Dust off query efforts to comply with industry changes

Okemena Ewoterai used to take a folder off a shelf and peer through the papers inside looking for hints—scraps of stories that could lead her to a better understanding of why a particular patient needed to be in her hospital. When she found them, Ewoterai would pull out a piece of paper of her own and send a query to the treating physician hoping to gain clarification.

"When I started, everything was on paper," says Ewoterai, associate director of clinical documentation improvement at Montefiore Health System in New York City's Bronx borough. "We'd write the query and find the physician out on the floor."

CDI query practices have changed a lot over the years—from queries stuffed into paper charts, to verbal interactions captured in the medical record, to the fully vetted processes and electronically interconnected systems of today. With so many shifts, CDI specialists may need to take a step back and take stock of the changes they've worked through, reassessing current practices against industry recommendations and shoring up policies to prevent well-known pitfalls.

Industry recommendations

In 2001, AHIMA published its first query practice brief, "Developing a Physician Query Process," thus creating an industry standard on which facilities could base their own query policies and procedures. In it, AHIMA outlined documentation expectations for both physicians and coders, identified possible query formats, and provided definitions to help describe leading queries.

In 2008, AHIMA crafted its "Standards of Ethical Coding," which further delineated coding and querying activities, stating that HIM/coding professionals could only assign codes and data "clearly and consistently supported" by documentation "in accordance with applicable code set and abstraction conventions, rules, and guidelines." Furthermore, when such information is missing, the "Standards" directed coders to "query the provider for clarification and additional documentation prior to code assignment."

Following the 2007 CMS implementation of MS-DRGs, however, AHIMA updated its recommendations with the publication of "Managing an Effective Query Process" in 2008. The brief limited queries to situations where the documentation is conflicting, ambiguous, or incomplete, and reiterated that those submitting queries should not direct the

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>
> *Fran Jurcak*

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physician to any particular diagnosis, nor indicate any financial or quality reporting outcomes as a result of any potential answer that the physician might provide. The brief offered additional specifics about various query media, stating that handwritten sticky notes, scratch paper, or other notes that could be easily removed and discarded are not permissible.

At the time, AHIMA recommended the use of standardized query forms which included checklists of possible diagnoses along with options for "unable to determine" and "other." Simpler "yes/no" questions, it said, were not permissible, except in determining whether the condition was present on admission.

Query guidance changed again in 2010, as members of ACDIS joined with AHIMA on its "Guidance for Clinical Documentation Improvement Programs," which more definitively addressed the issues of leading versus non-leading queries, offered a checklist for conducting compliant written and verbal queries, and acknowledged the important role that the verbal query process plays.

In 2013, ACDIS and AHIMA again collaborated to create the "Guidelines for Achieving a Compliant Query Practice." Although updated in 2016 to reflect changes associated with the ICD-10-CM/PCS implementation, it remains essentially unchanged and represents the latest rules governing physician queries. The brief defined leading queries and offered recommendations for handling clinical validation concerns.

With all this information, different professionals interpret query practices in different ways, says **Fran Jurcak, MSN, RN, CCDS,** director of clinical innovations at Iodine Software in Austin, Texas, a committee member on several practice briefs.

Some programs implemented ultra-conservative query policies that mandated inclusion of items recommended in the earliest practice briefs, such as always offering options for "unable to determine" or "other" on query forms.

> **The whole industry has grown up in the past 10 years. It is more professional in its query processes than it was in the beginning.**
> *Shelia Bullock*

Many programs still conclude queries with unnecessary disclaimers reminding physicians that the query in no way intends to question the clinical judgment of the provider, Jurcak says.

"I get that there's a long history here and a fear around being compliant," she says. It stems from allegations of fraud related to upcoding by encouraging physicians to document conditions not clinically present in order to obtain better reimbursement.

But rather than sticking with outdated recommendations, CDI programs need to regularly review their policies and procedures and review queries to ensure adherence to those policies, she says.

Sometimes providing "unable to determine" or "other" as options actually allows physicians an opportunity to evade the question, Jurcak notes.

"We have more guidance now about what's compliant in terms of querying," says past ACDIS Advisory Board member **Shelia A. Bullock, BSN, MBA, CCDS, CCS, CAHIMS, CCM,** assistant professor of health informatics and information management at the University of Mississippi Medical Center in Jackson. For example, early query practice briefs didn't allow yes/no queries, but that interpretation changed.

"We don't use the phrase 'in your best medical judgment' on our query forms anymore," Bullock explains, "because, in reality, isn't the physician always supposed to use his or her best medical judgment? In years past, we put that on the query form as a way to assure the physician that we weren't trying to diagnose their patients."

This stems from lack of physician understanding in the early days of CDI, says Jurcak. Now, most physicians are now at least tangentially aware of documentation issues. "We've come a long way in physicians' acceptance of CDI," she says.

It isn't just query practice recommendations that CDI programs need to be informed about, either. To craft effective queries, CDI professionals need to stay abreast of disease processes and clinical recommendations, such as the recent shift in malnutrition assessment and the

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adoption of Sepsis-3 criteria by the Surviving Sepsis Campaign.

CDI professionals also need to review and apply changes included in the *Official Guidelines for Coding and Reporting* and *AHA Coding Clinic for ICD-10-CM/PCS* into query practices and adapt policy changes as needed, Bullock says.

For example, new recommendations included in the 2017 ICD-10-CM *Official Guidelines for Coding and Reporting* call on coders to base assignments on the provider's statement rather than on an independent interpretation of whether a condition exists. (Read the related article in the September/October 2016 edition of **CDI Journal,** "New rules add import to clinical validation queries.")

"There's always a need to reeducate the CDI team about practical query process and application of the coding guidelines," Bullock says. "In the end, you have to really be up-to-date on everything."

Electronic health records

Evolution of industry guidance aside, "the greatest change to the CDI query process has been the implementation of the EHR," says Bullock.

While many, like Ewoterai, remember paper and verbal queries, nearly all CDI programs, including Montefiore, now have some kind of electronic query system or hybrid EHR system in place. In some cases, such systems make tracking and reporting data and submitting queries easier, she says. In others, EHRs have introduced new difficulties.

At Montefiore, CDI specialists take their laptops up to the hospital floor with them. They use Epic and send a query via the messaging system to the physician's in-basket. A widget shows up at the top of the medical record to alert the physician that a query exists.

Many CDI programs have adapted EHR notes or alerts to their own query processes; others have purchased other software or hardware systems to help CDI staff prioritize reviews, interrogate the medical record, query the physician, and track responses and other important data related to the process. Some healthcare facilities have several EHR systems in play, says **Mark N. Dominesey, RN, BSN, MBA, CCDS, CDIP, CHTS-CP,** CDI manager at Children's National Medical Center in Washington, D.C.

Organizations taking this tack need to include CDI and coding concerns early in the implementation process, he says. "Too often, programs go with build-ons and afterthoughts that just don't work in the end. Interoperability helps, but those involved need to understand the intricacy of the query process to be effective."

Montefiore's query tracking system is separate from its EHR, but Ewoterai says it has taken the program's data assessment capabilities to a new level. The team reviews common query targets and can provide physician education based on those concerns. They can review documentation improvement opportunities by physician, as well, and create a physician report card as an additional method of education and improvement, she says.

"If a physician is constantly getting queries on sepsis, we can see that and we can educate, and we can see the progression of that physician's documentation," says Ewoterai.

Obstacles such as physician wariness, CDI learning curves, system integration, and copy-and-paste concerns persist, says **Staci Josten, RN, BSN, CCDS,** senior manager for CDI/UR Services at UASI in Cincinnati. EHR systems have spurred a desire for remote CDI efforts, allowing teams to review medical records from the comfort of their own homes and query physicians without the face-to-face interaction long known as a hallmark of CDI professionals.

"In an ideal world, you'd have a mix of remote and on-site staff—an appropriate mix," Josten says, because it takes a certain level of self-discipline to work well remotely while avoiding distractions, temptations, and laundry. Plus, face-to-face interaction is important for physician education and buy-in, she says.

"You might be a query machine and be able to review 30 records, and that's great," agrees Dominesey, "but CDI programs still need people out on the floor doing the rounds, learning, and educating the clinical care team."

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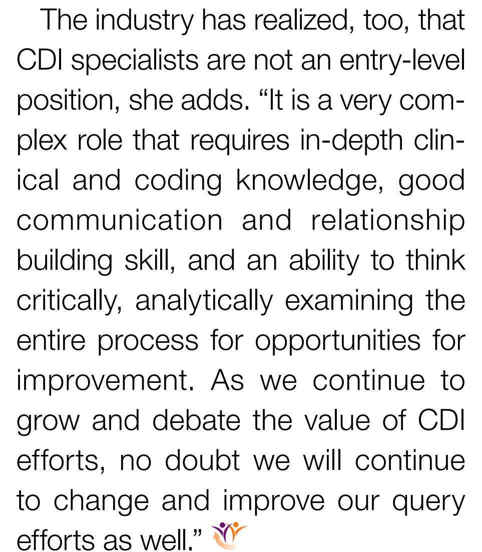
everything," says Jurcak, "but in the end, it still comes down to the CDI professional. You still need to find the appropriate information from within the medical record, deduce the overall clinical picture of the patient, and compose a succinct, compliant, effective query to the physician. We'll never replace CDI."

Query practice growth

Clearly, CDI queries have changed quite a bit since the days of colored sheets and sticky notes. To keep up with these changes, CDI programs need to:

- Establish facility or system-based query policies and procedures in alignment with industry norms
- Regularly review industry recommendations related to physician query efforts and amend policies and procedures as needed
- Educate staff as coding regulations and guidance shift
- Maintain awareness of alterations in clinical diagnosis and treatments
- Develop an internal query audit program to ensure CDI query compliance and assess improvement opportunities
- Review EHR and e-query practices against changes in the industry



"The whole industry has grown up in the past 10 years," Bullock says. "It is more professional in its query processes than it was in the beginning."

The industry has realized, too, that CDI specialists are not an entry-level position, she adds. "It is a very complex role that requires in-depth clinical and coding knowledge, good communication and relationship building skill, and an ability to think critically, analytically examining the entire process for opportunities for improvement. As we continue to grow and debate the value of CDI efforts, no doubt we will continue to change and improve our query efforts as well."

OPINION

Query practice changes through the years

by Sylvia Hoffman, RN, CCDS, C-CDI, CDIP

Queries are definitely not what they used to be. When I first started as a CDI specialist, back when dinosaurs roamed the earth, the query process was a muddy exercise in creative writing. CDI specialists wrote all kinds of crazy things in order to get physicians to answer a query. Then in 2001 came the first AHIMA practice brief, "Developing a Physician Query Process," which gave order and standards to the query process. It stated that a query should not:

1. "Lead" the physician: Sound presumptive, directing, prodding, probing, or as though the physician is being led to make an assumption
2. Ask questions that can be responded to in a "yes" or "no" fashion
3. Indicate the financial impact of the response to the query
4. Be designed so that all that is required is a physician signature

AHIMA updated recommendations in 2008 with "Managing an Effective Query Process" and its "CDI Documentation Toolkit" in 2010. These provided a set of specific examples to assist the CDI department. The toolkit went on to suggest that the query process needed standardization and monitoring within each organization, and included a tool to help ensure quality assessments and auditing of CDI efforts.

These tools helped advance the query process into a new age of transparency and accountability. However, there were still many questions pertaining to specific confusing processes.

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