COSMOS
Navigate the Compliance Universe

Compliance Today - March 2024

Ronald Hirsch (rhirsch@r1rcm.com, linkedin.com/in/ronald-hirsch-md-facp-chcqm-chri/) is Vice President of Regulations and Education at R1 RCM Inc. in Murray, UT.

Richelle Marting (richelle.marting@richellemarting.com, linkedin.com/in/richelle-marting-jd-mhsa-rhia-cpc-cemc-cpma-63b93134/) is an Attorney, at Marting Law LLC in Olathe, KS, and Director of Managed Care for North Kansas City Hospital, Meritas Health Corporation.

Set the record straight on leading queries

by Ronald Hirsch and Richelle Marting

Case: A 73-year-old male with Medicare Advantage (MA) insurance presents to the emergency department at 6:15 a.m. Tuesday with complaints of fever and cough. The patient has no chronic medical issues and "doesn't like to see doctors." He had a right below-knee amputation (BKA) after a traumatic injury 20 years ago. He has a 100-pack-year history of smoking but last smoked more than 10 years ago. He received his fall influenza booster, Pneumovax, at age 65 and the respiratory syncytial virus vaccine early in 2023. In the emergency department, he has a temperature of 101.8, pulse 88, respiratory rate 18, and pulse oximetry on room air of 91%. The physical examinations documented by the physicians do not include extremity examination as it was not felt to be pertinent to the patient's illness. His chest x-ray demonstrates a left lower lobe pneumonia. Laboratories show normal electrolytes, his hemoglobin is normal, and his white blood count is 11,600 with a left shift.

Accurate capture of all diagnoses is critical to many functions within healthcare. At the most basic level, the primary and secondary diagnoses allow the hospital to prepare an accurate claim for hospital admission. Myriad quality measures rely on the documented and submitted diagnosis codes, including the Medicare Hospital Readmission Reduction Program and mortality measures. Many payment programs, such as MA, rely on the patient's diagnosis to calculate the "capitation payment" the plan receives to cover that patient's medical costs.

As the importance of capturing the diagnoses increased, so did the amount of effort put into assisting physicians in properly documenting these diagnoses, using the "right words" that allowed the most specific code to be added to the claim. Initially called clinical documentation improvement programs, the intent and name of these programs evolved to not simply increase the accuracy or "integrity" of the medical record but "improve" the financial yield.

Concept of querying

As with many new programs, professionals started gathering to share best practices and learn from each other's mistakes and missteps. Through some of these efforts, the concept of querying was developed. Rather than just "asking" or "suggesting" that physicians improve the integrity of their documentation, it was determined there should be a standard way to communicate with physicians and other providers via a query.

Over time, guidelines help professionals craft queries in ways that facilitate the objective of completing the incomplete, clarifying the unclear, or specifying the unspecified within the record. And over time, the nomenclature used to characterize these guidelines evolved to reference parameters for "compliant" queries. The concern then arises that a query structured in a format maligned with those guidelines creates a compliance issue or concern. The nomenclature may have become more of a misnomer than a true characterization of the evolved guidelines. When the American Health Information Management Association (AHIMA) eventually developed its first practice brief on developing a physician query process, AHIMA explained that the compliance function queries served were to satisfy Medicare Conditions of Participation and The Joint Commission (TJC) accreditation standards that medical records be complete and accurate. The guidelines did not suggest that queries themselves were subject to regulations or TJC standards.

"Compliant," as it came to be used, referred to the original primary function of queries helping serve as a tool to meet Medicare and TJC requirements for maintaining a complete and accurate medical record. Over time, the industry has come to describe queries themselves as compliant or noncompliant. In turn, payers have done the same, even refusing to recognize information recorded by providers in response to queries if the query format or content did not align with a professional association's recommended practice.

In 2022, the Association of Clinical Documentation Integrity Specialists (ACDIS) and the AHIMA published the most recent guideline for achieving a compliant query.[1] ACDIS defines a leading query as "*one that is not supported by the clinical elements in the health record and/ordirects a provider to a specific diagnosis or procedure.*"[2] (emphasis added)

While it is the position of ACDIS and AHIMA that leading queries can contribute to entries that may compromise the accuracy and integrity of the record, and hospitals may have adopted policies that specify the proper procedures for developing queries that indicate leading queries are not permitted, are leading queries "illegal"? Should a leading query form a basis to ignore the provider's response, regardless of whether indicators in the record appropriately support the diagnosis at issue? Is the MA plan or hospital at risk of accusations of violating the False Claims Act (FCA) if the clinical documentation integrity (CDI) specialist asked the physician to specifically document the BKA the physician documented it, and the coder placed the Z89.511 code for "acquired absence of right leg below knee" on the claim and the risk adjustment factor score submitted to CMS is increased due to this code?