WHITEPAPER

AAPC

Do Your Physician Queries Hold Up to Payer Scrutiny?

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I was talking to a colleague the other day about when and how to query and the importance of avoiding the pitfalls of a leading query.

While we've all received education regarding queries, there still seems to be a gap in understanding. My colleague expressed frustration for being asked to write queries when there is either not sufficient clinical support, querying for a CC/MCC symptom that is not appropriate to report separately, or writing a leading query that the facility does not recognize as a leading query. Not only is my colleague an auditor, she is also a nurse who has worked in Clinical Documentation Improvement (CDI) Programs, so she understands both sides of the situation.

In today's reimbursement world, finding every CC/MCC to ensure the MS-DRG/APR DRG has the highest yet most appropriate value is an absolute necessity. Facilities using a post-discharge review with a team of nurses, coders, and physicians to identify missed potential CC/MCCs are doing it right.

Coders do not have the level of clinical knowledge that CDI staff do, which is why teamwork between the two creates the best results.

Writing a query that is not only compliant but truly necessary is critical to ensure correct code assignment, the integrity of the medical record and the information contained within. With the evolution of electronic medical records and the creation of query templates to assist coder and CDI teams, it's imperative that both still use critical thinking skills to ensure that the query being submitted is compliant and not wasted effort.

Many hospitals have implemented — and educated their staff on — a query practice and corresponding templates. This has resulted in some policies developing an "always query for…" scenario, which is useful. This may range from always querying for the specific type which is acute vs. chronic or with conditions such as unspecified COPD vs. COPD with respiratory failure. Even with these policies in place, ensuring that queries are written appropriately and submitted for the correct reason is critical to make sure the data in the medical record accurately depicts the complexity of care received.

The medical record is a nonfiction story. It tells the story of a person in the hospital; and like every story, there is a beginning, a middle, and an end. Within this story is an abundant amount of information regarding what occurred during the hospital stay. Loosely, coders extrapolate information from this story to determine why the person is there, the events surrounding the reason for the visit, and at the end, assign a DRG (be it MS-DRG or APR DRG) that provides a 'financial summary' of the story.

There are multiple authors in this story and the information does not always sync well. There can be missing pieces, conflicting information, statements without clear support or evidence, illegible documentation, as well as other issues. This is where queries come in. They help find the missing pieces (diagnoses or procedures) and resolve conflicting statements (patient has Acute Renal Failure by Dr. A, no evidence of Acute Renal Failure by Dr. B). For example: the patient has acute respiratory failure, but there are no lab values or clinical evidence documented to support the statement.

Many of the issues my colleague and I run into as auditors is that the queries being written are either not compliant — they are leading or lack sufficient clinical support — or they violate The Official Guidelines for Coding & Reporting. The result? The diagnosis documented is rejected in the audit, which generally results in a DRG adjustment, usually to a lower weighted DRG. The American Health Information Association began providing compliance briefs in 2001 to ensure the integrity of queries being submitted, and create standardization of a query practice to ensure consistency and accuracy with the joint effort of ACDIS starting in 2013.

Knowing when and how to write a query can be a difficult process, especially for new coders. The CDI teams provide support to the entire process and occasionally even they have difficulty, particularly when querying for a CC/MCC that may violate coding guidelines. With the advent of ICD-10, coders must have more of a clinical understanding than they used to, and the CDI staff need more coding support. With the two teams working in harmony, they are a powerful tool.

When to Query

So, when should we query? As per AHIMA 2020 Guidelines for Achieving a Compliant Query Process:

- "To support documentation of medical diagnoses or conditions that are clinically evident and meet Uniform Hospital Discharge Data Set (UHDDS) requirements but without the corresponding diagnoses or conditions stated

- To resolve conflicting documentation between the attending provider and other treating providers (whether diagnostic or procedural)

- To clarify the reason for inpatient admission

- To seek clarification when it appears a documented diagnosis is not clinically supported

- To establish a diagnostic cause-and-effect relationship between medical conditions
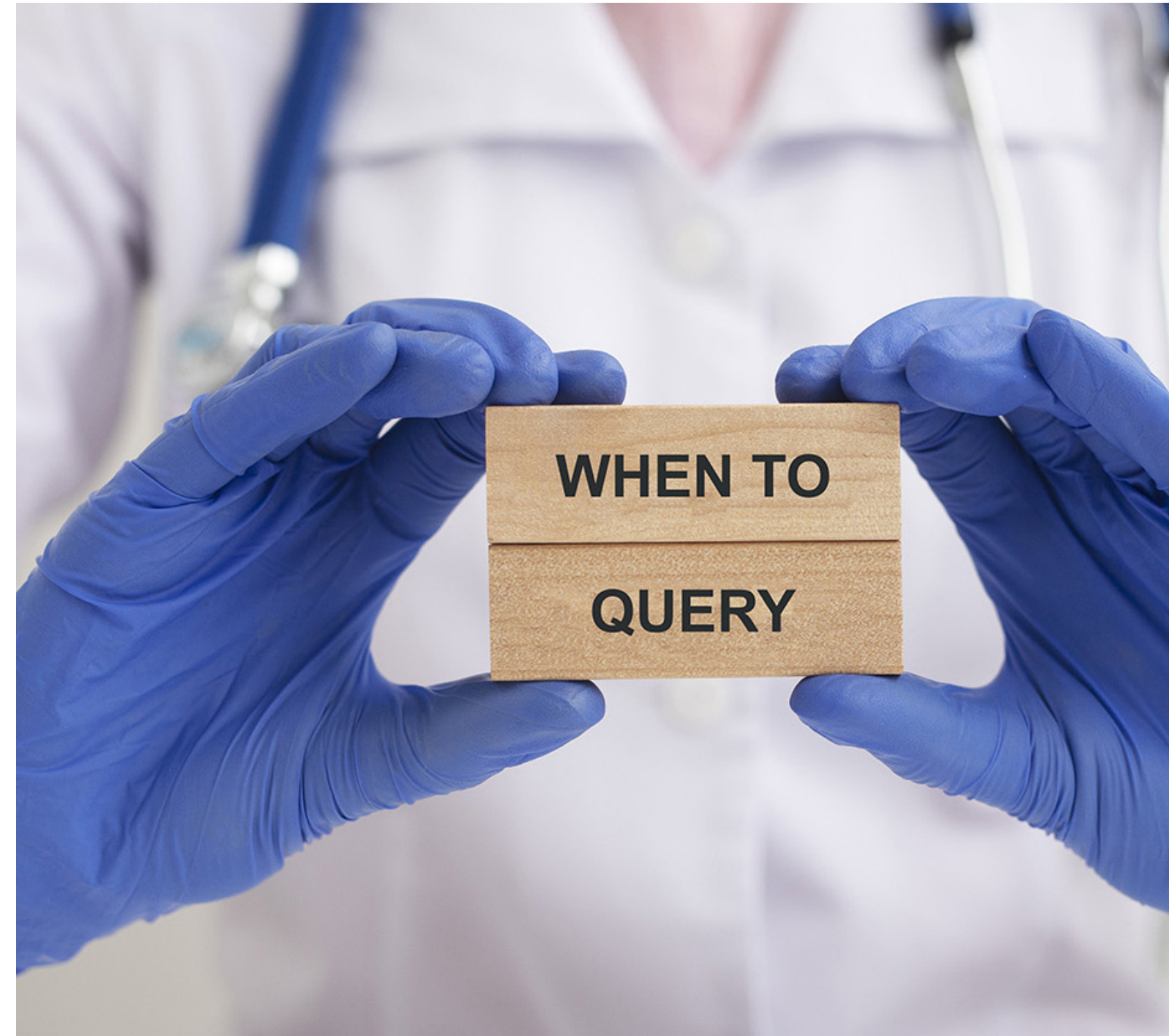
- To establish the acuity or specificity of a documented diagnosis to avoid reporting a default or unspecified code

- To establish the relevance of a condition documented as a "history of" to determine if the condition is active and not resolved

- To support appropriate Present on Admission (POA) indicator assignment

- To clarify if a diagnosis is ruled in or out

- To clarify the objective and extent of a procedure"

Sounds easy, right? Most often yes, but there are moments when it's not entirely clear when looking at the medical record. For example:

A patient is admitted to the hospital for a CVA. Three (3) days post-admission, the patient is stable and appears to be doing well. The patient suddenly goes into cardiorespiratory arrest, a code blue is called, and the patient is intubated secondary to the cardiorespiratory arrest and the patient expires. The death summary indicates only the following: CVA, chronic diastolic heart failure, and COPD for final diagnoses. No ABGs are drawn, there is no documentation of oxygen saturation, and all of the patient's lab values (up to this time) were within normal limits. A query was generated for respiratory failure. The query states as follows:

The patient is admitted due to CVA and went into respiratory arrest and then was intubated.

Could you confirm if the patient had:

- Acute respiratory failure
- Acute on chronic respiratory failure
- Other
- Clinically undetermined

Is this a compliant query based on the AHIMA guidelines provided? Technically, it could meet the cause and effect between two conditions, but this is not a compliant query. Here's why:

1. There is no clinical indication documented to support asking for respiratory failure. No ABG, no documentation of respiratory distress, no O2 sats.

2. Code blue documentation notes the reason for intubation is the cardiorespiratory arrest.

3. The query itself is not compliant as it:

   1. Did not provide any clinical indicators to support the request

   2. Lead the provider to only respiratory failure and did not provide any other conditions that would support the intubation (i.e. airway protection).

Had the physician answered the query in the affirmative, despite it not being compliant, and it was coded to acute respiratory failure, the DRG would have gone from 065 to (CVA w/o CC/MCC) to 064 (CVA w/MCC) resulting in a reimbursement difference of approximately $8500.00. (MS-DRG).

According to AHIMA's compliance brief, "All queries, including verbal queries, should be memorialized to demonstrate compliance with all query requirements to validate the essence of the query (see below).

Regardless of how the query is communicated, it needs to meet all of the following criteria:

- Be clear and concise
- Contain clinical indicators from the health record
- Present only the facts identifying why the clarification is required
- Be compliant with the practices outlined in this brief
- Never include the impact on reimbursement or quality measures

As we see in the above query, one of the criteria was not met, resulting in an invalid query — outside of the fact that there was no support to even justify a query.

How to Query

It's not just knowing when to query, it's also how. Had the above example documented more information (e.g., difficulty breathing, decreased oxygen saturation levels, SOB, etc.), those indicators would support the need for generating the query for respiratory failure. With this and the addition of one more multiple choice of 'airway protection,' it would have been a compliant query.

Let's take a look at the components of a query. There are three: supporting information/clinical evidence, the question, and the options.

When creating a query, there needs to be documentation/ evidence to support the question. Unlike the example above, a proper query would provide clinical support, either in the form of lab values, diagnostic statements, or both to support the question.

The next step is to ask the question in such a way that it does not directly lead the physician to the answer you want (if you are looking for a diagnosis of say "acute blood loss anemia," the question given cannot lead to only that response).

If you want a specific diagnosis, say, acute respiratory failure, when using the multiple-choice query, acute respiratory failure cannot be the only diagnosis provided. There should be other reasonable options that the clinical criteria can support (acute respiratory distress, acute respiratory distress syndrome, etc.).

Types of Queries

There are three types of queries: open-ended, multiple-choice, and yes/no. The multiple-choice query is the most popular. So, how do you decide which one to use?

Open-ended queries are good for situations when the documentation is clear the patient is being treated for a condition, but there is not enough information to create a multiple-choice or a yes/no query. For example:

A patient is admitted with the following: short of breath, respiratory rate of 24, a temperature of 101.4, heart rate of 120, physical exam notes increased work of breathing, rhonchi, and sputum culture positive for Klebsiella, and treated with IV Rocephin.

> Query: Documentation notes that the patient is short of breath, has a respiratory rate of 24, a temperature of 101.4, heart rate of 120, physical exam notes increased work of breathing, rhonchi, and sputum culture positive for Klebsiella, and treated with IV Rocephin.
>
> Based on your clinical judgment, if clinically significant, can a diagnosis be provided for the above symptoms and treatment

Yes/No queries are used to provide further clarification of a diagnosis already documented and needs further specification. Typically used for provider clarification of a diagnosis found in radiology/laboratory, pathology, and other diagnostic reports. For example:

A patient is admitted due to a sigmoid colon mass and undergoes an excisional biopsy. The discharge summary final diagnosis is mass in the sigmoid colon. The pathology report notes adenocarcinoma of the sigmoid colon.

> Query: The patient admitted secondary to mass in the colon underwent excisional biopsy. Pathology findings note the patient has adenocarcinoma. Do you agree with pathology findings?
>
> > Yes – agree with pathology findings
> > No – do not agree with pathology findings.

A Yes/No query cannot be used to provide a new diagnosis.

Multiple-choice queries are used when various conditions can meet the clinical criteria and clarification as to the condition being treated is needed. A new diagnosis can be introduced, provided there is clinical support for the diagnosis. For example:

Clinical indicators/evidence: the patient is short of breath, with increased work of breathing, tachypnea, SpO2 of 88 on room air, ABG pO2 <60 on room air. The patient was on BiPap and NC 4L. Based on your clinical judgment, please specify if the patient is being treated for:

- Acute respiratory failure
- Chronic respiratory failure
- Acute on Chronic respiratory failure
- Acute respiratory distress
- Acute respiratory distress syndrome
- Other (please specify)
- Clinically undetermined

Please further specify the type of respiratory failure if indicated:

- Hypoxia
- Hypercapnia
- Hypercarbia

Guidelines for a Compliant Query Practice

Why is this so important? An inappropriately written query reduces the integrity, accuracy, and reliability of the documentation in a medical record. It also has financial implications if the record is audited and the query is rejected as a leading query and the resulting diagnosis that had a DRG impact is removed. Then, the facility needs to reimburse the payer. You can avoid these pitfalls by ensuring your queries are written when and how they should be.

You can ensure that the queries you write meet the Guidelines for a Compliant Query Practice with this quick checklist:

1. Does it meet one of the AHIMA requirements for querying?
2. Does my query have all the information needed to support the query? Any or all of the following:

    1. Documentation of clinical evidence
    2. Documentation of treatment
    3. Documentation of supporting lab and other diagnostic results if appropriate

3. Does my question lead the provider directly to the answer I am seeking?

    a.   Yes? Re-write the query
    b.   No? Good to go!

4. Is my query in the correct format? (open-ended, multiple-choice, yes/no)
5. Does my query have all of the following criteria:

    1. Clear and concise language
    2. Contains clinical indicators from the health record
    3. Presents only the facts identifying why the clarification is required
    4. Does not include the impact on reimbursement or quality measures
    5. Compliant with the AHIMA Guidelines for Achieving a Compliant Query Practice

Knowing when and how to write compliant queries is difficult, but necessary. With practice and assistance from CDI professionals as well as management staff, it can be done. Have faith in yourself and happy querying!

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