the same queries over and over, we thought, ‘Let’s provide them with some education,’ ” Lueck says. The outpatient CDI team gives the
providers quarterly results and an associated education session for each of the top four queried diagnoses, which can change depending on data trends.

While some of the top outpatient queried diagnoses mirror the inpatient side of things, some diagnoses are unique to outpatient. According to Lueck, their number one diagnosis in the last year was depression. “It by far blew the other diagnoses out of the water,” she says.

Depression isn’t queried frequently on the inpatient side because it’s rarely a condition that requires an inpatient admission. Often, providers document depression with no severity included. The clinical indicators are there, but the severity and specifications are not, Lueck says.

While the inpatient CDI team queries for acute respiratory failure regularly, Lueck says that chronic respiratory failure frequently shows up in the outpatient team’s top queried diagnoses. Charts for patients with chronic respiratory failure often reference a dependence on oxygen but neglect to list a specific diagnosis. Many providers, according to Lueck, have been taught that they need to document oxygen dependence so that patients’ oxygen and insurance companies will reimburse for their therapy. While that’s a good practice, the CDI team still had to educate the providers to include the specific diagnosis linked to the oxygen dependence as well.

The outpatient CDI team also queries for uncontrolled diabetes regularly, partly because of the way the providers are using their forms for charting. “[Diabetic] patients come in all the time and are not always controlled,” Lueck says. “Providers keep checking off the easy box of ‘controlled,’ so we need to remind them to document all pertinent complications related to their diabetes.”

According to Lueck, the CDI team is currently working on education for morbid obesity and malnutrition documentation as well and will likely dig into those diagnoses next.

Just like their top diagnoses, the querying process for outpatient CDI also differs from the inpatient team’s process. Lueck’s team looks at patient records prospectively the day before the patient’s scheduled visit to identify any potential HCCs, then sends out queries prior to the visit. Once the visit is complete and coded, they do a follow-up review retrospectively to ensure the diagnoses were all coded and supported.

“Before we query for diagnosis specification,” says Lueck, “we will look into the notes on the record and see if they have supporting documentation.” If not, the CDI reviewer sends a query and allows the provider five days to update the documentation before coding.

Because the team’s provider advisor and manager are always in the loop and ready to help, Lueck has not yet had to escalate any queries for non-responses.

“We know that it can take a while for providers to catch on,” she says. “The process is all about learning for long-term results, not reprimanding.”

**Tracking and trending**

Lueck and her team have been tracking their results for the past year, which was “a lot of trial and error,” she says. Since last year was their first full year of data, they now have a basis for trending. Specifically, Lueck says they intend to track and trend their progress with depression diagnoses year-over-year using the same audit tool that tracks most queries for HCCs.

As with any new endeavor, new outpatient CDI professionals need to be patient and remember that not everything will improve overnight. Take solace in the fact that, unlike the inpatient setting where the patient’s record needs to be completed before discharge, you will more than likely see your outpatient patients again soon and you’ll have another chance to get their documentation correct. HCCs need to be captured and reported on an annual basis, so as long as that happens, you’ll be in good shape, Lueck says.

As with anything, extend some grace to the providers and try to see things from their perspective. Spend some time shadowing them on an average day, Lueck suggests, so you can see firsthand what their processes are and how appointments can be derailed by patient needs. “Remember, the patient is leading the visit, not the doctor,” she says. “If you learn how their clinic works, it might just change the way you write a query.” 🌸
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**Visit the ACDIS Blog Weekly to find out what events are coming up in your area!**
A few years back, I watched a video titled The Evolution of Dance, performed by Judson Laipply. Through his renditions of hits like Elvis Presley’s “Hound Dog,” John Travolta’s “Greased Lightning,” Michael Jackson’s “Thriller,” or AC/DC’s “You Shook Me All Night Long,” the comedian engulfed us in his frenetic ability to express the changing times with his agile and accurate dance moves. It was captivating and made sense to all who watched, regardless of generation. The nostalgic journey through time brought each person together for a single response: laughter!

Perhaps the less perceptible effect, though, was that every song change brought different meanings and memories to each viewer. Even though what was happening outwardly was the same (laughter), what each person felt was very different.

Our journey through CDI could be considered similarly. It has been an intriguing evolution of rhythm and sound over years of challenges in a complex healthcare system, and it has brought to light differing concepts and arenas for expression. We have seen the industry evolve from simply querying for CC/MCC capture to embracing complex quality concepts and integrated team relationships. With the addition of intricate data analytics and the growing promise of artificial intelligence, we are learning to move quicker and adapt to each new beat at a faster pace than ever before.

So, what’s the most important thing to remember given the undulation of it all? We all have a unified cause: integrity! Hopefully that encompasses personal and professional integrity too, but here in the pages of CDI Journal we’re chiefly concerned with documentation integrity.

With all the changes in this profession, I often find myself in discussions over what, when, and where to query in the outpatient setting. Since inpatient is by definition at the point of care, there is typically little discussion regarding the focus, timing, and direction of an inpatient query. In the outpatient realm, however, we have to ask these three questions:

- What is the focus of chart review?
- When will the provider see the query during the patient’s care?
- Where should I place the query so that the provider(s) sees it and addresses it?

Remember, regardless of setting and timing, compliant query practice never changes. A prudent CDI professional should never compromise how he or she approaches a query for the sake of the setting. Since the intent remains the same, the practice of writing a query remains the same. It’s just like driving. Whether you’re driving in the hectic heart of Charlotte or the clear open hills of Mayberry (to take some examples from here in North Carolina), the fundamentals are the same: You must have your hands and feet firmly in place and your eyes open wide. Think of query compliance this way. The fundamentals do not change with the setting.

If you have questions regarding compliant query practice, then I suggest familiarizing yourself with the jointly published ACDIS/AHIMA “Guidelines for Achieving a Compliant Query Practice” and also ACDIS’ 2018 position paper, “Queries in the outpatient setting: Developing a compliant, effective process.”

Program focus

Understanding the focus of the program is often the greatest challenge in the outpatient setting. Many CDI professionals are asked to start an outpatient program but given little to no organizational direction. I suggest leaders first ask a few probing questions. Finding the organizational needs is an obvious first step, but when it comes to querying, we must find the customers’ needs too. For this, we must know our customers. Our customers are the providers we’re seeking information from.
Of course, our customers are ultimately the patients, but for the purposes of outpatient CDI, we’re faced with the daunting task of clarifying documentation in a time-crunched, highly regulated system from those pressed to produce good outcomes for the sake of human life. So, before you start sending queries, find your focus!

Before you begin half-heartedly and robotically asking for greater specificity of depression and rambling about how it affects risk adjustment, ask yourself whether doing so will make a difference. Maybe it will make a difference in follow-up care, utilization of resources, and even a patient’s medication regimen with the added benefit of accurately reflecting risk adjustment. If it will, then make sure you can convey that information to those you choose to query. In my experience, when people understand the “why,” they’re much more willing to provide the supporting documentation for the greater cause.

**When and where**

When to query and where to place a query are not only organizationally dependent concepts but often change with many other factors, such as geographical location, provider specialty, size of practice, and—frustratingly—EHR alignment. In outpatient settings beyond hospital walls, we typically see prospective queries (queries sent in advance of a patient’s scheduled visit).

The key to prospective querying is knowing why the patient is presenting for the encounter. For instance, it does no good to ask for diabetes specificity when a patient has an acute visit for an earache. Perhaps the provider may tangentially address the diabetes during that visit, but physicians will often ignore queries for conditions that aren’t the visit’s main focus.

It’s also important to understand how encounters are entered into the EHR and query purposefully. This ensures queries and outcomes are meaningful and allows scalability of resources, while decreasing frustration for providers by helping them avoid needless clicks in the EHR. Some organizations now schedule more time for yearly physicals and wellness visits to help with documentation integrity and with meeting value-based and quality measures.

**Time and maturity**

When we began our outpatient program, the challenges seemed insurmountable. We started with three clinics—basically those who agreed to let us in. We sat with providers, shadowed, listened, and learned. We waited nearly six months before sending one paper query. This time, however, was well spent. We began to understand the providers’ challenges and complaints: too many clicks, no time, a constant push to see more patients—the list goes on.

We’ve come a long way—our first queries were placed on fluorescent color-coded paper, and now we have them embedded in the EHR. Even still, we have so much more to learn, and we continue to struggle with the what, when, and where of an evolving healthcare system that continues to place administrative burdens on clinicians. But we must continue to move forward.

At this point, some providers still request the paper queries (which will not happen). Some wish to see the query as they open an encounter, some as they close the encounter. Some use our electronic tools and others do not. Some answer queries promptly and some simply ignore them. All these scenarios may sound familiar, and if you’re just starting your program, then you’ll probably encounter them soon.

Outpatient CDI encompasses a world of challenges in its multiple directions. Even so, whether you choose to focus on risk adjustment, procedures in outpatient surgery, the emergency department, or any of a plethora of outpatient models, we must learn to march to our own organizational tune. We’re all aiming for the same outcomes, but there is no one-size-fits-all model, and that’s a beautiful thing—it means the journey you’re embarking on is yours to make. Each of us brings different backgrounds, thoughts, and expertise, so create your dance and make it a memorable rhythm! 🎊

**Editor’s note:** Vaughn is the manager of outpatient CDI at Wake Forest Baptist Health in Winston-Salem, North Carolina. Opinions expressed are those of the author and do not necessarily represent those of ACDIS, HCPro, or any of its subsidiaries. Contact Vaughn at jessvaug@wakehealth.edu.
All queries, regardless of their origin, are bound to follow the ACDIS/AHIMA “Guidelines for Achieving a Compliant Query Practice.” In order to ensure queries stand up to outside scrutiny and are effective, many CDI leaders have put query audit practices in place for their departments as they bring on new team members.

Implementing such a process, however, can be time consuming, and it requires a gentle touch to ensure team members understand that the process isn’t meant to be punitive, but instructive.

“Discussing my findings with the staff is probably the most challenging part of the process. No one wants to be told that they’re doing their work incorrectly, especially if they have been in the job for a while,” says Kimberly Moore, BSN, RN, CCDS, CDI educator for the Los Angeles market of Providence St. Joseph Health.

Audits can be a touchy subject, but the risks of not auditing far outweigh any potential awkwardness.

Why audit

A new staff member’s onboarding presents the perfect time for a query compliance check-up, according to Moore. New CDI professionals may need additional education and follow-up to ensure that their queries remain compliant and effective as they get up to speed. Catching issues early is imperative to their long-term success, and periodic check-ins will ensure that things don’t slip into non-compliant practices or habits.

“We became aware that a new staff member’s queries were not compliant. This was disappointing. Based on these findings, I now regularly review or spot audit their queries,” Moore says. “Not auditing can be very problematic because people get into a habit and that just becomes what they do.”

“We have found issues in the past with leading queries,” adds Judy Moreau, RN, MBA, vice president of mid-revenue cycle at Trinity Health in Livonia, Michigan. “That’s something we want to get ahead of quickly before it becomes a larger compliance issue.”

Queries under the microscope: Compliance audits
Catching small issues prevents them from growing into insurmountable problems down the road, but compliance isn’t the only thing that should be viewed under the microscope. For health systems with multiple CDI teams across different facilities, a query audit process also ensures that each facility follows the system’s predetermined processes and procedures. The method will shine a spotlight on any facility-to-facility discrepancies that could have otherwise stayed in the shadows, Moore says.

“We recognized that each team had their own way of doing their work,” she says. “We had set in place some very solid guidelines for how our work should go, but in my first month, we could see that everyone was doing things differently, and not always efficiently.”

(For more information about developing systemwide processes, read this article from the July/August 2018 edition of the CDI Journal.)

In addition to the benefits for the organization and the CDI team, query audits can also improve physician engagement, Moore adds. In fact, part of the impetus for a query audit practice at Providence St. Joseph Health came from physician complaints that the CDI team was sending queries before the providers had time to do a full patient workup and document their findings. When this happens, physicians can become frustrated and disengaged from the CDI process, even when queried at the proper time.

“Auditing charts and looking to see if they prematurely queried has been helpful,” Moore says. Through the query audit process, she says, “I can help the CDI staff as individuals grow, but I can also help the organization.”

**How to audit**

While query audits have a myriad of benefits, building a process can cause headaches. According to Andrea Eastwood, RHIA, BAS, director of clinical encounter and documentation excellence at Trinity Health, the best first step is to determine what to evaluate, who will do the evaluating, and what tool you’ll use to track the audit findings.

Because Trinity Health has one corporate CDI team as well as separate teams at each facility, Moreau and Eastwood developed the audit processes and forms at the corporate level and then handed them down to the individual facility managers/team leaders for implementation.

“It took a while to just get the tool built and agree on what elements we were going to be monitoring,” says Moreau. “The goal was not to make it too onerous for the field because if it was, we wouldn’t get cooperation. [...] The managers, team leads, and directors have to get the mindset that this needs to be a part of their routine. That was difficult.”

Ultimately, through a series of iterations, they narrowed the form down to evaluate only the “essential” components:

- Query format
- Grammar and punctuation
- Query type
- Compliance (specifically non-leading)
- Verbal query memorialization

A year after implementing the initial process, Moreau and Eastwood reevaluated the form and assigned a weight to each component based on its importance, which Eastwood says also took some trial and error.

“Not every element is equally important,” she says. For example, “we originally weighted the compliance a little less, but then we decided that it’s a pass/fail issue.”

Other components such as grammar and punctuation, while important, shouldn’t cause a CDI specialist’s query to “fail” the audit. Repeated issues in such areas, however, may trigger some additional education for that team member.

“We want the queries to look professional. They’re part of our legal health record, so we want to make sure it’s in a format that’s easy to understand and is also professional,” says Eastwood.

Because the team is dispersed across multiple facilities with different managers and team leads, Eastwood and Moreau handed the process off to those leaders and asked them to conduct the audits for their own staff. Initially, they were asked to conduct 10 query audits on each CDI specialist, using the form to determine their performance. Now, the query audits will become a regular and periodic...
exercise for the leaders to ensure all practices remain above board.

At Providence St. Joseph’s, the job of auditing staff queries falls to the CDI educators who review work for a group of facilities under their purview. Moore suggests reviewing a selection of charts from each team member and evaluating both the queries the member sent and those he or she chose not to send. Also, look at the circumstances of each case, she adds, including what the staff member recorded when conducting his or her review in their CDI documentation system.

“I review five cases from each team member, some with queries and some without,” she says. “I also review some cases that had queries with no response to see if there was a reason the doctor didn't respond. When they do obtain an answer from the physician, I also look into their worksheet and see what the clinical indicators were.”

For her reviews, Moore evaluates the following components:

- Query composition, format
- Validity of the query based on clinical indicators
- Timeliness of the query
- Query compliance

Like Eastwood and Moreau, Moore highly stresses the importance of a tool to track audit findings. This enables you to determine if a team member has repeated trouble spots and identify any additional education opportunities.

“When you’re doing the audits, have a good reporting tool to put your data in so that it’s an organized process,” Moore says. “Having the data without acting on it, however, would make this work worthless.

Educating staff

A query audit process safeguards the organization and CDI program from potentially noncompliant practices, but it also offers an opportunity for staff education and professional development. Even without a formal education measure resulting from the audits, Moore says that the process keeps the staff vigilant with their own practices.

“Auditing their queries has made them more aware when they're doing reviews to word search and make sure their queries are appropriate,” she says. “They’re more mindful.”

If you’re seeing similar issues across other staff members, it can provide a basis for further group education on query practices or developing an education plan for the department. Sometimes, Moore says, the audit findings may require you to go back to the basics of query practice and lay a firm foundation for the staff to build on.

“It’s been a guide for further education with queries,” Moore says. “I’m working on education for query compliance in the next month’s training—a back to basics thing.”

In addition to group education, Moreau suggests CDI leaders use custom approaches for each audit and develop a plan to meet each staff member where they are, focusing on their unique situation. Some staff members may do well with self-guided education through the organization’s intranet system; others may need more handholding.

“As they’re entering each component [into the audit form] for the CDI specialist, it rolls up into a percentage score,” Eastwood says. “Depending on how they score, they might require additional query education.”

“We have the site's team lead put together an action plan which typically includes education,” Moreau adds. “Sometimes we put a query buddy in place. We have a float pool of CDI specialists at our system office, so if they need a query buddy or need audits on all their charts, we’ll assign one to that person.”

The float team member acting as a query buddy can offer guidance and spot-audit the CDI specialist’s queries until he or she improves. The float team members, however, are not above reproach themselves—all their queries are also audited using the same standards.

Regardless of educational process, Moore says that the first, and often the most difficult, step is always a conversation with the staff member about audit findings. Having an educational plan in place will help ease any ruffled feathers during this conversation.

“I collect the data. Then, I schedule one-on-ones,” she says. “I want to make sure they understand that this is a nonthreatening situation and these audits are truly to help them.”
Queries as part of the permanent medical record

Q: Most of the hospitals in our system make the query a progress note in the patient’s medical record. The provider puts an “X” by the appropriate answer choice and signs the note. At that point, the query is part of the permanent medical record and can be used for coding.

However, I’ve heard people from other organizations say that they’re receiving denials because the provider didn’t actually document the diagnosis/query answer anywhere except on the query itself.

In your opinion, what’s the best way to avoid this issue? How should we proceed?

A: We get this question fairly frequently in our Boot Camps. I do think it is important for providers to “weave” query responses through the progress notes and document them in the discharge summary, which I’m sure you’re already teaching them to do. The problem is that sometimes that doesn’t happen.

I believe organizations can fight these denials in a few ways. First, make sure your queries are supported by clinical indicators found throughout the chart, and that the query is compliant and clinically solid. Identify and summarize this clinical support with examples found throughout the record, comparing the clinical indicators to accepted diagnostic criteria as appropriate.

The second piece of advice is to develop a solid pattern/template for your appeals (so you can consistently use the same argument, which can be tweaked over time). Address why the query is clinically supported and compliantly written with a confirmed physician response that is incorporated within the record. The provider should also be involved in writing the appeal and verifying his or her conclusion as to why the diagnosis is clinically valid.

Then, point out that coding/CDI provider query is an accepted and compliant practice and that we have been instructed to do so to obtain accurate and complete records. To support your case, use the ACDIS/AHIMA “Guidelines for Achieving a Compliant Query Practice,” and this statement published in the 2008 Inpatient Prospective Payment System final rule, p. 208, which directs hospitals to make attempts to improve all aspects of clinical documentation (emphasis added):

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.

Include the statement from the Official Guidelines for Coding and Reporting, p. 1: “A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.”

Lastly, focus on this issue when contracting with private payers, and incorporate guidelines into the contracting process stating that physician response to queries (when compliantly written and applied per policy) must be recognized as a valid record entry. I don’t know if any organization’s worked such a statement into their payer contracts, but it could provide powerful support.

My bet is if you can appeal and win these denials, payers won’t jump to use this denial rationale again.

Editor’s Note: Laurie L. Prescott, RN, MSN, CCDS, CDIP, CRC, CCDS-O, CDI education director at HCPro in Middleton, Massachusetts, answered this question. Contact her at lprescott@hcpro.com. For information regarding CDI Boot Camps, click here.
CODING CORNER

Six things coders wish providers knew about neoplasm coding, documentation

by Sarah Nehring, CCS, CCDS

In my experience, some of the largest disconnects between provider and coder thinking occur when it comes to neoplasm-related admissions. Consequently, it’s also where some of the greatest query frustration occurs. To help ease some of the consternation and bridge the gap, here are six things coders wish providers knew about coding neoplasm-related admissions.

6. Pathology

Based on the query responses I’ve seen and the conversations I’ve had with providers (and coders) over the years, I believe pathology queries cause more unease and resistance than almost any other type of query. So why do we keep sending them?

The Official Guidelines for Coding and Reporting prohibit inpatient coders from assigning codes based on the pathology report. Outpatient coders can do it, but inpatient coders can’t. It’s a distinction that frustrates us just as much as it frustrates physicians.

To complicate matters further, the Uniform Hospital Discharge Data Set (UHDDS) defines the principal diagnosis as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.” For neoplasm-related admissions, the “after study” diagnosis is often the diagnosis documented only in the pathology report. This means CDI specialists or coders ask physicians to document the clinical significance of pathology findings in the discharge summary even if the results were not available until after discharge.

Physicians’ responses to these queries can be negative. You may hear responses like, “I can’t addend a chart with pathology results that came back after discharge—you’re asking me to commit fraud!” Or there may be concern about medical legal risk. This concern is understandable and laudable, but also unfounded.

It is compliant and necessary that the pathology findings be documented in the discharge summary, even if they became available after discharge, because the specimen was collected during that admission and the pathologic diagnosis is the diagnosis after study.

One final note: Copying and pasting the pathology findings into the discharge summary isn’t enough. We need a physician’s clinical interpretation of those findings.

5. Primary versus secondary sites

When commenting on pathology findings or documenting known cancer, please document the primary and all known or suspected secondary sites of cancer. More than that, please document any adjacent tissue/organ that you suspect or know is involved, particularly if this involvement is impacting the tumor management.

The Official Guidelines for Coding and Reporting indicate that invasion of a malignant tumor from one organ/body part into another should be coded as a secondary cancer (metastasis). An example of primary site with secondary site invasion is a pituitary malignancy that invades/involves the surrounding brain tissue. This would be coded as primary pituitary malignancy with secondary brain malignancy/brain metastasis.

It might make some providers uncomfortable—perhaps even indignant—to know that local involvement/invasion is coded as metastasis, since metastasis clinically indicates distant spread of the malignancy, not local invasion. I believe, however, that clinicians will agree that there is a difference in severity between a duodenal cancer that can be resected and a duodenal cancer that involves the superior mesenteric vein, making the tumor unresectable. Coding the superior mesenteric vein invasion/involvement as a secondary site of cancer is
compliant with coding guidelines and allows us to capture that difference in severity.

It should be noted that the guidelines do not allow the coding of tissue layer invasion. In other words, a uterine cancer that involves more than one layer of the uterine wall is not coded as uterine cancer with metastasis. If the uterine cancer has invaded adjacent colon tissue, however, that may be coded as a secondary site.

4. Reason for admission

In many cases when providers may logically think that they’re admitting a patient due to cancer, the cancer isn’t always the principal diagnosis from a coding perspective. If the patient is admitted for surgical resection of cancer, it’s a no-brainer that the cancer is principal. If the patient is admitted with symptoms that lead to a new diagnosis of cancer, the cancer will be the principal diagnosis.

When a patient is admitted with symptoms related to a known malignancy, however, things start to get complicated. If you’ve linked the symptoms to cancer progression in the documentation, the cancer will likely be sequenced as the principal diagnosis. The more common scenario, though, is that if the symptoms are related to a complication of the cancer, the complication should likely be the principal diagnosis.

Consider a patient who was admitted with bile duct obstruction related to known pancreatic cancer and common bile duct stents were placed. From a clinical standpoint, the admission was due to the cancer, but from a coding standpoint, the admission was for treatment of the bile duct obstruction. If the documentation is not clear regarding the obstruction, a query may be sent to clarify. If, for instance, the documentation consistently indicates, “Patient with known pancreatic cancer admitted with jaundice. An endoscopic retrograde cholangiopancreatography was performed and bile duct stent placed,” and there is no clear documentation that bile duct obstruction was present, a query will be necessary.

Similarly, think about a patient admitted for altered mental status (AMS) in the setting of brain cancer that improves with dexamethasone treatment. In this case, is the AMS due to the cancer or due to the associated cerebral edema? And can the AMS be further classified as encephalopathy?

This kind of clarity and specificity in the documentation impacts the principal and secondary diagnosis assignment and consequently the reimbursement, length of stay, severity of illness (SOI), and risk of mortality (ROM). We know sometimes you can’t pin symptoms to one specific cause or aren’t comfortable doing so. In those cases, please document what you think the cause could be and what you’re treating. For example, “Encephalopathy: likely due to known brain metastasis with associated cerebral edema. Mental status improved with dexamethasone” is excellent documentation, but keep reading to improve it further.

3. Uncertain diagnoses

“Uncertain diagnosis” is the term that coders (and the Official Guidelines) use to describe diagnoses documented as “probable,” “suspected,” “likely,” “questionable,” “possible,” “still to be ruled out,” “compatible with,” “consistent with,” or other terms that indicate uncertainty. Uncertain diagnoses cannot be coded in the outpatient setting. They can, however, be coded in the inpatient setting as long as the diagnosis in question is still suspected at the time of discharge.

For inpatient encounters, to support code assignment, the discharge summary must include documentation of any condition that is uncertain, but was treated during admission and not ruled out at discharge. If that documentation of “encephalopathy likely due to known brain metastasis and associated cerebral edema” doesn’t make it into the discharge summary—even if well supported by clinical evidence in the record—a payer/auditor could challenge the diagnosis, quote the Official Guidelines, and say that because it is not documented in the discharge summary, it must have been ruled out.
2. Cancer as a secondary diagnosis

Coding malignancy as a secondary diagnosis often contributes little to a patient’s overall SOI/ROM scores for an inpatient admission, which might seem wrong. However, remember that people don’t actually die from malignancy; they die from complications that arise due to the malignancy. Similarly, for inpatient encounters when malignancy is not directly or indirectly the reason for admission, it’s the complications of malignancy that are likely to increase resource consumption, require monitoring and treatment, and extend the length of stay.

With that in mind, it’s important that physicians and mid-level providers document any and all complications of the malignancy that are being monitored or treated, including (but not limited to):

- Obstructions and organ dysfunctions
- Any bleeding related to the cancer (such as hemorrhage from esophageal cancer)
- Brain compression or cerebral edema related to brain metastasis
- Hematological diagnosis related to the cancer or the treatment (anemia, thrombocytopenia, pancytopenia)
- Dehydration and electrolyte abnormalities
- Cancer cachexia and malnutrition

You might be surprised by how much coding these things can affect SOI, ROM, and expected length of stay. The more thorough your documentation of neoplasms and neoplasm-related complications, the better for your observed to expected outcomes.

1. We’re all on the same team.

Several years ago at an ACDIS conference, one of the speakers said something like this: “We think differently. Aren’t we lucky?” I’m reminded of this often, particularly when it’s clear there’s been a breakdown in communication between a CDI professional or a coder and a physician. Although we approach the documentation from different perspectives and rely on it to accomplish different tasks, our goal is ultimately the same. We all want to work in a facility with an excellent reputation and top-notch resources available to provide the very best patient care. You do the hard part providing that care; please trust that when we query you, we’re doing what we can to help you reach that goal.

Editor’s note: Nehring is the inpatient lead coder at a large teaching hospital in central Illinois. Contact her at nehrings4@gmail.com. Opinions expressed do not necessarily reflect those of HCPro, ACDIS, or any of its subsidiaries.
Within the constantly evolving healthcare landscape, physicians are under more and more pressure to not only provide exceptional patient care and correctly diagnose patients, but also undertake an increasing amount of administrative tasks. A recent study published in the Annals of Internal Medicine found that physicians spend an average of 16 minutes and 14 seconds per patient encounter using electronic health records (EHR). Another report from the National Academy of Medicine found that between 34% and 54% of doctors and nurses experience burnout from long hours and added need of after-hours documentation.

To help provide insight and suggestions for CDI professionals to ease these burdens, ACDIS has begun the Provider Engagement Series. This written collaboration with the ACDIS Advisory Board intends to discuss the why and how of provider engagement and the critical role CDI plays in fighting physician burnout and providing EHR support.

According to Tracy Boldt, RN, BSN, CCDS, CCDS-O, CDIP, manager of CDI for Essentia Health in Duluth, Minnesota, a large reason her team has had success with provider engagement is because they’ve tailored their approach to physicians’ needs, adjusting for differences in methodology between the system’s hospitals.

“One of our hospitals rounds three days a week in critical care,” she said on a recent episode of the ACDIS Podcast: Talking CDI. “Other hospitals will attend meetings once a month or just have ad-hoc meetings.”

The CDI team at Essentia Health attends most of the physician orientations, but team members split time and duties between on-site and remote work. “We use a hybrid approach,” Boldt said. “Some of our staff is more comfortable being in the facility, others prefer to share that time working from home.” Their program has someone on-site in most of their hospitals a majority of the time, just not the entire team.

This approach—allowing staff to determine what works for CDI and physicians alike—lets the Essentia Health CDI team play to the culture of each facility in their organization. The CDI specialists become resources for the clinicians rather than just asking them to do more administrative and documentation work.

“One of our facilities has a really strong relationship with individual providers,” Boldt said. “They will reach out for help with documentation-related questions.” And, she said, it’s not always just documentation physicians need help with—they sometimes ask for assistance with EHR-related questions, too. “They might need help with preference lists or smart phrases,” she said, “but in general, it’s all around helping them perform excellent documentation at the point of care, so I think that’s what you’re getting at is how do you engage providers beyond a query.”

Being a resource for non-documentation-related questions, however, does require that the CDI staff receive education on topics outside their traditional CDI purview, Boldt says. To avoid scope creep, Boldt suggests playing to the existing strengths of your team.

“We have a CDI specialist who is very good with the EHR [and they have] good relationships with the IT team,” she said. She explained that when there is a request by a particular specialty or department, the person on
the CDI team with the applicable knowledge will work together with the requester to find a solution. “It is really important as a manager to ensure you see all of what a team is willing to do but also wants to do,” Boldt said.

While queries are an easy way to get something sent electronically, if you are not in front of physicians and becoming their partner, you’re doing them a disservice. Because of this, Boldt is a “believer in reducing queries.” Making themselves available to the physicians for questions and making sure physicians know that the CDI team is there as a resource has helped Boldt’s team decrease queries over time.

Of course, it’s all well and good to “believe” in reducing queries and improving physician engagement, but CDI leaders are often hard pressed to determine the best ways to track and trend their progress. Many CDI teams, including Boldt’s, use homegrown tracking systems built through Excel® spreadsheets and customize the items to their needs. When it comes to tracking physician engagement efforts, you need to look at data points beyond the normal slew of performance indicators (query response rate, agree rates, etc.).

“The CDI team will document on a spreadsheet the hours they spend away from chart review, and if those hours are for their own education or physician education,” Boldt said. The spreadsheet can be sorted to look at particular specialty areas and see how many hours have been dedicated to that team. Boldt’s program also uses an external vendor that allows them to look at predictive analytics, home in on particular departments or physicians, and compare with peers in relation to documentation opportunities.

Time away from the computer and regular record reviews can have a negative effect on productivity, especially if the organization has a review or query quota. According to Boldt, this issue can be partially assuaged by refocusing your productivity standards and looking at different measures than a daily quota. (For more information about query productivity, read the findings from our latest survey on p. 9.)

“Our productivity is based on monthly averages,” Boldt said. “We have a goal of expected charts per day, whether initial, concurrent, or retrospective, and then that average is totaled out by month. That allows for flexibility within the review process. […] I think our team will tell you they work hard every day ensuring documentation is portraying the efforts Essentia Health practitioners provide. At the end of the day, patient care is Essentia Health’s number one goal, and partnering with practitioners around documentation opportunities helps meet our overall mission.

Physician engagement doesn’t happen overnight, Boldt said. If you’re seeing fair or poor engagement among physician staff, Boldt suggests looking at your current practices and trying something different to improve those rates. “Perhaps it’s just the way you’re communicating,” she said. Maybe “they just need more case studies or elbow-to-elbow time with you. […] I highly encourage your CDI team become partners and advocate for the benefits of excellent documentation.” 🌟
Got queries? They need to be compliant

by Trey La Charité, MD, FACP, SFHM, CCS, CCDS

Let’s face it: Our organizations are under tremendous scrutiny. As the healthcare dollar shrinks, all payers strive to minimize patient care expenses to maintain profit margins. While the upfront denial of medical services is the largest weapon used against our facilities, recovery auditing of previously paid claims has become an increasingly popular (and painful) addition to the arsenal. Add the United States Office of Inspector General’s (OIG) desire to take back previously paid traditional Medicare funds, plus the added threat of levying the False Claims Act against you, and a healthy insecurity about your CDI efforts is warranted.

One area of risk unique to CDI is the physician query. Queries are likely the most widely used tool by CDI specialists to accurately portray a patient’s clinical situation. While the creation of the individual physician query usually garners most of the attention in these discussions, maintenance of query compliance is equally important and frequently overlooked. In other words, getting compliant tends to be the focus as opposed to ensuring the long-term persistence of that compliance. With this in mind, providing some methodologies to preserve query compliance should help keep your facility out of the penalty box.

The CDI specialist must first understand why monitoring for long-term query compliance is imperative. The most frequent reason a query is noncompliant is both simple and obvious: People are human. Humans make mistakes (I apparently make them all the time; just ask my wife!). When it comes to querying, honest errors are normal. The creator momentarily forgot the criteria for a compliant query.

If an honest mistake isn’t quickly discovered and corrected, however, the frequency of that mistake could increase. Over time, without intervention, a consistent pattern develops. Before you know it, your CDI peeps have innocently created a compliance nightmare.

Standardization

Standardization is one of the main mechanisms a CDI program can use to maintain long-term query compliance. Construction of disease-specific query templates is the gold standard. All members of the CDI team are expected to use the same specific query every time the same disease presents itself. The CDI specialist needs only to add the appropriate clinical indicators obtainable from the medical record before sending it to the provider.

Several CDI programs have over 100 effective, disease-specific query templates. Adopting this strategy has the added benefit of standardizing the appearance of the query. Physicians thrive on pattern recognition. When something is presented exactly the same way every time, success eventually occurs every time.

An additional consideration when creating standard templates is making the content and final question succinct and specific. Because of their time pressures, physicians have limited attention spans. A physician presented with a query containing a lengthy narrative will close it and move on. The more concise and direct the query, the higher the probability it will receive due diligence. I recommend presenting the clinical indicators in a bullet-point, “just the facts” format as opposed to the traditional paragraph format.

Lastly, I suggest placing the question before the clinical indicators that support the potential answers. This capitalizes on a test-taking strategy used by physicians. Physician board exams are comprised of questions that are notoriously long, with Tolstoy-length diatribes of clinical information. In all that text, however, there is usually only one small clue needed to answer the one-sentence question at the end. Physicians learn to skip the narrative and read the actual question at the bottom first. Then they go back to read the question, scanning paragraph by paragraph to find the clue they are now searching for.

Understanding the actual question being asked before reading the text is more effective and efficient than reading all the text first and hoping to remember the tidbit.
needed to ultimately choose the correct answer. Constructing queries similarly lets physicians use a practical and familiar strategy to read them.

**Query audits**

With that being said, the best mechanism for maintaining query compliance is regular query auditing. If your program doesn’t routinely monitor the quality of its outgoing queries, you have no idea of your effective compliance. Additionally, your educational efforts are unlikely to be reinforced. If this is the case, consider how many honest mistakes may have crept into your queries. Your entire program may be noncompliant with industry standards, all while you’re completely unaware.

This scenario creates a fertile ground for the OIG, who will intentionally misconstrue this lack of oversight as a “systematic effort to defraud the Medicare program” and deploy the False Claims Act. The fallout could be catastrophic for you and your organization.

While query audits take time, effort, and possibly additional employees you do not have, the alternative is too great a risk. Begin with quarterly audits to prevent becoming overwhelmed if you are insufficiently resourced. While monthly sampling should be the goal, this may not be a realistic starting point.

Next, pick a standard number of queries to review for each CDI specialist. I suggest initially reviewing five charts per CDI specialist if you are reviewing monthly and at least 10 if you are only able to review quarterly. This should give you a reasonable idea of the performance of each CDI staff member.

The specifics you should review for are variable. My recommendation is to start with a defined set of parameters and add other items for review as problems discovered by the initial set are ameliorated. Suggested starting points include:

- Did they use the correct query template? (if templates are utilized.)
- Can the query be construed as leading?
  - The question being asked should not include the desired answer.
  - The suspected disease process should be clinically present.
- The suspected disease process was not previously ruled out by another provider.
- Is there financial ramification information in the query regarding what MS-DRG, length of stay, or reimbursement would result if the query were answered correctly?
- Were all available and relevant clinical indicators included to support the suspected diagnosis?
- Are uncertain diagnoses (i.e., those diagnoses modified with words like “possible,” “probable,” “suspected,” “likely,” etc.) used in the question or in any of the potential answers?
- Do all queries, whether in multiple-choice or yes/no format, include one answer option of “unable to determine” and one answer option of “other” with space available for providers to add their alternative clinical opinions?

If time permits, the corresponding charts can be reviewed for significant diagnoses that were clearly clinically present but not documented to determine whether the CDI specialist failed to generate queries to capture those diagnoses. If you have questions regarding what you should be looking for in a query compliance review, the ACDIS *Provider Query Toolkit: A Guide to Compliant Practices* is a great resource. You can also review the article on p. 36 of this edition for more guidance on query audits.

In the current world of nonstop healthcare reimbursement review, the persistent belief is that the provider is guilty until proven innocent. Additionally, it is substantially easier and cheaper to prevent denials, recoupments, and compliance investigations than it is to fight through the arduous appeal processes. Every prevention effort employed will minimize revenue reclamation efforts that show up at your door. Regularly audit your queries—you may be surprised at what you find. 🕵️

**Editor’s note:** La Charité is a hospitalist at the University of Tennessee Medical Center at Knoxville, a clinical assistant professor, and the medical director of UTMC’s CDI program. He is a past member of the ACDIS Advisory Board and the author of three books. La Charité’s comments and opinions do not reflect necessarily those of UTMC, ACDIS, or its Advisory Board. To reach La Charité, email him at Clachari@utmck.edu.
Brian Simpson, MS, RRT, CCDS, CDIP, CCS, CCDS-O, CCS-P, CRC, is a CDI professional at Penn Highlands Healthcare in DuBois, Pennsylvania. He has been in the CDI field for just over four years.

**ACDIS: What did you do before entering CDI?**

**Simpson:** For more than 20 years, I worked as a registered respiratory therapist (RRT) and exercise specialist in critical care and then pulmonary and cardiac rehabilitation. In the year before I joined CDI, I worked as a clinical analyst in revenue integrity.

**ACDIS: Why did you get into this line of work?**

**Simpson:** I had a sudden deterioration in my lung function after suffering from severe chronic asthma my entire life. In a matter of two weeks, I went from running marathons to being dependent on supplemental oxygen 24/7. I had just begun a new position as a transition-of-care coordinator in our case management department. As it was apparent to my director that I could not work clinically anymore, she asked me if I would be interested in training for a CDI position. I currently face the decision of double lung transplantation and consider myself lucky to have found the awesome profession of CDI. If this hadn’t been offered to me, I would have had to have stopped working and accept disability.

**ACDIS: What has been your biggest challenge?**

**Simpson:** I think the biggest challenge was learning all of the many coding guidelines. It took a while to think not only as a clinician, but as a coder. It was a little difficult learning to write queries, especially when questioning a physician about clinical validity.

**ACDIS: What has been your biggest reward?**

**Simpson:** Working with new residents and following their progress in clear and concise documentation. Also, I’ve enjoyed explaining and helping them understand that we, as CDI specialists, are not “about the money” but about improving the continuity of care.

**ACDIS: How has the field changed since you began working in CDI?**

**Simpson:** I think the awareness and understanding of CDI has really increased. Seeing how most of our physicians have begun to understand and accept what we are trying to do, it’s been rewarding to send a query and see the physician response in the chart without a fight.

**ACDIS: Can you mention a few of the “gold nuggets” of information you’ve received from colleagues on The Forum or through ACDIS?**

**Simpson:** I’ve enjoyed reading many of the white papers and learning from the many query templates from different institutions. I’ve also had many questions answered through the ACDIS Forum, ranging from denials and appeals to certification exam prep.

**ACDIS: What piece of advice would you offer to a new CDI specialist?**
Simpson: Stay up to date with coding guidelines and be able to support your query if questioned by a provider. Stay humble when speaking with a physician and try not to be intimidated. Lastly, I would recommend reading your query at least two or three times before you send it. Be confident in your knowledge.

ACDIS: If you could have any other job, what would it be?

Simpson: I think being a travel guide author would be very exciting. To see so many beautiful and exciting places while being paid. What could be better than that?

ACDIS: What was your first job?

Simpson: Actually, my first job didn’t come until my senior year of my bachelor’s degree, when I began working as an ABG tech at a large teaching facility in Pittsburgh.

ACDIS: Can you tell us about a few of your favorite things?

- **Hobby:** Working on my bachelor’s degree in HIM, and when my health allows, traveling.
- **Non-alcoholic beverage:** Iced tea.
- **Foods:** Mexican and pizza.
- **Activity:** It used to be running, having competed over 20 half-marathons, 18 full marathons, and one ultra-marathon. Now it is going to the gym and working with a personal trainer in an effort to be as healthy as these lungs will allow.

ACDIS: Tell us about your family and how you like to spend your time away from CDI (if you wish).

Simpson: I am single and live with Duke (my 12-year-old English Springer Spaniel) and Henry (my 4-year-old tabby cat). I am very fortunate to have friends to travel and spend time with.

ACDIS: Is there anything else you’d like to add?

Simpson: I’m thankful every day to have the opportunity to learn and grow in such an interesting field.