Physician Queries: Proper vs. improper ways to write them

In October, 2008 the long awaited AHIMA Practice Brief was submitted on Managing a Proper Physician Query Process. As more and more hospitals implement this process along with Clinical Documentation programs (often referred to as CDMP programs), it becomes critical that coders understand the proper ways to query a physician.

In the new practice brief, the following is emphasized:

“In today’s changing healthcare environment, health information management (HIM) professionals face increased demands to produce accurate coded data. Therefore, establishing and managing an effective query process is an integral component of ensuring data integrity. A query is defined as a question posed to a provider 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. Documentation can be greatly improved by a properly functioning query process.”

Proper Physician Query examples:

When we look at ways of how we query physicians, here are some examples from the brief on proper ways to query a physician:

It is recommended that the healthcare entity’s policy address the query format. A query generally includes the following information:

- Patient name
- Admission date and/or date of service
- Health record number
- Account number
- Date query initiated
- Name and contact information of the individual initiating the query
- Statement of the issue in the form of a question along with clinical indicators specified from the chart (e.g., history and physical states urosepsis, lab reports WBC of 14,400. Emergency department report fever of 102)
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Example 1:

Dr. Smith—In your progress note on 6/20, you documented anemia and ordered transfusion of 2 units of blood. Also, according to the lab work done on xx/xx, the patient had a 10 point drop in hematocrit following surgery. Based on these indications, please document, in the discharge summary, the type of anemia you were treating.

Example 2:

Dr. Jones—This patient has COPD and is on oxygen every night at home and has been on continuous oxygen since admission. Based on these indications, please indicate if you were treating one of the following diagnoses:

- Chronic Respiratory Failure
- Acute Respiratory Failure
- Acute on Chronic Respiratory Failure
- Hypoxia
- Unable to determine
- Other:____________________

Improper Physician Query Examples:

It is not advisable to record queries on handwritten sticky notes, scratch paper, or other notes that can be removed and discarded. The preferred formats for capturing the query include facility-approved query form, facsimile transmission, electronic communication on secure e-mail, or secure IT messaging system.

It is recommended that queries be written with precise language, identifying clinical indications from the health record and asking the provider to make a clinical interpretation of these facts based on his or her professional judgment of the case. Queries that appear to lead the provider to document a particular response could result in allegations of inappropriate upcoding. The query format should not sound presumptive, directing, prodding, probing, or as though the provider is being led to make an assumption.

Example 1 of an improper query:

Dr. Smith—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.
Example 2 of an improper query:

Dr. Jones—This patient has COPD and is on oxygen every night at home and has been on continuous oxygen since admission. Please document “Chronic Respiratory Failure.”

In these examples the provider is not given any documentation option other than the specific diagnosis requested. The statements are directive in nature, indicating what the provider should document, rather than querying the provider for his or her professional determination of the clinical facts. In the first example, the statement “the patient has anemia” may be presumptive, and the statement “please document ‘acute blood loss anemia’” is directive and clearly leading the provider. In the second example, the provider is inappropriately asked to document chronic respiratory failure.

The AHIMA Practice Brief on the Physician Query Process will be a valuable tool for facilities and coders to refer to on the proper ways of clarifying key diagnoses and procedures for coders to come to the correct DRG and reimbursement of charts they are coding. Knowing the proper way of how to submit physician queries is a key compliance requirement that all coders should be well educated on.

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