Physician Queries: The Good, the Bad, and the Ugly

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Learning Objectives

• At the completion of this educational activity, the learner will be able to:
  – Describe the AHIMA/ACDIS Query Brief and its significance to the concurrent query process
  – Generate compliant and appropriate query statements
  – Identify appropriate language to query for supporting clinical indicators for unsupported diagnoses in the medical documentation
  – Define query opportunities in varying clinical scenarios

Agenda

• Review of the 2013 AHIMA/ACDIS query brief
• Importance of clinical indicators
• Query process
• Unsupported diagnoses
• Clinical examples
Compliant or UGLY?

Query on first day of admission:
Based on documentation, 96 Y/O female patient with PMH: anemia, colitis, spastic colon, dementia, DM2. In your professional medical opinion, please clarify the known primary diagnosis (possible/probable), for which you are evaluating, monitoring, and treating as per clinical indicators above. Please indicate acuity as acute/chronic/acute on chronic and if POA (present on admission).

Query Goal

• “The desired outcome from a query is an update of a health record to better reflect a practitioner’s intent and clinical thought processes, documented in a manner that supports accurate code assignment”

• What is the desired outcome?
Goal: Accurate Code Assignment

• How do you get there?
• How do you ask a specific question without being “leading?”
• What separates a good or compliant query from an UGLY query?
• Can a query be compliant and still target specific documentation issues?

When to Query?

• “The generation of a query should be considered when the health record documentation:
  – Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
  – Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
  – Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
  – Provides a diagnosis without underlying clinical validation
  – Is unclear for present on admission indicator assignment”

• Was it fair to ask the question this early in the chart?

Timing Is Everything

- Identification of the query
  - How soon into the admission?
  - Does an H&P need to be reviewed?
- Clarity and consistency
- Earlier rather than later
- Assisting with identification of present on admission (POA)

Communication of the Query

- Communication of the query
- Posting through electronic means
- Leaving a paper copy
- Contacting a physician (phone/pager)
- Contacting a physician’s office
- Face-to-face interaction

Best time for a physician to discuss
Timing the Conversation

- Identify teachable moments
- Participation during rounds
- Scheduled appointments
- Physician meetings

Compliant or UGLY?

- A patient with history of DM and COPD is admitted to the ICU from a nursing home with pneumonia. The admitting H&P examination reveals a WBC of 14,000; a respiratory rate of 24; a temperature of 102 degrees; heart rate of 120; hypotension; and altered mental status. The patient is administered an IV antibiotic and IV fluid resuscitation.

- The patient has elevated WBCs, tachycardia, and is given an IV antibiotic for Pseudomonas cultured from the blood. Are you treating for sepsis?
What’s the Issue?

• Plenty of clinical indicators
• Not enough choices
  – What other diagnoses may be possible?
  – Does the query allow the physician to say no?

Therefore perceived as leading

Compliant or UGLY?

• Based on your clinical judgment, can you provide a diagnosis that represents the below-listed clinical indicators?
• In this patient admitted with pneumonia, the admitting history and physical examination reveals the following:
  – WBC 14,000
  – Respiratory rate 24
  – Temperature 102°F
  – Heart rate 120
  – Hypotension
  – Altered mental status
  – IV antibiotic administration
  – IV fluid resuscitation
• Please document the condition and the causative organism (if known) in the medical record

But will the physician understand what documentation is needed?
**Target the Concern**

- Specificity allows for easy identification of appropriate clinical indicators
- Physicians say “Tell me what I need to know”
- Where is the line between leading and non-leading?

**How to Query**

- “Although open-ended queries are preferred, multiple choice and “yes/no” queries are also acceptable under certain circumstances.
- Multiple choice query formats should include clinically significant and reasonable options as supported by clinical indicators in the health record, recognizing that there may be only one reasonable option.”

Introduction of Diagnoses

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

• Allows for specificity in the query

Getting the Documentation

• Conversation
  – Teachable moments
    • “Can you help me understand …”
• Follow up
  – Persistence to resolution
• Options
  – Other physicians involved in the care?
• Escalation
  – Physician champion
Verbal Queries

• “Because the patient record should provide a sequence of events, best practice is to capture the content of a verbal and/or written query, as well as any practitioner response to the query. This practice allows reviewers to account for the presence documentation that might otherwise appear out of context.”

• Verbal queries should be captured in the same manner as written queries.


Compliant or UGLY?

• Based on your clinical judgment, assessment of the patient, and clinical indicators below, please clarify and document in a progress note and/or discharge summary if you are treating:
  Sepsis
  Severe sepsis
  Other condition _______________________
  Risk factors:
  – Nursing home resident
  – Hx DM and COPD
  Signs/symptoms
  – WBC 14,000
  – Respiratory rate 24
  – Temperature 102° F
  – Heart rate 120
  – Altered mental status
  Treatment
  – IV antibiotic administration
  – IV fluid resuscitation
  – ICU bed
  • Please document the condition and the causative organism (if known) in the medical record
Credibility

- CDS individually
- CDI program
- One opportunity for first impression
- Queries must be:
  - Clinically sound
  - Neat
  - Organized
  - Easily understood

Content

- Fact-based questions
- Open-ended
- Clinical in nature
- Asking for the physician’s/provider’s opinion
- Short and concise
Key Components to a Compliant Query

• “Include … the relevant clinical indicator(s) that show why a more complete or accurate diagnosis or procedure is requested.
  – Clinical indicators supporting the query may include elements from the entire medical record, such as diagnostic findings and provider impressions
• Should not indicate the impact on reimbursement”


Clinical Indicators

• Risk factors
  – The patient brings these to the hospital
    • History of a CVA
    • History of smoking
    • COPD
    • Weight loss reported over the last six months
    • Resident of a nursing home
Clinical Indicators

- Symptoms (patient complaints):
  - Headache
  - Back pain
  - Nausea

- Signs (assessment findings):
  - Vital signs
  - Lung or heart sounds
  - Results of various laboratory and radiology studies

Example: Feeling thirsty is a symptom of dehydration; poor skin turgor is a sign of dehydration

Clinical Indicators

- Treatment:
  - Medication
  - Surgery
  - Planned investigations
  - Consultations
  - Holding some treatments
    - Hold Lasix due to dehydration
  - Includes planned interventions as an outpatient
    - Outpatient GI consult for “chest pain”
A Minute to Discuss TREATMENT

• Coding guidelines
  – Clinical evaluation
  – Therapeutic treatment
  – Diagnostic procedures
  – Extended length of hospital stay
  – Increased nursing care and/or monitoring

Non-Leading Query

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

Use of clinical indicators assists in preventing a query from being leading.
Compliant or UGLY?

• The following clinical information needs clarification. For accurate coding and severity-of-illness reflection, please reply to this query and provide any corresponding diagnoses for the clinical picture listed below.
  – Pt 71 yr old female admitted with chest transcervical fx of femur with ORIF repair. HGB 11.7 dropping to 8.5 and HCT 35.1 dropping to 26.0. Treatment with transfusion of 2 units PRBC and continued monitoring of labs.

Compliant or UGLY?

• Based on your clinical judgment and assessment of the patient, please clarify and document in a progress note and/or discharge summary if you are treating:
  – Acute blood loss anemia
  – Anemia, unspecified
  – Chronic anemia
  – Other: ________________________________
Additional Query Issues

Unsupported Diagnoses

Query example:

• To ensure accurate and compliant reporting of all diagnoses being monitored and treated during the patient’s stay, it is important to document the associated clinical indicators for each diagnosis. There is documentation of _______________ in the medical record. Please provide documentation of the clinical findings/assessment in your next progress note and the discharge summary to support reporting of this condition.
Unanswered Queries

- Appropriate clinical indicators
- Directed and compliant query
- Posted to physician twice
- Paged physician twice
- Left message at physician office

**NOW WHAT?**

Escalation

- “CMS recommends that each facility develop an escalation policy for unanswered queries and to address any staff concerns regarding queries. In the event that a query does not receive a professional response, the case should be referred for further review in accordance with the facility’s escalation policy. The escalation process may include, but is not limited to, referral to a physician advisor, the chief medical officer, or other administrative personnel.”

Escalation Process

• Development of facility policies and procedures
  – Supported by ACDIS and AHIMA
  – Provides consistency
  – Monitor outcomes to support necessary change
• Identification of physician champion
  – Peer-to-peer conversations
  – Clinical knowledge and support
• Oversight committee
  – Identify and eliminate barriers to process success
  – Celebrate and communicate success

More Examples
• Can the etiology of the patient’s pneumonia be further specified? It is noted in the admitting history and physical examination (H&P) this obtunded patient had a history of nausea and vomiting prior to admission to the hospital and is treated with clindamycin for RLL pneumonia. Based on the above, can the etiology of the pneumonia be further specified? If so, please document the type/etiology of the pneumonia in the progress notes.

• Patient was admitted with a UTI and possible lobar pneumonia/RLL. Sputum culture still pending but does have many bacteria present along with many white blood cells. In coding language, lobar pneumonia refers to a type of pneumonia, not the location. In your opinion, are you treating:

1. Lobar pneumonia
2. Viral pneumonia
3. Bacterial pneumonia
4. Simple pneumonia
5. Unable to determine
6. Other ____________________________
Compliant or UGLY?

Based on your clinical judgment and assessment of the patient, please clarify and document in a progress note and/or discharge summary if you are treating:

- Metabolic encephalopathy or
- Other condition _____________________
  - Risk factors: elderly patient with hx CVA and dementia admitted with pneumonia and acute renal failure
  - Signs/symptoms: AMS, negative head CT
  - Treatment: neuro consult, neuro checks, IV abx

Compliant or UGLY?

Based on documentation, 72 Y/O with hx of smoking, emphysema, HTN, pulmonary nodule; presents with severe SOB, hypoxia, 53% RA, two-word dyspnea, tachy-HR 126, RR 32, 99% on 10 L nebs. Zithromax given. Per H/P “chronically hypoxic,” COPD exacerbation. Per your PN: Acute hypoxic respiratory distress due to severe COPD exacerbation, accelerated HTN in ED.

In your medical opinion, based on the above clinical indicators and treatment, please clarify if you are treating a possible or suspected (even if resolved):

- Acute respiratory failure
- Chronic respiratory failure
- Acute on chronic respiratory failure
- Other more appropriate diagnosis
Compliant or UGLY?

In your clinical opinion, is there an additional corresponding medical diagnosis related to the following clinical information?

- Risk factors: 84 WM with COPD, s/p herpes simplex with related personality changes, symptomatic cholelithiasis s/p lap chole, and recent URTI which is not clear per H&P.
- Clinical indicators: 2/27 surg: POD2. Low-grade fever is of concern, although he does not appear septic.
- Treatment: Begin empiric abx with Cefepime, Vanco, and Metronidazole, pending C&S.

Thank you. Questions?

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