Mastering Physician Queries in the Hospital Setting

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Wolters Kluwer

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Learning Objectives

- Evaluate when to query physicians
- Describe a compliant physician query
- Identify key guidelines for effective queries
- Determine when to issue concurrent, retrospective or post-bill queries
- Describe the steps for a compliant query
Why Query Physicians?

• Complete and accurate documentation is key
• Querying is a vital part of that documentation process
What is a Physician Query?

• Communication tool to improve the accuracy of coding by actively involving the physician in the clarification and full completion of any documentation

• Present specific facts derived from the medical record and identify why clarification is needed
A query is defined as a question to a physician to obtain additional, clarifying documentation to improve the specificity and completeness of the data used to assign diagnosis and procedure codes in the patient’s health record.
Query Guidelines

• Condition or diagnosis established already in the medical record
• All payer types regardless of the impact on reimbursement – not just a “DRG thing”
• A query never indicates the financial impact
• Statement of facts
• Non-leading queries
• Documentation of clarification
When to query?

• Does the patient’s health record have:
  – Conflicting information
  – Ambiguous information
  – Incomplete information
  – Clinically relevant information not addressed
  – Any significant reportable condition or procedure?

If you answered “yes” to any of the above the coder should query the provider
A diagnosis of COPD on an anesthesia evaluation is signed by the anesthesiologist. No other medical record documentation exists stating COPD. Should COPD be reflected by the attending physician in the body of the record such as the H&P in order to be coded?
• Coding Clinic Second Quarter 2000:

  – It would be appropriate to assign 496-COPD. The anesthesiologist is a physician & coding is based on physician documentation. However, if there is conflicting information in the record, query the physician for clarification. It is the responsibility of the coder to query the physician to determine if this diagnosis should be included in the final diagnostic statement
Coders are instructed to query the physician more than 50 times in the AHA Coding Clinic:

- To seek clarification
- If the documentation is ambiguous
- If there is conflicting documentation
Challenging Handwriting
Legibility Issues

- Illegible entries in the patient health record can cause:
  - Misunderstanding of the patient’s condition
  - Serious patient injury
  - Incorrect reimbursement
  - Legal viability
  - Data collection and reporting
Four Specific Documentation Scenarios

• Completeness
• Clarity
• Consistency
• Precision
Completeness

• Missing test results
  X-ray reports available but provider doesn’t document the abnormal results
• Progress notes missing
• Short stay summary missing with no other provider documentation
Completeness - Missing Documentation

• Missing documentation is not a query issue.
• Coders must simply address the record as incomplete and acquire the missing documentation that needs to be present in the record.
Completeness - Unaddressed Documentation

• Documentation that exists in the record yet is unaddressed is, or certainly may be, a query issue

• Unaddressed findings such as abnormal labs or x-rays suggestive of diagnoses need to be discussed with a clinician and their significance established before they can be coded

• Here, a physician query may prove useful
Clarity

• Diagnosis may have evolved from a lesser to more significant condition.
• Diagnosis is documented without documentation of cause or suspected cause or no clinical validation
  - Clarifying a potential cause & effect relationship
• Present on admission (POA) determination can’t be made for the diagnosis with current provider documentation
Example of Clarity issue:

Patient is admitted with pneumonia. The admitting H&P exam reveals WBC of 14,000; a respiratory rate of 24; a temperature of 102 F; heart rate of 120; hypotension; and altered mental status. The patient is administered an IV antibiotic and IV fluid resuscitation.
Clarity Query:

**Query:** Based on your clinical judgment, can you provide a diagnosis that represents the below-listed clinical indicators?

In this patient admitted with pneumonia, the admitting history and physical examination reveals the following: WBC 14,000, Respiratory rate 24, Temperature 102°F, Heart rate 120, Hypotension, Altered mental status, IV antibiotic administration, IV fluid resuscitation

Please document the condition and the causative organism (if known) in the medical record
Consistency

• Differing diagnoses between two or more providers
• Documentation of clinical indicators, diagnostic tests, and treatment but no relative condition documented that is consistent with those findings
Example of Consistency Issue:

A patient is admitted with chest pain radiating through to his middle back. The provider orders multiple tests to rule out cardiac diagnoses which are all ruled out. On day 2 of the stay, the provider orders the head of the bed to be raised, no coffee or fatty foods, and a 20 mg dose of omeprazole daily. On day 4, the patient's symptoms subside and he is discharged home. There is no diagnosis documented by the provider.
Consistency query:

Query: Based on your clinical judgment, can you provide a diagnosis that represents the below-listed clinical indicators?

- This patient was admitted with chest pain radiating through to his back. Cardiac testing was performed and a cardiac condition was ruled out based on the documentation. The patient received a no fat, no coffee diet with orders to elevate the head of the bed and 20 mg of omeprazole daily.

- Please document the condition and the causative organism (if known) in the medical record.
Precision

- Documentation of an unspecified diagnosis when clinical reports and clinical documentation is noted suggestive of a diagnosis subject to greater specificity
- Requesting further specificity or the degree of severity of a documented condition
Example of Precision issue:

A patient is admitted for a right hip fracture. The H&P notes that the patient has a history of chronic congestive heart failure. A recent echocardiogram showed left ventricular ejection fraction (EF) of 25%. The patient’s home medications include metoprolol XL, lisinopril, and Lasix.
Query: It is noted in the impression of the H&P that the patient has chronic congestive heart failure and a recent echocardiogram noted under the cardiac review of systems reveals an EF of 25 percent. Can the chronic heart failure be further specified as:

–Chronic systolic heart failure____________________
–Chronic diastolic heart failure____________________
–Chronic systolic and diastolic heart failure_________
–Some other type of heart failure___________________
–Undetermined_________________________________
–Clinically irrelevant_____________________________
Timing of a Query

- Concurrent
- Retrospective
- Post-bill
Timing of a Query

Concurrent

– Query issued while the patient is still in house
– Happens in real time
– Encourages more timely, accurate and reliable responses
Timing of a Query

Retrospective

– Initiated after the patient is discharged but prior to the bill being submitted
– Effective in cases that have additional information available in the health record
– Short stays where concurrent reviews are generally not completed
– When concurrent queries are not feasible
Timing of a Query

Post-bill

– Initiated after the bill has been submitted
– Most often completed after an audit (internal or external)
– Comment on Post-bill
When NOT to Query

- Do not query to question a provider’s clinical judgment
  - Chest x-ray is negative but the provider documents clinical pneumonia
- Do not query when the benefit is strictly for reimbursement
- Clinically insignificant findings or irrelevant information
How to Query

Format:

- Patient name
- Admission date / date of service
- Medical record number
- Account number
- Date of query
- Name/contact information of Coder/CDI
- Statement of the issue
How to Query

Statement of the Issue:

– Written as a question
– Include clinical indicators from the chart
– Ask the practitioner to make a clinical interpretation of the facts in the chart
– Query format should not sound presumptive, directing, prodding, probing or as though the practitioner is being led to a diagnosis
Avoid “Leading Queries”

Per AHIMA:

“A query is never intended to lead the provider to one desired outcome. The query must provide reasonable clinically supported options, include clinical indicators, and must not result in a yes/no answer. The query must include the option that no additional documentation or clarification can be provided.”
Yes/No Queries

• In general, queries should not be designed to ask questions that result in a yes/no response

• Original Exception:

  POA queries when a diagnosis has already been documented.

  Was the condition POA? yes/no
Yes/No Queries

- 3 additional exceptions
- Substantiating or further specifying “a diagnosis that is already present in the record”
- Establishing a cause-and-effect relationship between documented conditions such as manifestation/etiology, complications and conditions/diagnostic findings
- To resolve conflicting practitioner documentation
  - In all yes/no cases, provide an “other” option
Dear Dr. Jones,

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.
Query Policy and Procedures

Organizational policy and procedures should address:

• Format
• Frequency
• Templates
• Non-compliance
• Maintenance

AND:
Query Policy and Procedures

More important than anything else:

• The policy MUST address whether the physical query form becomes a permanent part of the medical record or whether the physicians are required to clarify the query answer in a progress note or as an official addendum to the medical record.
More important than anything else:

- CMS and QIOs have shown themselves to be OK with a physician query form in the medical record “to the extent it provides clarification and is consistent with other medical record documentation”.

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Summary

• Quality of coding is dependent on quality of documentation
• Query is a communication tool
• Fact-based to clarify documentation and improve data integrity
• Components include timeliness, language, and relevance
• Policies and procedures are key to success
Summary

• Continuously foster a relationship with your physicians!!! Do you have a physician advisor?

• Always keep the query open-ended and allow the physician to document the specific diagnosis OR check an “OTHER” box!!

• Good query forms even include a specific statement that explains “the question asked does not imply that a particular answer is desired”. If your query seems TOO focused on a desired answer, it may in fact be “leading”

• You walk a very fine line!

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Summary

- YOU, the coder, must be guided at all times by AHIMA’s Standards of Ethical Coding, as well as, all other official coding guidelines, UHDDS guidelines, AHA Coding Clinic Guidelines, and by all that is initially dictated by the Conventions of the Classification.
ICD-10-CM and ICD-10-PCS

• If you are mastering the process for physician queries NOW…

• …the transition to ICD-10-CM and ICD-10-PCS will occur far more efficiently.
References

- DHHS QIP TOPS #: PRO 2001-13
- AHIMA Issue: Use of Physician Query Forms, 2001
- AHIMA Practice Brief: Guidance for Clinical Documentation Improvement Programs, 2010
- AHIMA: Physician Query Examples, 2013
Questions?

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