Writing Successful Physician Queries

A Physician’s Rx for Composing Effective, Compliant Physician Queries

AHIMA

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INTRODUCTION

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Training and Experience Overview

• (CCDS Planned) *Scheduled*  CDI Specialist Certification  Association of CDI Specialists
• Board Certified  ’03-Presnt  Pediatric Board Certification  American Board of Pediatrics
• F.A.A.P.  ’03-Presnt  Fellow/Diplomat in Good Standing  American Academy of Pediatrics
• M.P.H.  ’95-’99  Medical Management & Admin  George Wsh U Sch of Public Health
• M.D. & License  ’94-’99  Medical Doctorate  George Wash U School of Medicine
• M.S.  ’91-’92  Cellular Physiology; Biophysics  Georgetown University
• B.S.  ’87-’91  Biology, Chemistry, Music  Baldwin-Wallace College

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• Adolescent Med Physician  U MD Eastern Shore, Intermittent  Ocean City, MD
• Resident Pediatrician  Pediatric & Adolescent Medicine  Sinai Hosp, J Hopkins, U Maryland
Experience with Physician Queries

First introduction to queries - while working as a pediatrician:
• “Please clarify the significance of this pt’s anemia.”

CDI and physician querying
• Hands-on training as a CDS – querying
• Auditing queries and compliance
• Teaching querying
• The 10K Query™ Method
Conclusions, findings and claims made in this presentation, and in the corresponding text article, are those of the author. They do not necessarily represent views of the American Health Information Management Association, of Navigant Consulting, Inc., or of associated governing bodies or organizations.

Andrew Rothschild, MD MS MPH FAAP, is an Associate Director for Navigant Consulting, Inc. He has no additional financial disclosures.
Preface:

Background
Payment and Physician Documentation

1983 - Inpatient Prospective Payment System (IPPS)

• Revised payment philosophy
  – Reimbursement linked to diagnoses and procedures
  – New focus on physician documentation
    Concerning, considering the reputation of physician documentation…
Accurate coding without querying is sometimes impossible

- Aside: Apology on behalf of physicians everywhere…
Recognizing the Need for Clarification

Office of the Inspector General (OIG)

• “…policies must create a mechanism for [HIM/coding professionals] to communicate effectively and accurately with the clinical staff…for proper and timely documentation.”

Common Mechanism:

• Physician querying

Note: AHIMA definition of Physician Queries:

• “Questions asked to physicians to obtain additional, clarifying documentation to improve the specificity and completeness of the data used to assign diagnosis and procedure codes...”

AHA Coding Clinic (2Q 1998)

- The physician should be queried when documentation is “suggestive” of a condition, but not clearly documented by the attending physician.

AHIMA, Standards of Ethical Coding

- Coders “should consult physicians for clarification and additional documentation prior to code assignment when there is conflicting or ambiguous data in the health record.”

American Health Information Management Association. Standards of Ethical Coding. 2008
Unsupported Claims and Potential for Query Abuse

2000-2001 – Sharp increase in concern

• HHS/OIG investigations
  – 664 prosecutions or settlements (2000)
  – ~$8 Billion in unsupported or unnecessary claims (2001)
  – Healthcare Corp (HCA) pled guilty
    Charges included “up-coding”
    >$840 million
  – Pneumonia project (“up-coding”)
    100 hospitals investigated
    34 settled out of court
    $35 million

The Department of Health and Human Services and The Department of Justice. Health Care Fraud and Abuse Control Program Annual Report For FY 2001. April 2002
Unsupported Claims and Potential for Query Abuse

2000-2001 – Sharp increase in concern

• CMS memo to Peer Review Organizations (PROs):
  – Query responses were no longer to be accepted as sufficient documentation for PRO DRG validation reviews
  – Public hearings regarding physician querying ensued

• CMS retracted their instruction to PROs:
  – Re-stated to allow appropriate physician querying
  – Re-emphasized their warning of potential query abuses
Increasing Incentives to Ensure Coding Accuracy

Examples of policies increasingly dependent on documentation details:

- Medicare Severity DRGs (MS-DRGs)
- CMS Core Measures
- The Health Care Quality Indicator (HCQI) Project
- Severity of Illness (SOI) and Risk of Mortality (ROM) reporting
- Hospital/physician ‘grading’ systems (HealthGrades®, HHS Hospital Compare)
- Recovery Audit Contractor (RAC) reviews
- OIG whistleblower or targeted investigations (ex., pneumonia upcoding)
- Recently expanded False Claims Act (FCA) policies
- Present on Admission (POA) policies
- The Documentation and Coding (Behavioral) Adjustment
Pending Incentives to Ensure Coding Accuracy

Examples of pending policies highly dependent on documentation details:

- Pending State Medicaid and other payor movements to APR (3M™ All Patient Refined DRGs)
- The Medicaid Integrity Program (MIP) – under development
- The MIP Advisory Committee – Collaboration of the FBI, OIG, Regional CMS, State Medicaid
- The Division of Fraud Research & Detection (DFRD) of the Medicaid Integrity Group (MIG)
- Program Integrity master dataset for fraud and abuse research by the MIG, Medicare Program Integrity Group, HHS-OIG, and the DOJ – under development
2009 CMS Final Rule acknowledges financial incentive in MS-DRGs

- “…Hospitals have a financial incentive under the MS-DRG system…to ensure that they code…as precisely as possible, consistent with the medical record”

CMS defends hospital querying incentives

- “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.”
- “Hospitals’ efforts to improve the specificity and accuracy of documentation and coding are perfectly legitimate”

Medicare Payment Advisory Commission: Letter to Acting Administrator Leslie Norwalk, June 11, 2007:12
SECTION 1:

QUERY COMPLIANCE
CMS on Appropriate Querying

CMS – Revised Position (2001)

• “Our position allows the use of the physician query form to the extent it provides clarification and is consistent with other medical record documentation.”

CMS Assigns Query Assessment to PRO Reviewers

• “The PRO reviewer shall use his or her professional judgment and discretion in considering the information contained on a physician query form along with the rest of the medical record…”

Peer Review Organization. TOPS 2001-13
AHIMA states that queries may be made in the following situations:

- For clinical indicators without documentation of the diagnosis
- When clinical evidence suggests a higher degree of specificity or severity
- For a cause-and-effect relationship between two conditions or organisms
- For an unstated underlying cause when admitted with symptoms
- For a diagnosis when only the treatment is documented
- To establish present on admission (POA) status

ICD-9-CM states that queries may be made in the following situations:

- When the *intended meaning* of a diagnosis is uncertain due to inconsistent uses of similar terms
  - Ex: septicemia / bacteremia / sepsis / SIRS
- When the *complex nature of a diagnosis* may obscure accurate coding
  - Ex: Unclear association between sepsis and an acute organ failure
- When unclear if *more than one principal diagnosis* meets criteria
- When unclear if a condition is a *complication*
- When unclear if a *chronic condition* is newly diagnosed / resolved / healing / remote
  - Ex: History of lung cancer

Basis for Querying

Query when needed to clarify:

• “…conflicting, incomplete, or ambiguous documentation…[or] POA status…”
• “…accuracy of code assignment and quality of health record documentation, …”
• “…unclear clinical significance” (compression fx—new or old?)
• “…illegible, incomplete, unclear, inconsistent, or imprecise [documentation]…”

AHIMA - On Establishing Hospital Policy

• Healthcare entities should develop policies and procedures that clarify which clinical conditions and documentation situations warrant a request for physician clarification

AHIMA. “Standards of Ethical Coding.” 2008
Queries should:

- Use precise language
- Identify documented clinical findings, indicators, observations
- Ask the provider to make a clinical interpretation of these facts
- Always include basic query components:
  - Identifiers (name, record number, account number)
  - Admission and query dates
  - Clinical indicators
  - Question addressing the documentation concern
  - Name and contact information of the coder/CDS

CMS on Leading Queries and New Information

CMS

“If the physician query form is leading in nature or if it introduces new information, the case shall be referred [to IPRO physician] for review.”

What constitutes “leading” or “new information”?

CMS “defers the promulgation of specific guidelines addressing these practices to health information management experts and organizations.”

PRO TOPS 2001-13


**Inappropriate Query Basis**

Queries should *not*:

- “…inappropriately increase reimbursement.”
- “…misrepresent quality of care. …”
- …be asked without “…clinical information in the health record prompting the need for a query.”

**Is it important to follow AHIMA recommendations?**

- On previous slide, CMS indicates that we should look to HIM organizations for specific guidelines
- Each querying program should have a clear, established (written) query policy (AHIMA or equivalent)

AHIMA. “Standards of Ethical Coding.” 2008
AHIMA states that queries should *not*:

- Target a diagnosis that would not be supported by the chart
- Sound presumptive, directive, prodding, or as if leading to an assumption
- Ask “yes” or “no” questions (unless for POA indicator of a documented Dx)
- Indicate financial impact or quality reporting
- Require only a physician signature
- Be leading
- Be poorly constructed
- Question a provider’s clinical judgment
- Utilize blanket querying
- Routinely target insignificant or irrelevant findings
- Introduce new information

What is “leading?”

Reduce perceived “grey zones” complicating this issue:

• Further specify the question:
  – Is the query (itself) leading?
  – Does the query appear to lead? (I.e., is it leading in nature?)
  – Did the query lead the physician (to a different or new diagnosis)?
  – Is the query leading, but supported by facts and documentation? (I.e., is it leading but valid, or correct?)
  – Is the query non-compliant with mandated policies (CMS, OIG, etc.)?
  – Is the query in violation of the updated FCA (i.e., fraudulent)?

Most guidelines specifically refer to only one of these issues

Leading Queries

AHIMA – On Leading Queries

• “Queries that appear to lead the provider to document a particular response could result in allegations of up-coding.”
  – Note that the definition of leading is not dependent on how obvious or correct the diagnosis may be
    • It is dependent on how the query is stated
    • “Would you agree that this patient was decapitated?”

Leading vs. Non-compliance

• A leading query is not necessarily non-compliant with mandates (CMS, OIG, etc.)
  – Rather, it is a ‘red flag’ for non-compliance and prompts a review

This presentation follows the safer path:

• Avoid unnecessary compliance reviews by avoiding leading queries

AHIMA’s message has been misstated as instructing that:

- Queries should not lead to a diagnosis that is not supported by evidence
  - Distorts the message from AHIMA or CMS
  - This would imply that leading questions are acceptable, as long as the diagnosis is supported by facts
    - Only physicians can diagnose, even in obvious cases

To clarify:

- Queries may be leading even if the CDS/coder believes they are supported by facts
  - The physician may disagree
- Leading queries warrant review (per CMS)
  - A reviewed query may or may not be found non-compliant

NB: Most hospital administrators prefer not to gamble
Why avoid leading queries? Why not target only fraudulent queries?

- Risk Reduction – Leading queries targeted by OIG and CMS
- Defense – HIM organizations could be considered “standard of care”
- Ethics – Repeated attempts to influence a diagnoses raises questions
- Physician pushback – When subtly attempting to sway a physician’s opinion
- Diagnosing – Leading questions often diagnose for the physician, incurring additional legal risks
What constitutes a “leading query”? 

AHIMA does not specifically set out to define a “leading query,” but it addresses the definition in reference to an example of a leading query:

• “…the provider is not given any…option other than the specific diagnosis requested.”
  – In other words: The question gives the desired answer


This corresponds with generic definitions of “leading question” (Wikipedia) -

• “A question that suggests the answer or contains the information the [questioner] is looking for. . .For example, this question is leading:
  ‘You were at [home] on the night of July 15, weren't you?””
What constitutes a “leading query”?

A medically equivalent leading query, by inference:

• “Your patient has acute blood loss anemia, doesn’t she?”

• Or, more simply: “Does your patient have acute blood loss anemia?”
  – The only option noted for the physician is the desired answer

• The leading query, re-stated with added niceties and pleasantries:
  – “The patient’s hematocrit dropped from 38 pre-op to 20 post-op “s/p hemorrhage.” If you feel the patient has acute blood loss anemia, please document this in the progress notes.”
  – This query sounds more pleasant, but it still specifies the intended answer, thus meeting the definition of a leading question or query
Examples of Leading Queries

Dr. ___________________________ Date: 1-30-08

Did this patient have:

- rhabdomyolysis?
- delirium tremens?
- gangrenous necrosis feet?
- chronic continuous alcoholism?
- acute alcoholic hepatitis?
- excisional debridement of feet?

If so please document in your summary.

Thank you,
AHIMA’s example of a leading query:

**Physician Query**

“Based on your documentation, this patient has anemia and was transfused 2 units of blood. Also, there was a 10 point drop in hematocrit following surgery. Please document ‘Acute Blood Loss Anemia,’ as this patient clearly meets the clinical criteria for this diagnosis.”

This contradicts AHIMA’s guidance that:

- Queries should *not* sound presumptive, directive, prodding, or as if leading to an assumption;
- Queries should *not* be leading

Note that this is a rather extreme example, in that it is leading in multiple ways.

Examples of Leading Queries

**Physician Query**

“Pt’s creatinine now 3.5. If you feel the patient has ARF, please document this in your progress note.”

-OR-

**Physician Query**

“Creatinine increased to 3.5. Please document any associated diagnosis (eg: ARF or other)”

These contradicts AHIMA’s guidance that:

- Queries should *not* introduce new information
- Queries should *not* be leading

**Diagnosing for the physician is inappropriate** – and can agitate physicians

- Avoid being the *first person* in the chart to mention a diagnosis

AHIMA. Practice Brief, ”Managing an Effective Query Process“

This contradicts AHIMA’s guidance that:

- Queries should *not* sound presumptive, directive, or prodding
- Queries should *not* be leading
- Queries should state clinical indicators
- Queries should *not* utilize blanket questions
- Queries should *not* be asked without clinical information in the health record prompting the need for a query

**Physicians tend to resist chastising queries**


Defining a diagnosis for a physician is usually not recommended
• Different physicians follow different criteria; May vary by case
• Possible Exception: Predetermined, hospital approved values or forms

This also contradicts AHIMA’s guidance that:
• Queries should not sound presumptive, directive, or as if leading to an assumption
• Queries should not be leading

AHIMA. Practice Brief, "Managing an Effective Query Process"
Examples of Leading Queries

**Physician Query**

“Patient with documented CHF. Please specify type and acuity in your progress note.”

This contradicts AHIMA’s guidance that:

- Queries should state clinical indicators
- Queries should *not* utilize blanket questions
- Queries should *not* be asked without clinical information in the health record prompting the need for a query.

While this is an appropriate question, it should include relevant facts; Ex:

- “SOB, Bilateral infiltrates on CXR, ECHO 25% EF”


Pt admitted for documented “bronchitis;” CXR: “barrel chest,” Abnormal PFTs. Please specify the type of bronchitis, ex:

___ Chronic obstructive bronchitis ___ Chronic bronchitis (NOS)
___ Chronic infectious bronchitis ___ Other
___ Chronic tracheitis

AHIMA advises:

• Multiple choice formats +/- checkboxes may be used “as long as all clinically reasonable choices are listed, regardless of…reimbursement”
  – In this example, all options lead to the same higher weight DRG

• Including the options:
  – “Unable to determine”
  – “Other ________________” (To be specified by physician when responding)

AHIMA. Practice Brief, "Managing an Effective Query Process"

*Journal of AHIMA* 79, no.10 (October 2008): 83-88
Examples of Leading Queries

**Physician Query**

“Patient with documented pneumonia; Progress notes state ‘ill appearing,’ ‘worsening,’ WBC increased 20 to 46. Please note any additional diagnoses.

Current DRG: Simple Pneumonia (weight 0.7316)

Target DRG: Sepsis (weight 1.1209)”

This contradicts AHIMA’s guidance that:

- Queries should *not* indicate financial impact or quality reporting
- Queries should *not* be leading
- Queries should *not* introduce new information

AHIMA. Practice Brief, "Managing an Effective Query Process"

Fraudulent Queries: The False Claims Act (FCA)

1863 Lincoln Law – to combat fraud against the Union Army

False Claims Act (FCA) – to combat fraud against the government

Fraud Enforcement Recovery Act (FERA) of 2009 – to update various types of fraud

• Section 4 – Updates the FCA: Now prohibits “knowingly…causing…a false…statement material to a false or fraudulent claim.”
  – “Knowingly” includes: “act[ing] in deliberate ignorance of the…falsity of the information”
  – “Material” is redefined in the FERA as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money..."
  – Proof of intent to defraud is not required
  – The updated FCA “does not require that the person submitting the claim [has] actual knowledge that the claim is false”

Fraud Enforcement and Recovery Act of 2009, Section 4: Clarifications to the False Claims Act to Reflect the Original Intent of the Law. S386, pp. 5-9
Fraudulent Queries: The False Claims Act (FCA)

Liability has been expanded to include:

- Individuals who are not directly employed by the hospital
- Submissions to government contractors, grantees, or any recipient if “the money…is to be spent or used on the Government’s behalf or to advance a government program or interest.”

Example scenarios of potential liability:

- Physicians who document diagnoses they should know are inappropriate could be held liable if their diagnosis later influences the hospital’s submission of a fraudulent claim
- An HIM professional or CDS could be held liable if their query inappropriately sways a physician to document a financially impacting diagnosis that they should have known was incorrect or inappropriate

Fraud Enforcement and Recovery Act of 2009, Section 4: Clarifications to the False Claims Act to Reflect the Original Intent of the Law. S386, pp. 5-9
Fraudulent Queries: The False Claims Act (FCA)

Case Example:
- Whistleblower, June 2009
- Reviewing “to increase reimbursement”
- Advising doctors to include the higher reimbursed diagnosis
- Settled for 2.75 million

Liability if the case gone to trial and lost:
- Hospital: 3x damages + ($5.5K to $11K per false claim)
- Individuals: 3x damages in which they were involved + ($5.5K to $11K per false claim to which they contributed)

Fraud Enforcement and Recovery Act of 2009, Section 4: Clarifications to the False Claims Act to Reflect the Original Intent of the Law. S386, pp. 5-9
SECTION 2:

QUERY EFFECTIVENESS
Compliant queries are not always effective

» Ex: “Please document the diagnoses reflective of this patient’s lab/test abnormalities.”

Effective queries are not always compliant

» Ex: “The hematocrit dropped from 40 pre-op to 10 post-op. Please document acute blood loss anemia (if in agreement).”
Effective Queries Generally…

• Are **specific** enough to elicit a **diagnostic** opinion
  – Neither leading, nor vague

• Are **well written, logical and clinically valid**

• Assume physicians **lack coding knowledge**

• Focus not only on query intent, but on **query perception**
  – **Physician-friendly** (phrasing)
  – Address the **physician’s perspective and state-of-mind**
  – **Respectful, not chastising**
  – Engender **trust**
  – Avoid **coder lingo**
A query is effective if it achieves (or is likely to achieve) its goal

- I.e.: Physician documented clarification of the queried issue
  - Regardless of any financial or quality impact

Writing effective queries

- Subjective and varying
  - Many viable approaches; No “correct” answer
  - No specific guidelines or requirements
- Improves with experience
- Involves communication skills
- May vary by location, sometimes by physician
- Often requires translating a coding issue into physician-friendly terms
PROBLEM: Target audience

- Askia coding question. . . Get a coding response:

Patient Dx’d w/ ARF and malnutrition. After review, for accurate coding of the correct DRG, please clarify the principal diagnosis.
Physician-Friendly Terminology

Physician Comment:

“Docs are not speaking the same language as the coders/CDS…

They ask strange questions.”
### Physician-Friendly Terminology

**Breaking the language barrier**

<table>
<thead>
<tr>
<th>CDS / Coder Terminology:</th>
<th>Physician Perception:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence</td>
<td>Lawsuit</td>
</tr>
<tr>
<td>Treating physicians</td>
<td>All physicians</td>
</tr>
<tr>
<td>Add a complication/comorbidity</td>
<td>Increase my complication rate</td>
</tr>
<tr>
<td>Guidelines</td>
<td>Harassment</td>
</tr>
<tr>
<td>HIM</td>
<td>Opposite HER</td>
</tr>
<tr>
<td>Hospital coding</td>
<td>Pro-fee coding</td>
</tr>
<tr>
<td>DRG</td>
<td>Unrelated to me</td>
</tr>
<tr>
<td>Medical Records</td>
<td>Obstacles to patient care</td>
</tr>
<tr>
<td>CMS</td>
<td>(...Na na na … I can’t hear you…)</td>
</tr>
</tbody>
</table>
Physician State-of-Mind

When leaving a poorly written query -
• Vague
• Confusing
• Illegible
• Inaccurate

Related physician comment:
• “It isn’t effective to make the attending play guessing games. It won’t happen.”

When querying unfamiliar diagnoses:
• Confirm clinical logic (via Internet or colleague)

Poorly written queries forfeit physician trust, invite misunderstandings, and lead to unintended responses
When querying physicians who are unaware of the querying program

Related physician comments:

- “Docs think the query form is part of a project.”
- “I’ve never seen a documentation specialist.”
- “I have never seen a query form.”
When correcting physicians in a query -
- Identifying a physician’s documentation omission or error
- Defining something physicians believe they know (Ex, PDx)
- Stating “Guidelines require…” or “Physician Reminder…”

Physicians have reported:
- Embarrassment
- Insult
- “Public humiliation”
Regarding queries:

- With apparent emphasis on reimbursement
- For borderline results
- To document in a way that contradicts their clinical beliefs

Physicians have reported:

- “CC Shopping”
- Harassment
- Antagonism
When leaving lengthy or redundant queries:

**Pt Present from Nursing Home**

- C TEMP (100.9), AMS, DYSPEA, CONFUSION,
- LETHARGY, FEBRILE, HYPOVENTSIVE (96/45)
- COARSE RHONCHI RLL, PULSE 67, RR 18
- WBC 10.9, LACTATE 2.2, ED FINAL DX SEPSIS + PNA 1x
- MTP IMP: POSS PNA → Pt started on MAXIME 1g/12hrs

Can you please indicate if Pt also being Tx for Sepsis?

Physicians have reported:
- No time for this
- “Just tell me the question”
The 10K Query™ Format:

10 Keys to Composing an Effective Query
Dear Dr……………………..,
Patient with……………………………….......
Results showed “………,” and now “………”
If………………………………………..……….,
Please document the Dx……………….………

Closing,

Physician Query

Dear Dr……………………..,
Patient with………………………………….……
Results showed “………..,” and now “………..”

If………………………………………………………………….,
Please document the Dx…………………………

Closing,

………..”
**Key #1: Personalize Inclusively**

Options for Addressing the Physician

- **No Specified Physician**
  - Impersonal
  - Risks “passing-the-buck”

- **Addressing a specific Attending**
  - Personalizes and assigns responsibility

  - **PDx Query: “Dear Dr. Writewell”**
    - A PDx must be documented by the attending

  - **SDx Query: “Dear Dr. Writewell”**
    - Unnecessarily limits who can document a secondary diagnosis
    - Dr. Writewell might not be “on-board,” but colleagues might be

- **Personalize Inclusively**

  - **SDx Query:**
    - “Dear Dr. Writewell/Hospitalists”
    - Assigns responsibility, but still encourages other “on-board” physicians to respond
Key #2: Start with The Principal Diagnosis

Begin the query with observations, not questions

- Questions are often seen as time consuming or invasive

Start with the PDx

- Opens with an agreement
- Prevents unintended responses

“Pt. admitted with UTI; Now with receiving albuterol…”

“Pt. admitted w/ GIB; Now hematocrit…”
Key #3: Add Facts and Quotes

Add facts and quotes

• Provide the evidence on which the query is based
• Facts are not inappropriately leading
  – Facts don’t make physicians defensive
    • Residency fosters defensive reactions
  – The physician begins with an agreement
• Relevant facts often imply the problem - making the question an afterthought
• Quotes avoid sounding like you are interpreting

“…Swallow study positive; CXR ‘c/w aspiration’…”
To physicians, all queries imply blame...something is wrong or incomplete
- “I didn’t do it!” (example)
- Avoid implying the physician has done something wrong

Divert perceived “blame”
- Blame someone else!

“Per nursing, ‘a decubitus ulcer...’”;

“The radiologist states: ‘c/w LLL pneumonia...’”
Key #5: Leave a Way Out

Getting to the question:
Provide a “way out”

- Forcing a change is leading
  - Makes physicians defensive
- Don’t box the physician in
  - When a resident is ‘pimped’ with a question asking ‘DxA or DxB’?

“\textit{If possible,…”}
“\textit{…or other.”}
“\textit{…whether or not…”}
“\textit{…the association, \textit{if any.”}
Key #6: Politely Request Help

Asking the Question:

Politely Request Help Clarifying or Understanding

• Physicians don’t like being questioned
• All physicians like to help
  – Imply the physician’s help is requested to clarify an issue in the chart
Key #7: Permit Uncertainty

Asking the Question:

* Permit uncertainty
  - Physician billing does not allow “suspected” diagnoses
    - Most physicians don’t realize the hospital needs these diagnoses
  - Avoid phrases like “if known” or “the definitive diagnosis”
    - Failure to do so results in: “I’m not certain” or “I don’t know”

Caution: Wording should not encourage the physician to “stretch the truth”

- Ex: It would be inappropriate to ask if a patient’s simple migraine (no fever; normal labs) “…could possibly be due to a more significant condition, like encephalitis, meningitis…”
Asking the Question:

* Ask the right question – Be specific
  • Usually, this is for the likely diagnosis
    » Unless necessary, avoid focusing on “the significance,” “the condition,” or “your opinion”
      › Vague or already implied

“…the likely **diagnosis**. . .”

“…the probable **etiology**. . .”
Key #9: Keep it Open-Ended

Asking the Question:

• Avoid “Yes or No” questions
• Focus on the fact (test, lab), rather than the diagnosis you suspect

“…please clarify the likely diagnosis necessitating ceftriaxone.”

• Exception: POA status, if already documented
Key #10: Close and “Own the Query”

Closing the query:

Be polite and own your query

“Thank you.
MyName, CCS
x542”

• Actively follow-up all queries
10K Query™ - Summarized

This abbreviated list can be used as a check-list when leaving or reviewing queries:

1. Personalize inclusively
2. Start with the PDx
3. Add brief facts, quotes
4. Divert perceived blame
5. Provide “way out”
6. Politely request help
7. Permit uncertainty (“…the suspected…”)
8. Request Dx or Etiology
9. Leave open ended, asking to clarify facts
10. Close: “Thank you”, Signature, Contact #
Final Considerations Before Querying

Conceptual issues to consider before finalizing the query:

Step back and double-check

- Does the query make sense? (*a common error)
- Is the query specific without leading?
- Exactly what question is communicated?
- Is the query brief?
- Will the physician’s eyes go to the right words?
  - Underline or highlight
- Does the query match the physician’s personality?
- Is the Dx worth querying?
Final Considerations Before Querying

Keep it short
Avoid redundancies

• Which reads better?

A) “On admission, hemoglobin was 12 and hematocrit was 38, but on day 2, the hemoglobin had dropped to 9 and the hematocrit dropped to 30. Currently, the hemoglobin is 8 and the hematocrit is 27."

- OR -

B) “Hct dropped 38 to 27 over 24 hrs.”
The Quest for Consistency

• Consistency and Reliability are essential to a successful query process
  – Relies on conscious efforts to maintain consistent approaches and methods
• For example, some degree of consistency when querying…
  – Similar illnesses
  – Different payors
  – Difficult physicians
  – By different coders (or by different CDS)
• Also, similarity in deciding when to query
  – Ex., For which lab abnormalities
The 10K Query™

Examples of Query Types
Ex #1: Querying for an Undocumented Diagnosis

Physician Query

Dear Dr. Illegible / Hospitalists,

Pt admitted for asthma exacerbation
Per nursing, “Pt now w/ dysuria, +U/A;” UCx & Cipro started

If possible, please document the Dx likely causing urinary symptoms and necessitating Cipro.

Thank you,
Name, RHIT x741

The following slide breaks this query down into the 10 Key Query components…
Dear Dr. Illegible / Hospitalists,

Pt admitted for asthma exacerbation;
Per nursing, “pt now w/ dysuria, +U/A;” UCx & Cipro started

If possible, please document the Dx likely causing these symptoms and necessitating Cipro.

Thank you,
Name, RHIT x741

1. Personalize (Inclusively)
2. Start w/ PDx
3. Divert perceived blame
4. State or quote facts that set-up the question
5. Leave a way out; (Exs: If you agree; …or other Dx:______)
6. Politely request help
7. Request “the Dx” or “the etiology”
8. Permit physician uncertainty: Suspected; Believed; Probable; Likely
9. End the query focusing on facts; Avoid ending with the suspected Dx
10. Own the query; “Thank you” (personalize, contact #)
Dear Dr. Vague and Residents 8/5/09, 7am

Pt w/ documented pneumonia s/p choking. Per OT, ‘abnormal swallow study since CVA 3wks ago. I.D. note: “Clinda for anaerobic coverage.”

In order to accurately reflect patient severity, please document the probable type (or class) of pneumonia this patient is thought to have.

Thank you,
Name, RHIT x345
Dear Dr. D./Attendings 07/28/09 8am

Pt admitted w/ pneumonia; Nutritionist notes BMI 16, alb 2.0, “c/w severe protein-calorie malnutrition.”

If in agreement, please re-document the diagnosis; otherwise, please document a corrected/clarified diagnosis.

* Please include severity, type, and any suspected etiologies.

Thank you,
Name, RHIT x775
Dear Dr. D./Hospitalists  7/30/09,  7:00 am

Pt admitted w/ documented pancreatitis;  Per H&P, “Symptoms began 24 hrs ago; No associated PMHx.”

If possible, please specify the likely acuity of her pancreatitis
(Ex: acute, chronic, acute on chronic, other, unknown).

Thank you,
Name, CCS  x445
Ex #5: Querying to Link Diagnoses

Physician Query

Dear Dr. D./Attendings  7/29/09, 9:00 am

Pt w/ documented DM and PVD. If possible, please clarify whether or not these diagnoses are believed to be associated.

Thank you,
Name, RHIT  x4332

- A yes or no question to clarify presence or absence of a link between two documented diagnoses is occasionally necessary
  - Use “whether or not” to avoid leading
Dear Dr. D./Attendings
8/28/09, 9:00 am

Pt. w/ multiple complex issues (including …). When possible, please clarify which diagnosis/diagnoses are suspected to have contributed to the current admission.

Thank you,
Name, RHIT X322
Dear Dr. D./Attendings

8/20/09, 9:30 am

Pt admitted for COPD exacerbation, but also noted to have CAP, UTI and “moderately controlled DM.” Please note which of these diagnoses (or others) were the contributory reasons for the current admission.

Thank you,
Name, RHIT x779
Identifying Query Issues
Personalize inclusively

Start w/ PDx

Divert perceived blame (Blames the physician)

Leave a “way out” 
And keep it open-ended

Politely request help

Using “suspected” or “likely” validates that uncertainty (R/O) is acceptable

Specifically request a diagnosis or etiology to decrease irrelevant answers

“Thank you” and take ownership (personalize and leave a contact #)

State or quote the facts

When possible, focusing on explaining facts can prevent leading questions

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Main issues:
• No individualization (set-up / framing)
• Starts with a (condescending) request

Physician response? 1) 2)
Main Issues:

- Illegible query requesting clarification
- Clinical logic regarding INR(?)
- Use of arrows
- What question is conveyed?
Physician’s written comment:

- “Some query questions are bizarre - are these people even medical professionals?
  I was asked me why a patient with diabetes would have neuropathy!
  It’s a known complication!”
**Physician Query**

**Regarding Sepsis Documentation:**

A patient was admitted under your service 12/22-1/23; A 2 y.o. female w/ abdominal pain, distention and fever. Found to have platelet count of 29 & hgb of 7.5. Abdominal X-ray revealed HSM, R/O leukemia, which was confirmed as ALL. Blood Culture drawn in the ED revealed + Gm+ cocci, strep. On 12/23 she was started on cefepime & vanco for a 10-day course.

“+B/C” was documented in the record -- which does not give us a Dx.

Can you please render your opinion as to whether the pt was treated for possible sepsis or another Dx, given +B/Cs & i.v. antibiotic treatment?

**Main Issues:**

- Leading
- Length and redundancy
- Condescending

How can this be shortened?
Regarding Sepsis Documentation:

A patient was admitted under your service 12/22-1/23; A 2 y.o. female w/ abdominal pain, distention and fever. Found to have platelet count of 29 & hgb of 7.5. Abdominal X-ray revealed HSM, R/O leukemia, which was confirmed as ALL. Blood Culture drawn in the ED revealed +Gm+ cocci, strep. On 12/23 she was started on cefepime & vanco for a 10-day course.

“+B/C” was documented in the record, which does not give us a Dx.

Can you please render your opinion as to whether the pt was treated for possible sepsis or another [re. the suspected] Dx, given +B/Cs & i.v. antibiotic treatment?

Revised by shortening alone:

“Patient w/ ALL; Blood cx revealed Strep. – vanc./cefepime x 10 days; Please render your opinion regarding the suspected diagnosis.”
Main Issue:
- Forces the physician to answer
- Begins with an instruction / request
The physician’s response?

Please include in next progress note possible or suspected source of fever on admission.
Dear Doctor,

Based on the patient elevated wbc, fever, chills and confusion, wouldn't you agree that you are treating sepsis?
If so, please document in the record.

Main Issues:
• Directive
• Leading

Suggested revision:

Dear Dr. Drew/Attendings,

Pt admitted for fever and confusion. WBC 40 and antibiotics started. If possible, please document the diagnosis believed to be causing the pt’s symptoms and warranting iv antibiotics.
Thank you. A. Kwerier, CCS x435
Dear Dr.

Based on other documentation in the patient’s medical record, there is evidence that you are definitively or possibly treating a specific organism or type of pneumonia. Please provide documentation in the record regarding the type of pneumonia the patient may have.

Examples:

Actinobacter
Anthrax
Aspiration
Candida
Chlamydia
E. coli
Enterobacter
Gram negative
Gram positive
Hemophilus influenzae
Klebsiella species
Legionella
MRSA
Mycoplasma
Proteus mirabilis
Pseudomonas
Serratia
Staph aureus
Streptococcus
Viral

Main Issues:

• Blanket query
• Leading by circling “answer”
Dear Dr. __________________ Date: __________

Based on other documentation in the patient's medical record, there is evidence that you are definitively or possibly treating a specific organism or type of pneumonia. Please provide documentation in the record regarding the type of pneumonia the patient may have.

(Pneumonia dx d/s p/CVA/ @ Swallow study)

Examples: R/O...

- Actinobacter
- Anthrax
- Aspiration
- Candida
- Chlamydia
- E. coli
- Enterobacter
- Gram negative
- Gram positive
- Hemophilus influenzae
- Klebsiella species
- Legionella
- MRSA
- Mycoplasma
- Proteus mirabilis
- Pseudomonas
- Serratia
- Staph aureus
- Streptococcus
- Viral

Document these findings in the record

Is this a leading query?

- No
- The goal of diagnosing is to have facts point to the answer

1. (Personalize inclusively)
2. Start with the PDx
3. Add brief facts, quotes
4. Divert perceived blame
5. Provide “way out”
6. Politely request help
7. Permit uncertainty (“...the suspected...”)
8. Request Dx or Etiology
9. Leave open ended, asking to clarify facts
10. Close: “Thank you”, (Signature, Contact #)
Main Issues:

- Coding logic
  Need to re-document?
  Would “borderline” be coded anyway?
- Directive language
Documented: “Dx: Hip Fx, Severe Hemorrhage, Hct 40 -> 20”

The query appears to be leading - despite unstated context:
• The physician had been queried verbally in a compliant manner; this query was left as a reminder.

The OIG or CMS will not call to ask about context
• Written queries should be compliant, regardless of context
Main issue:
• Limited list
• Use of “vs.”

Suggested revision of the last query line (above):
• Add relevant symptoms (T=104, AMS)
• “Please specify the diagnosis likely indicated by the pt’s symptoms and blood culture results.”
Part 1 of the query noted a preliminary +blood culture.

Part 2 of this query:

```
If possible, can you determine if this may be a suspected sepsis, bacteremia, or other? Thank you.
```

Main Issue:
• “…can you determine…”
• Ineffective use of “suspected”

Anticipated physician response?

“No – Can’t be certain.”
Main Issues:

- Lacks individualization / “set-up”
- Starts with the question
- Clinical logic – why not both diagnoses?
- Impact on coding?
Compliant, but non-specific – not effective

• Potential Answers: “Hemorrhagic,” “Severe,” “Post-op…"

Preferable: When seeking very specific terminology, it helps if able to use a pre-printed query with an extensive list of options

• Alternatively: Specify request “… the suspected cause or type of anemia and its acuity (acute, chronic, or both).”
Unintended Physician Responses

What to do?
- Intervention!
- Discussion
- Supervisor and/or physician champion
Documented response to a query about acute blood loss anemia: (recreated)

- Clearly, this physician has not received (or believed) the intended message behind physician querying.
Main Issues:

- Leading
- What specific question is asked?

“If there’s a clinical indication of an MI?”

Expected answer?
Yes – several: diaphoresis, left arm pain, jaw pain….
Main Issues:

- Source of information (ER list of patient’s belongings!)
- Lacks clinical significance and evidence for query (PDx: Syncope; Gait not addressed clinically)
- Leading
Dear Dr. Drew,

You have documented “RLL pneumonia” in the medical record. To accurately code this diagnosis, specify the type(s) of pneumonia (if known).

Main Issues:
- Accusatory (“you”)
- Not physician-friendly
- Requires certainty (“if known”)
- Lacks evidence/support/indicators

Physician-friendly option:

Dear Dr. Drew/Hospitalists,

The patient has documented “RLL pneumonia” and “+swallow study;” Rx-clindamycin. To accurately reflect patient severity, please specify the suspected type(s)/cause(s) of pneumonia.

Thank you. Bea Kompliant, CCS x455
Main Issues:
• Coding logic(?)
• Better query – Septic Shock
• Leading
AHIMA recommendations regarding lists in queries

- Include all reasonable options
- Include option: “Other__________________”
  (To be filled in by the physician)
- Include option: “Unable to determine”

How would the answer differ if the list were omitted?
Main Issue:
• First to diagnose pneumonia
Main Issues:
• “i.e.” means “that is,” not “for example” (makes more leading)
• Not necessary to give the example in this case
• Failure to use quotations makes the question confusing
• Apparent misuse of the clinical term
Questions?

Thank You

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