HCA Healthcare

DEPARTMENT: Regulatory Compliance Support	POLICY DESCRIPTION: Query Documentation for Clinical Documentation Improvement (CDI) & Coding – Compliance Requirements
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SCOPE: All personnel responsible for performing, supervising or monitoring CDI efforts and/or coding of inpatient services including, but not limited to:

Facility/HSC/Health Information Management   Administration
Corporate Regulatory Compliance Support   CDI Specialist
Case Management/Quality Resource Management   Ethics and Compliance Officer
Service Centers   Physician Advisors
Nursing
Parallon Business Performance Group HIM
External Coding & CDI Vendors/Contractors

This policy applies to queries initiated for all inpatient services provided in Company-affiliated HSC/facilities (acute care and freestanding psychiatric) unless otherwise indicated in a separate policy.

For queries specific to the assignment of ICD-10-CM code of J15.69 (Pneumonia due to other gram-negative bacteria), refer to Company Policy Memorandum entitled *Special Coding Practices on ICD-10-CM Code J15.69*.

For outpatient services, refer to the Coding Documentation for Outpatient Services Policy, REGS.COD.002. This policy's forms may be utilized for outpatient services if there is not a specific outpatient query form.

PURPOSE: The purpose of this policy is to establish processes to clarify documentation regarding diagnosis, conditions and/or procedures that are representative of the patient's severity of illness, risk of mortality, and resource consumption during an inpatient hospitalization. It also defines when a query will be initiated and outlines the appropriate query processes to be utilized.

POLICY: Appropriate querying will improve the accuracy, integrity and quality of patient data; minimize variation in the query process; and improve the quality of the physician documentation within the body of the medical record. Company-affiliated facilities will follow appropriate processes to:

1. ensure control processes are implemented to minimize potential compliance risks;

2. improve the quality of the physician documentation within the body of the medical record;

3. accurately reflect the patient's clinical picture for severity of illness and risk of mortality;

4. promote accurate ICD-10-CM/PCS code assignment and/or Present on Admission (POA) Indicator;

5. generate a query either concurrently or retrospectively consistently within the procedure

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section below;

6. ensure appropriate reimbursement based upon the acceptable medical record documentation; and

7. initiate queries as appropriate when documentation within the medical record fails to meet one of the following criteria: legibility, completeness, clarity, consistency, and/or precision.

PROCEDURE:

1. **Query Process**

   A query may be generated by a CDI Specialist or a Coder. Additional guidance regarding implementation and use of appropriate queries can be found in the HCA Query Handbook located on the Company's Intranet site on the Regulatory Compliance Support page. A query may be initiated when the medical record documentation:

   a. is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent (unless otherwise indicated in a separate Company Policy Memorandum);

   b. describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis;

   c. includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure;

   d. provides a diagnosis without underlying clinical validation; and

   e. is unclear for POA indicator assignment.

   Note: REGS.DOC.001 defines when a query should be initiated for facilities with a CDI program.

2. **Query Documentation**

   The Company has developed and requires utilization of the approved standardized query forms which are available on the Company's Intranet. The approved query forms include all of the required query data elements for an appropriate query. If there is a unique payer requirement that impacts the standard query form, the facility/HSC must contact Regs immediately for resolution of query format discrepancies via the Regs Helpline at https://regshelpline.app.medcity.net.

3. **Query Format**

   a. The query process can be conducted and documented on a concurrent (pre-discharge), retrospective (post-discharge) or post initial billing (after billing) basis.

   b. The query may be posed verbally, in writing, or electronically utilizing one of the approved and required standardized query forms; and must be maintained as part of the medical

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record.

c. Verbal queries must be documented in writing using HCA Standard Query Forms. The physician must provide the response to the query and authentication within the body of the medical record or on the query form. A query must not be posed to elicit only one response for a condition, diagnosis, procedure and/or POA indicator. It should never be the intent of a query to lead the physician to a particular outcome.

d. The query must include clinical indicators, provide reasonable options, and must include the ability to respond that no additional documentation or clarification can be provided. Clinical indicators supporting the query may include elements from the entire medical record and may, when appropriate, be sourced from previous internal and/or external health records if pertinent to the present encounter.

e. The yes/no query format may only be utilized on HCA query forms that have the printed yes/no query responses. These query forms are to be used in the following circumstances:

   (1) Substantiating or further specifying a diagnosis already present in the health record;

   (2) Establishing a cause and effect relationship between documented conditions; and

   (3) Resolving conflicting documentation from multiple practitioners.

f. It is appropriate to ask the physician multiple questions if there are multiple conditions, diagnoses, procedures and/or POA indicators that require clarification, however, each question must be on a separate query form unless they are related. It is inappropriate for Coders or CDI to present multiple questions on one physician query form that are **not interrelated** as to the reason for the query.

g. The selection of the approved query form will be determined based upon the specific type of query that is being initiated.

h. Uncertain diagnosis language should only be used when the physician has documented a diagnosis using a term of uncertainty (e.g. "likely", probable", etc.).

4. **Query Response**

The query response from the physician that will be used to support CDI, a code and/or POA indicator assignment must be documented by the physician in the body of the legal medical record and/or, at a minimum, on the query form kept as a permanent part of the medical record. The legal medical record is defined as the customary documentation (e.g., discharge summary, H&P, consultation), based on the patient type, which are contained in the medical record to furnish documentary evidence of the course of the patient's illness and treatment during each hospital admission. The physician must have the ability to access the patient medical record prior to responding to a query. This medical record may be in paper or an approved electronic form.

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For concurrent, retrospective and post-billing queries:

a. The response to a query (including the physician's documentation of the sign, symptom, condition, diagnosis, procedure or POA indicator) must be documented by the physician and be signed, timed and dated with the date/time that the information is added to the medical record.

b. It is not acceptable for a coder or CDI to document a verbal response from the physician as a result of a query anywhere within the medical record.

c. When the physician's response dictates a rebill, the rebill process must be initiated promptly following the Company's rebilling guidelines. Overpayments shall be refunded within 30 days of the confirmation.

d. Post Initial Billing Query -The physician's response to a post initial billing query must be obtained within 2 weeks (14 calendar days) of the query initiation and must also be within 12 months of the patient's discharge date. If the physician's response to the post initial billing query generated is not obtained within 2 weeks, the query is neither considered nor acceptable for supporting the code/MS-DRG assignment. The query would be retired if no response is received 14 days post query initiation.

e. When no additional documentation can/will be provided by the physician in response to a query, the query should be updated by the physician and/or person performing the documentation review that no additional documentation is warranted or will be provided.

5. **Billing and Incomplete/Delinquent Record Count for a Record with a Query**

At the time of discharge, Coders will assess any unanswered concurrent queries to determine if a response will continue to be pursued. Any chart awaiting a response to a query should not be final abstracted (final billed) until the physician's response is received as noted below.

a. Queries should not be final abstracted (final billed) prior to a query response or until after 10 days post discharge, whichever occurs first. Upon completion of 10 days post discharge, the bill may be submitted with the exception of the following instances:

(1) Conflicting documentation

(2) Critical information missing in order to assign a code (i.e., there is no default code)

(3) Other reasons that are explicitly communicated by Regs and/or Parallon leadership

b. Any query awaiting a response must be held open for a minimum of 45 days post discharge, but no longer than timely filing. The following steps must be completed:

(1) Once the query has been initiated, HIM assigns a deficiency to the physician for this item. The deficiency must be included in the incomplete and, as necessary, the delinquent record count. If the physician has responded that no addition to or clarification of the medical record is necessary, the deficiency will be removed from

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the incomplete and, as necessary, the delinquent record count.

(2) The HIM/Coding and CDI leadership and staff must assist with contacting and following up with the physician. A clearly outlined process must be developed that, at a minimum, addresses who will be responsible for follow-up, what the appropriate follow-up mechanism is (e.g., phone, fax, office visit), when the next follow-up will occur, who it will be escalated to after unsuccessful attempts are made and what documentation will be kept to track the follow-up.

(3) The facility CFO and CMO must be engaged if no response has been received prior to or at the time the record becomes delinquent. The CFO or CMO must also contact the physician once the record is delinquent.

(4) The physician will be suspended for delinquent queries per the facility's Medical Staff Bylaws. As applicable, it is encouraged that facilities also enlist such bodies as the Medical Executive Committee, Medical Record Committee, President of the Medical Staff and/or Department Chairpersons to provide assistance in following up with physicians who are not responding to queries.

c. In the event that a chart awaiting a physician response to a query has not been resolved based on the above required steps and within 45 calendar days post discharge, the query may be administratively closed.

(1) The following steps must occur before the record is final abstracted (final billed) and be considered in the decision making process:

i. The HIM/HSC Director must make a notation on the query form or in the query system that a physician response to a query has not been resolved.

ii. The query deficiency must be removed from the incomplete/delinquent process and the response not further pursued.

iii. The documentation, on a chart by chart basis, must be retrievable and producible when requested (e.g., during an internal or external record review process).

iv. In the rare occurrence that a physician responds after a record has been final abstracted (final billed), the record must be reviewed to determine next steps for any potential data integrity impact and/or rebilling implications.

(2) In no event should the timeframe awaiting a physician response be greater than timely payer filing requirements.

(3) Records that are final abstracted (final billed) without a physician's response must be documented, tracked, monitored, trended and reported to administration, the Ethics and Compliance Committee and the appropriate Medical Staff Committees on a routine basis.

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6. **Medical Staff Approval Process**

   The facility must submit the standardized query forms for approval following the process outlined in hospital policy or medical staff bylaws or rules and regulations for adding forms to the medical record.

7. **Query Education and Tracking**

   a. All facilities should educate their physicians on the importance of concurrent documentation within the body of the medical record to support complete, accurate and consistent clinical documentation and coding.

   b. Education should be provided to the medical staff that Coders or CDI specialists will query physicians when there are questions regarding documentation.

   c. The concurrent query form and/or worksheet should be available to the Coder to ensure knowledge of interaction and outcome.

   d. Query tracking and trending must be performed for Coder and CDI generated queries. The trends should be assessed on a quarterly basis but, at a minimum, the analysis must be performed annually. The tracking must include the following outcomes for Coder and CDI Queries.

      (1) Was sufficient documentation provided in the medical record and no query was required?

      (2) Did the clinical picture support a diagnosis/procedure not documented by the physician and a query was required in order to obtain the appropriate documentation?

      (3) Did the physician respond to the query form?

         i. The physician responded with additional documentation in the medical record/query form.

         ii. The physician responded "no."

         iii. The physician responded "unable to determine."

         iv. The physician did not respond to the query and/or update the medical record.

      (4) Was the response appropriately documented and authenticated?

   e. Queries generated from the CDI program should be tracked and trended separately from Coder generated queries.

   f. Performance metrics should be established to measure the outcome of the concurrent and the retrospective queries. Consideration should be given to establishing baseline metrics as well as ongoing performance metrics. The following performance metrics

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could be considered, as applicable:

(1) Percentage of patient population concurrently reviewed;

(2) Percentage of physician queries with physician concurrence;

(3) Percentage of physician queries responded to;

(4) Percentage of physician verbal queries in the physician query population;

(5) Total number of queries by type and volume;

(6) Total number of physician verbal queries;

(7) Total number of physician queries issued and type of response received;

(8) Total number of retrospective coding queries issued;

(9) Total number of queries reviewed that were necessary vs. unnecessary;

(10) Case Mix Index (CMI) for same month the year prior to implementation of CDI compared to CMI with CDI Program;

(11) Average days post-discharge to final code inpatient records; and

(12) Severity of illness and risk of mortality scores.

g. Facility leadership must support this process to ensure its success. It is recommended that trending information be shared with administration and physician(s) trend(s) be included within physician education.

h. Results of query tracking must be available to Regulatory Compliance Support upon request and include, at a minimum, the total number of queries for each query form generated concurrently for CDI and retrospective coding including the four outcomes as listed in item 7d within this policy.

8. **Query Guidelines**

The personnel responsible for performing and supervising the CDI and coding practices must understand and NOT:

a. Query the physician seeking information or clarification that may result in the diagnosis of Pneumonia due to other gram-negative bacteria (ICD-10-CM code J15.69) per the Company's Special Coding Practices on ICD-10-CM Code J15.69.

b. Use uncertain language (e.g., "possible", "likely", "probable") in a query to a physician to clarify ambiguous, incomplete, or conflicting documentation unless referencing the term from specific physician documentation.

c. Generate queries to physicians that are not based on patient-specific clinical indicators.

d. "Lead" the physician by directing or sounding presumptive, by asking the physician to

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make an assumption or providing a query that is not supported by the clinical elements in the health record and/or directs the provider to a specific diagnosis or procedure. Indicate the financial impact or reimbursement of the response to the query on the query form.

e. Be rewarded financially based on indicators that may lead to inappropriate queries or patterns. Examples of inappropriate indicators include:

(1) Case mix;

(2) Base case mix;

(3) Complication and comorbidity (CC) and/or major complication and comorbidity (MCC) percentage; and

(4) DRG pair percentages or volumes.

g. Make repeated attempts to clarify the physician's response to a query with the intent only to receive a particular outcome.

h. Utilize a yes/no query format for new diagnoses that may have clinical indicators present but are not yet documented in the health record.

9. **Facility Query Compliance Monitoring**

a. Routine and periodic reviews should be completed by company staff or a certified external vendor to confirm adherence with this policy for CDI Specialists. This would include the review of the forms to assure concurrent questions are appropriate and compliant with this policy.

b. Query compliance reviews for coding purposes shall be completed by company staff (which includes coding supervisors or designee) or a certified external vendor annually (or more frequently as directed by facility leadership). Reviews must include review of the query process for compliance with REGS.DOC.002 to determine query appropriateness and accurate code assignment.

c. Findings from these reviews must be utilized to improve the query process, coding, and medical record documentation practices and for coder and physician education, as appropriate.

10. **Company-Wide Query Compliance Monitoring**

Compliance with this policy will be monitored by the Corporate Regulatory Compliance Support and Internal Audit Departments as well as the facility/HSC.

a. It is the responsibility of each facility/HSC administration to ensure that this policy is applied by all individuals involved in the coding and querying of medical record documentation of inpatient records.

b. Employees who have questions about a decision based on this policy or wish to discuss

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an activity observed related to the application of this policy should discuss these situations with their immediate supervisor in an effort to resolve the situation.

c. All day-to-day operational issues should be handled locally at the facility; however, if confidential advice is needed or an employee wishes to report an activity that conflicts with this policy and is not comfortable speaking with the supervisor, employees may call the toll-free Ethics Line at 1-800-455-1996.

For questions regarding this policy, please contact the Regs Helpline at https://regshelpline.app.medcity.net.

DEFINITIONS:

Query: A query is an established mechanism of communication between CDI Specialists/Coders and physicians to clarify ambiguous, incomplete or conflicting documentation in the medical record.

Concurrent Query: A concurrent query is defined as one that is initiated before the patient has been discharged from the facility.

Retrospective Query: A retrospective query is defined as one that is initiated after the patient has been discharged from the facility, but before the claim has been billed.

Post Initial Billing Query: The post initial billing query is defined as a query that is executed within 12 months of the discharge date as a result of additional documentation (e.g., discharge summary) being added to the record or findings during a retrospective coding review (internal or external) that occurs after the claim has been billed.

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REFERENCES:

1. Coding Documentation for Outpatient Services Policy, REGS.COD.002

2. Coding Documentation for Rehabilitation Facilities Policy, REGS.COD.013

3. Clinical Documentation Improvement (CDI) – Implementation Requirements, REGS.DOC.001

4. Special Coding Practices on ICD-10-CM Code J15.69 Policy

5. HCA Query Handbook (found on ATLAS intranet)

6. *Coding Clinic for ICD-10-CM and ICD-10-PCS* is the official publication of ICD-10-CM/PCS coding guidelines and advice as designated by four cooperating parties: American Hospital Association (AHA), American Health Information Management Association (AHIMA), Centers for Medicare and Medicaid Services (CMS), and the National Center for Health Statistics (NCHS).

7. *Guidelines for Achieving a Compliant Query Practice,* American Health Information Management Association (AHIMA), Chicago, Illinois, December, 2022

8. *Practice Brief on Continuous Clinical documentation improvement,* American Health Information Management Association (AHIMA), Chicago, Illinois, May, 2010

9. *Practice Brief on Managing an Effective Query Process,* American Health Information Management Association (AHIMA), Chicago, Illinois, October, 2008.

10. *Practice Brief on Developing a Query Process,* American Health Information Management Association (AHIMA), Chicago, Illinois, October, 2001.

11. *Practice Brief on Data Quality*, American Health Information Management Association (AHIMA), Chicago, Illinois, February 1996.

12. *AHIMA Standards of Ethical Coding*, American Health Information Management Association (AHIMA), Chicago, Illinois, Revised December 1999.

13. *Health Information Management Compliance, A Model Program for Healthcare Organizations,* Sue Bowman, Chicago, Illinois, 2004 Edition.

14. CMS memorandum to the Peer Review Organization entitled "Use of the Physician Query Forms" dated January 22, 2001.

15. CMS memorandum to the Peer Review Organizations entitled "Use of Physician Query Form" with Policy Clarification of Temporary Suspension of January 22, 2001, dated March 21, 2001.

ICD-9-CM Coordination and Maintenance Committee Meeting Minutes, December 6, 2002, Attachment 1-Sepsis & Septic Shock