

# THE LIVANTA CLAIMS REVIEW ADVISOR



*A monthly publication to raise awareness, share findings, and provide guidance about Livanta's Claim Review Services*

Volume 1, Issue 23

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## Higher-Weighted Diagnosis Related Groups (HWDRG) Validation – Physician Queries Revisited

The inaugural issue of The Livanta Claims Review Advisor, published in February 2022, addressed the use of physician queries. This month's issue of The Livanta Claims Review Advisor provides updated guidance to hospitals on this important subject. This month's content revisits the use of physician queries and adds information for hospitals seeking to establish compliant physician query policies and procedures.

### Introduction

In late 2022, the American Health Information Management Association (AHIMA) updated the industry practice brief, "Guidelines for Achieving a Compliant Query Practice." The AHIMA publication included the following six major topic updates:

- How to process answers of "Unable to determine"
- Query guidelines
- The compliant use of CDI query templates
- Guidelines pertaining to the use of problem lists in the query process
- Importance of policies & procedures
- Guidelines pertaining to the use of previous encounters in the query process

Pertinent details of these topics are outlined below.

### AHIMA Practice Brief:

[https://ahima.org/media/51ufzhgl/20221212\\_acdis\\_practice-brief.pdf](https://ahima.org/media/51ufzhgl/20221212_acdis_practice-brief.pdf)

## Definition of Query

As defined in the AHIMA industry practice brief cited above:

**“Query definition: a communication tool or process used to clarify documentation in the health record for documentation integrity and accuracy of diagnosis/procedure/service code(s) assignment for an individual encounter in any healthcare setting. A query may be developed by a healthcare professional or through a computer autogenerated query process.”**

## Reasons to Query

Querying the physician is sometimes necessary to obtain clarity about inaccurate, incomplete, or conflicting documentation in the medical record. The following list denotes common situations when it is appropriate to query.

- For resolution of conflicting diagnostic or procedural documentation between physicians
- For documentation of diagnoses or conditions that are clinically evident and meet the Uniform Hospital Discharge Data Set (UHDDS) requirements but were never stated in the health record
- For establishment of the acuity or specificity of a documented diagnosis to support reporting the most accurate and specific ICD-10 code
- To inquire about a cause and effect relationship between medical conditions
- For clinical validation of a documented diagnosis that does not appear to be clinically supported in the medical record
- For documented “history of” conditions to determine if the condition is active
- For clarification of the presence or absence of a complication

## Query Guidelines

AHIMA’s practice brief notes the following industry standard guidelines for physician queries.



1. The answer of “unable to determine” is not equivalent to “unable to rule out” and does not represent an uncertain diagnosis. If this answer is given, do not ask the same question of a different physician.
2. Do not query when there is already sufficient documentation to assign a valid code.
3. Only include clinically relevant options supported by the clinical indicators. For example, do not include hypernatremia in the answer options when the sodium level is low.
4. Do not query for confirmation of a condition that was already documented as having been ruled out.
5. Asking “yes or no” questions is only permitted when determining POA (present on admission) status, substantiating a diagnosis that is already present in the record, such as on a radiology or pathology report, or establishing a cause and effect relationship.
6. Do not query for a condition when a laboratory result is slightly abnormal but there was no documentation of follow up or treatment.
7. Do not query for conditions documented as insignificant or trivial, or those that are insignificant per coding guidelines.
8. Do not query for the same diagnosis multiple times when the physician states that no answer can be determined.
9. Do not support a query with clinical indicators that are clearly attributed to another reported condition.
10. When listing clinical indicators on a query, do not state them in diagnostic form, e.g., if the pulse is 140, do not call that tachycardia if it was not documented as such.

## Query Templates

When creating query templates, they must align with other standards in the AHIMA Query Practice Brief. The following list defines elements of a good template.

- Space for clear patient identification
- Information is able to be edited or customized
- Wording is clear and concise
- The template title does not lead the physician to a particular diagnosis
- The template should include space to note clinical indicators and their locations in the record. These clinical indicators should:
  - directly support the condition requiring clarification;
  - paint the clinical picture of the diagnosis queried;
  - use supporting documentation that will lead to the most accurate code; and
  - include information from the entire health record.
- The template should always allow the physician to enter their own answer.

## Problem Lists

AHIMA defines problem lists as lists of active diagnoses that are relevant to the current episode of care. These lists should not include resolved or insignificant conditions. There are two guidelines for using problem lists with queries:

- Organizations should develop and implement policies and procedures that designate who can update problem lists, especially after receiving a query response.
- When updating a problem list, elements that reflect financial reimbursement or quality impact should not be identifiable. Examples include relative weights, complications, hospital acquired conditions (HACs), major complications and comorbid conditions (MCCs), complications and comorbidities (CCs), and hierarchical condition categories (HCCs).

## Policies and Procedures

Organizations should develop policies and procedures to manage and monitor their query practices and confirm that proper procedures are being followed. Remember that queries of all documentation types are to be retained according to state regulations. Here are some examples of information to be included in policies and procedures:

- Template approval process
- Query audit processes
  - Frequency
  - Responsible staff
  - Development of the audit tool itself
- Multiple queries
  - How many topics per query?
  - How many queries in the same encounter?
- Clinical criteria
  - Organizations may define specific criteria for particular diagnoses.
- Timing
  - Define when queries can be sent in relation to the timing of the encounter.
    - Best practice is to send queries as close as possible to the time of the encounter.
    - Set rebilling policies when post-bill query answers would impact reimbursement.
- Retention
  - Specify whether completed queries will be a permanent part of the health record or of the business record.
- Escalation Policies
  - Process
    - Outline the expectations of each individual involved in the process, including time frames in which resolution or further escalation is expected.
    - Describe the escalation process, who it begins with, and the expectations for resolution.
  - Purpose
    - Dealing with unanswered queries
    - Addressing medical staff concerns regarding queries
    - Allow provider feedback on the query process

## Previous Encounters

While codes may not be assigned from previous encounters, there are times when information from previous encounters is appropriate. Below is a list of situations in which information from previous encounters may be included in queries.

- Diagnostic criteria allowing for further specificity of a currently documented diagnosis such as the type of heart failure, type of arrhythmia, stage of chronic kidney disease (CKD), etc.
- Treatment or clinical criteria that support a diagnosis documented in the current encounter
- Determination of the prior patient baseline that allows for comparison to the current presentation
- Establishment of a cause and effect relationship such as evidence of a complication
- Determination of the etiology of current signs or symptoms
- Verification of present on admission (POA) indicator status
- Clarification of whether a documented condition had previously resolved

## In Conclusion

The objective of a query is to ensure the reported diagnoses and procedures derived from the health record documentation accurately reflect the patient's episode of care. Livanta advises hospitals to query the physician before finalizing the claim to reduce the number of claim denials based on clinical validity during HWDRG reviews. For example, the physician documented pneumonia, but the patient only received one dose of antibiotics. Clarify the presence or absence of pneumonia before initial submission of the claim, or before adding the diagnosis when adjusting the claim.



## About Livanta

Livanta is the national Medicare Claim Review Services contractor under the Beneficiary and Family Centered Care – Quality Improvement Organization (BFCC-QIO) Program. As the Claim Review Services contractor, Livanta validates the DRG on hospital claims that have been adjusted to pay at a higher weight. The adjusted claim is reviewed to ensure that the diagnoses, procedures, and discharge status of the patient reported on the hospital’s claim are supported by the documentation in the patient’s medical record. Livanta’s highly trained, credentialed coding auditors adhere to the accepted principles of coding practices to validate the accuracy of the hospital codes that affect the DRG payment. When needed, actively practicing physicians review for medical necessity and clinical validity based on the presence of supporting documentation and clinical indicators.

Post-payment review of these HWDRG adjustments is mandated under statute and in CMS QIO Manual: Perform DRG validation on prospective payment system (PPS) cases (including hospital-requested higher-weighted DRG assignments), as appropriate (see §1866(a)(1)(F) of the Act and 42 CFR 476.71(a)(4)).

**Read more: CMS, Quality Improvement Organization Manual, Chapter 4 - Case Review**  
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c04.pdf>

## Questions?

Should you have questions, please email [ClaimReview@Livanta.com](mailto:ClaimReview@Livanta.com).

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