

# **The Physician Query Process & Compliance Issues**

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# Speaker

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# Disclaimer

- This material is designed and provided to communicate information about clinical documentation, coding, and compliance in an educational format and manner.
- The author is not providing or offering legal advice but, rather, practical and useful information and tools to achieve compliant results in the area of clinical documentation, data quality, and coding.
- Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful.
- Applying best practice solutions and achieving results will vary in each hospital/facility and clinical situation.

# Goals and Objectives

- Review the history behind physician queries
- Developing physician query policies and procedures: different models and staff
- Putting the physician query process into action
  - Why, When and How
  - CDI and HIM Coding
- Maintaining a compliant physician query process: traditional steps
- Risk Areas for Physician Queries and CDI Programs
- Summary of your action items for success

# Keep this Quote in Mind in Your/Our Healthcare Compliance World

- *The time is always right to what is right!*  
– Martin Luther King Jr.

# And the Golden Rule ...

- “If it’s not documented by the physician/provider, it didn’t happen.”

- Before MS-DRGs and now after ... In healthcare compliance and in coding, there is no deviation from this principle. We can’t code it if it isn’t documented, and thus we can’t bill for it.

# CMS' IPPS MS-DRG Clinical Documentation Integrity

- “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.”
  - Direct quote, CMS 2008 IPPS Final Rule, <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf>, p. 208.
  - **Opportunity in this statement, if put into action . . .**

# We have a Problem...

- There are 1.2 billion outpatient and physician office visits per year in the U.S. Research shows that between 10 and 70 percent of patient medical records contain documentation that is of poor quality, or on average about 45 percent. **Therefore, each year, about 500 million patient record entries are created that contain poor quality clinical documentation.**
- Source: CDMatters

# Recent Studies Relating to Documentation

- In a recent survey conducted by DJ Iber Publishing, a third of organizations reported that their concurrent query rates were between 10 and 24 percent, and another 22 percent of organizations reported that their concurrent query rates were between 25 and 35 percent.
- In a study published in the Journal of Bone and Joint Surgery, the researchers note that a possible reason for the widespread lack of proper documentation is a lack of emphasis on careful documentation in medical school, residency, and physician practices.

# History of Physician Query

- HIM Coding has since DRGs started been utilizing a physician query
  - Attestation was also used
- This might be verbal or ... as the years went by 1990's "forms" were created
- Concerns in 1998-2000 rose with "Up Coding" and OIG investigations
- "Some" Clinical Documentation Improvement activities began to focus on the concurrent timeline
- CMS January 2001 QIOs directed not to accept Query Forms

# History of Physician Query

- QIOs were concerned
  - CMS Town Hall Meeting July 2001
- CMS October 2001 directive allowed consideration of Query Forms... if ...
  - Certain steps and elements were in place and they were “Not leading”

# CMS guidance

- As described by the TMF Quality Institute (QIO for Texas), “Use of the physician query form is permissible to the extent it provides clarification and is consistent with other medical record documentation.” CMS’ position is that a query form should not be leading, and it should not introduce new information not otherwise contained in the medical record.
- A query form would be considered acceptable “to the extent it provides clarification and is consistent with other medical record documentation.”
- A query form should NOT be leading, and it should not introduce new information not otherwise contained in the medical record. This is not the same as asking for clarification or the clinical significance of findings or tests.

# CMS guidance

- Per DHHS (Department of Health & Human Services) Office of Clinical Standards and Quality - PRO 2001-13
- Query forms should be:
  - Clearly and concisely written
  - Contain precise language
  - Present the facts and identify why the clarification is needed
  - Present the scenario

# CMS guidance



- The query form can/should be used “to the extent it provides clarification and is consistent with other medical record documentation.”
- The query form should be phrased such that the physician is allowed to specify the correct diagnosis. It should not indicate the financial impact of the response.
- The form should not be designed so that the only thing required is a signature.

# Time Marches on... Query History

- AHIMA 2001 Practice Brief on Physician Query
- Between 2001 and 2008 HIM and Providers were “doing the best they could”
- Emergence of Clinical Documentation Improvement Programs or CDI
- Greater scrutiny with HIM Coding Queries and CDI
- AHIMA 2008 Practice Brief on Managing the Physician Query Process
- AND ....Greater scrutiny again with HIM Coding Queries and CDI

# Why do we need to query the Physician?

- Fact and Reality is: Disconnect between clinical terminology and the **classification system** terminology in coding (ICD-9-CM) And CPT also
- Lack of sufficient documentation or no documentation to support the healthcare claim/charges
- Documentation and charges did not meet medical necessity
- Documentation that is conflicting, contrasting, or ambiguous
- Documentation is nonspecific
- Reimbursements systems are “CODE DEPENDENT”

# Why we need to Query the Physician

- Querying for proper documentation is crucial to patient care, risk management, coding, and billing
- Not all documentation is complete at the time of coding
- Joint Commission and Medicare both require documentation of the clinical significance of abnormal test results
- Healthcare compliance (fraud and abuse)

# Why we need to Query the Physician

- OIG audit findings
  - DRG reports
- Recovery Audit Contractor (RAC) findings
- *AHA Coding Clinic* guidance—direction to query
- MS-DRGs require greater coding specificity, thus, the documentation also needs to be specific and detailed ... querying is needed
- Healthcare is complex!

# Documentation Presents Risks

- The physician uses symbols: plusses, minuses, up arrows, down arrows.
- In the clinical situation, it is incumbent on coders to seek clarification if that “Na” with an up arrow means hypernatremia or something else, such as sodium levels returning to normal.
- If the “Hb” with a down arrow and a level of 6.8 grams indicate that the transfusion was for anemia, what was the cause of the anemia if that’s indeed what was meant?
- Does “ETOH” with a plus mean the patient is alcoholic, an alcohol abuser, drinks socially, or had a positive blood alcohol level? There are codes for many of these and no code should be assigned to others.

# Capturing Severity of illness and Risk of mortality

- “My patients are sicker,” this is often said by physicians.
- How do we or how can we best demonstrate this?
- Reflect the resources used via physician documentation of the diagnostic information.
- Comorbid conditions are examples.
- SOI and ROM

# Capture Reportable conditions

- Document the condition if the condition affected the hospital care in terms of any one of the following:
  - Clinical evaluation
  - Therapeutic treatment
  - Further diagnostic studies, procedures, or consultation
  - Extended the length of stay
  - Increased nursing care and/or monitoring

# When to Query?

- Traditionally within the HIM coding process
  - At the time of coding “prebill”
- Retrospective audits identify opportunity to query the physician for clarification
  - After coding and billing has taken place
- Clinical Documentation Improvement programs **concurrently** review the medical record to identify opportunities to query the physician for clarification, etc.
  - While the patient is in the hospital

# AHIMA Practice Brief 2008

- “Concurrent queries are initiated “real time,” during the course of the patient encounter or hospitalization—at the time the documentation is naturally done. They, thus, encourage more timely, accurate, and reliable responses.
- Retrospective queries are effective in cases where additional information is available in the health record, in short stays where concurrent review was not completed, or whenever a concurrent query process is not feasible.
- Post-bill queries are initiated after the claim is submitted or remittance advice is paid. Post-bill queries generally occur as a result of an audit or other internal monitor. Healthcare entities can develop a policy regarding whether they will generate post-bill queries and the time frame following claims generation that queries may be initiated.”

# When there is Clinical Indications

- A thorough review of the medical record is needed.
- Review lab and radiology findings, MD order, nursing notes.
- Knowledge of “clinical indicators” for some common or specific diagnosis.
  - Nursing, MDs and HIM Coding professionals
- Prior audit would have indicated the focus of query/clarification to clinical areas or MS-DRGs.

# How Do We Query the Physician?

- *Without leading* the physician to a diagnosis
- Without suggesting a diagnosis
- It's a balancing act and it takes skill



# Query Forms Should

- Identify the patient and DOS
- Be clearly and concisely written
- Contain precise language
- Present the facts
- Contact information



# Physician Query or Clarification

- Query/Clarification/Communication all the same
- Verbal communication
  - Should not be leading either
  - Should maintain a record of verbal communications
- Written & Electronic messaging communication

# COMPLIANCE: CDI Case to Look At.....

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## Bayview settles claims case for \$2.75 million

By Tricia Bishop  
Baltimore Sun reporter  
*July 1, 2009*



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Johns Hopkins Bayview Medical Center Inc. has agreed to pay \$2.75 million to settle allegations that it filed false claims to federal health benefits programs for nearly two years, **the U.S.** attorney for Maryland announced Tuesday.

From July 2005 though February 2007, Bayview employees claimed that patients were treated for

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# Essentials of Hopkins Case

- Bayview employees were assigned to work in the coding department to assist in clinical documentation.
- They reviewed charts relating to inpatient hospital stays to determine if there was any way for the hospital to increase reimbursement by increasing the severity of the secondary diagnoses recorded for certain patients.
- The employees allegedly focused on lab test results which might indicate the presence of a complicating secondary diagnosis such as malnutrition or respiratory failure, and **advised treating doctors to include such a diagnosis in the medical record**, even if the condition was not actually diagnosed or treated during the hospital stay, in violation of billing rules adopted by federal health benefit programs.

Source: Department of Justice

# Essentials of Hopkins Case

- A physician would retrospectively review charts 2-3 times a week.
- If the physician found ONE or more abnormal lab value (e.g. low platelet count) without any documentation of a diagnosis or treatment, he would e-mail the attending physician to tell him or her that if they added a diagnosis that the APR-DRG SOI would increase.
- After this communication, he would place a “non-leading” query on the chart by which the physician would write the answer that had been previously negotiated.
- The way the OIG found this was to procure his computer and review his e-mails.

## SETTLEMENT AGREEMENT

### I. PARTIES

This Settlement Agreement (Agreement) is entered into among the United States of America, acting through the United States Department of Justice and on behalf of the Office of Inspector General ("OIG-HHS") of the Department of Health and Human Services ("HHS"); TRICARE Management Activity ("TMA"), through its General Counsel; the Office of Personnel Management ("OPM"), which administers the Federal Employees Health Benefits Program ("FEHBP")(collectively the "United States"), and the state of Maryland, through the Attorney General for the State of Maryland; Robin L. Enrick and Margaret E. Mayer ("Relators"); and Johns Hopkins Bayview Medical Center, Inc. (hereinafter referred to as "Bayview" or "the Settling Defendant") (hereafter collectively referred to as "the Parties"), through their authorized representatives.

### II. PREAMBLE

As a preamble to this Agreement, the Parties agree to the following:

A. Bayview is a Maryland corporation with its offices in Baltimore, Maryland. Bayview, as relevant to this Settlement, is in the business of providing acute inpatient care at its facility in Baltimore, Maryland.

B. The Relators, Margaret E. Mayer and Robin L. Enrick are residents of the State of Maryland. On July 26, 2007, Relators filed a *quij tam* action in the United States District Court for the District of Maryland captioned *U.S. ex rel. Margaret E. Mayer and Robin L. Enrick v. Johns Hopkins Bayview Medical Center, et al.*, Civil Action No. WDQ-07-2011 (hereinafter "the Complaint") alleging that the Settling Defendant violated the False Claims Act by submitting false or fraudulent claims to federal health benefits programs for reimbursement

# Another Example of Query and CDI Risk...

**EXAMPLE OF MESSAGE FROM RNDS TO PHYSICIAN REGARDING CLINICAL DOCUMENTATION CLARIFICATION**

Medicare requires the use of specific language to capture the severity and acuity of patients. This clarification is being sent from \_\_\_\_\_, RN documentation specialist.

Please render your clinical opinion if patient is also being managed for acute renal failure based on the risk factors of "volume depletion"; clinical s/s "creatinine elevated to 1.8 from baseline of ~1.2"; chart documentation "ARI" and treatment "follow with volume repletion."

Please check your response below. If you agree, I will update the problem list and prepare the clarification note for your electronic signature. It will appear for signature in your ORCA message in-box.

Agree       Disagree

Thanks!

- This query example appeared in the HFMA Journal in February 2010 in an article describing a successful EHR CDI program.
- And the Hospital this came from ... is?

# What is “*leading*”?

- “Leading” is implied when the expected answer is in the question
- Giving the expected answer to the question
- Examples:
  - Was the chest pain caused by unstable angina?
  - Was the patient on Lasix to treat CHF?
  - The patient was dehydrated, correct?

# Example of Leading Query

DOCTOR, <sup>NOT SEPTIC</sup> in case I miss you... <sup>JUST URROSEPTIC</sup>  
Dr. \_\_\_\_\_ if you  
diagnose w  
sepsis, please document  
sepsis as UTI. This would  
↑ the DRG to # 490.93. If it is  
a plain UTI, reimbursement  
From W 3662.67

# Leading or NonLeading?



- Patient seen in the ED/ER feeling tired, weak, mentally not clear, and fever. UA shows bacteria. ED/ER MD documents “Urosepsis” as the admitting diagnosis. H&P reports the patient is also hypotensive and is taken to ICU with IV antibiotics. Diagnosis is “Urosepsis” on the H&P and discharge summary after six days.
- Dr. XX, it appears this patient has clinical indications of Sepsis. Please document a sepsis diagnosis in the space below. Thank you.

# Leading or NonLeading?



- Inpatient chart documentation (lab work) shows lowered Hgb at 9.2 and a packed cell blood transfusion is given.
- There is no physician documentation of “anemia” anywhere in the record.
- Dear Dr XX, your patient has a drop in Hgb and this is a clinical indication of acute blood loss anemia, if you agree please document that diagnosis. Thank you.

# Reality Is ... Ethics and Compliance Matters... Even for Clinical Staff Involved in the Query Process

- The recent AHIMA Practice Brief and Ethical Standards for CDI are strong.
  - Know the rules
  - CMS looks to AHIMA as the authority
- Critical questions
  - Was the person posing the query involved in direct face-to-face patient care, prompting a “clinical discussion” directly related to patient care?
    - Really involved in patient care?
  - Are there policies and procedures guiding the “diagnosis suggestion” process?
  - To what extent does industry standards from AHIMA (a member of the Cooperating Parties) apply to individuals that are members of that organization?
  - Can an organization defend its query process?

# The Federal False Claims Act ("FCA")

- Well-utilized enforcement tool by DOJ and whistleblowers
  - AHIMA
- Liability for “knowingly” submitting or causing to be submitted a false or fraudulent claims and statements to the government
- “Knowingly” =
  - Actual knowledge,
  - Reckless disregard of the truth or falsity of the claim
  - Deliberate ignorance of the truth or falsity of the claim
- Enforced by DOJ (and OIG)
- Civil - “preponderance of the evidence”

# AHIMA Practice Brief: Managing the Physician Query Process

- October 2008



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## Managing an Effective Query Process

*Note:* This practice brief updates the 2001 practice brief “Developing a Physician Query Process,” with a continued focus on compliance.

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.

This practice brief offers HIM professionals important components to consider in the management of an effective query process. It is intended to offer guiding principles to implement the query process while in no way prescribing what must be done.

### Background

The “ICD-9-CM Official Guidelines for Coding and Reporting” are the official rules for coding and reporting ICD-9-CM. They are approved by the four organizations that make up the ICD-9-CM Cooperating Parties: the American Hospital Association, the American Health Information Management Association, the Centers for Medicare and Medicaid Services, and the National Center for Health Statistics. The guidelines may be used as a companion document to the official current version of the ICD-9-CM coding conventions and instructions.

The guidelines state:

A joint effort between the health care provider and the coding professional is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coding professional in identifying those diagnoses and procedures that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.<sup>1</sup>

# Medical Record Completeness

- According to the AHIMA Practice Brief the medical record should be:
  - 1) legible
  - 2) complete
  - 3) clear
  - 4) consistent
  - 5) precise.

# New AHIMA Practice Brief for CDI

- *March 26, 2010* **AHIMA: Physician Query Constraints Should Be Same for Coders and Clinical Documentation Improvement Specialists**
- Though AHIMA practice briefs are not binding, they're the industry standard.
- Multidisciplinary team was used to develop the Practice Brief, MS, RNs and HIM professionals.
- Can your HIM Coding Query process and your CDI processes stand up to industry standard?

# CDI Concurrent Query Process

- The clinical experience of CDI specialists doesn't give them license to ask physicians leading questions, AHIMA says. "There should not be different rules for different professionals," says Kathryn DeVault, AHIMA's manager of professional practices.
  - Scope of Practice
  - Job description allow to diagnose the patient?
- "There is a growing trend toward different query procedures based on the professional — coder versus CDI specialist — completing the query, but how would the [HHS] Office of Inspector General view this?"
- **Must have appropriate professional make a diagnosis**

# CDI and Query Process

- Using the word ***query***, some organizations present physicians with a “***documentation clarification***” or “***documentation alert***.”
- But a query by any other name is still a query, DeVault (AHIMA) says, and a leading query is inappropriate no matter what you call it. “It’s just semantics .”
- “You can’t choose to ignore AHIMA. They have the greatest body of knowledge in this area,” says Garry, former assistant director of medical documentation at New York University Medical Center.

# AHIMA CDI Practice Brief

- **May 2010 - Guidance for Clinical Documentation Improvement Programs**
- Healthcare consumers are unique. Each person has his or her own combination of medical conditions that organizations must somehow standardize for data comparison. One way to capture these data is by translating clinical documentation into codes such as ICD-9-CM and CPT.
- Historically, in the inpatient setting, data collection occurred after the patient was discharged. After discharge, HIM professionals checked the record for discrepancies that could hinder code assignment. HIM professionals would then query the provider for clarification. (For purposes of this practice brief, the term “query” will be used to identify any physician communication tool.)
- However, with the implementation of the prospective payment system, coded data took on greater significance and became a mechanism for reimbursement, quality measure reporting, and profiling. The increased need for interpreting coded data for meaningful comparison and quality reporting has led to the expansion of the HIM professional’s role in clinical documentation improvement (**CDI**).
- The focus of most **CDI** programs is on improving the quality of clinical documentation regardless of its impact on revenue. Arguably, the most vital role of a **CDI** program is facilitating an accurate representation of healthcare services through complete and accurate reporting of diagnoses and procedures.

# AHIMA CDI Practice Brief (Con't)

- Those who typically fill **CDI** roles include, but are not limited to, HIM professionals, nurses, physicians, and other healthcare professionals with a clinical or coding background.
- **CDI** programs use a variety of staffing models. The program may be staffed with one or more healthcare disciplines (e.g., HIM professionals, registered nurses, or other clinical staff).

# AHIMA CDI Practice Brief (Con't)

- A query is a routine communication and education tool used to advocate complete and compliant documentation. Although AHIMA refers to this communication to providers as a “query,” **CDI** programs may use different names, such as clinical clarification, documentation alerts, and documentation clarification.
- Regardless of what the communication is called, the query should adhere to the guidance outlined in the 2008 practice brief “Managing an Effective Query Process” and the new CDI practice brief.

# AHIMA CDI Practice Brief (Con't)

- If anemia is not already documented in the health record then the written query should not be titled “anemia.” However, if anemia is already documented in the health record, then a written query may be titled “anemia” and seek additional specificity regarding the type.

# Quality Assurance (QA) for CDI and Coding Query Process and Forms

- Random or focused sampling of CDI query process and forms
- Random or focused sampling of HIM Coding query process and forms
- Annual Review of Policy
- Annual Review of Forms
- Education

# Ethics and Integrity

## Code of Ethics

### **Association of Clinical Documentation Improvement Specialists (ACDIS)**

#### **Sections:**

- **Preamble** – Provides the ethical obligation of the members and credentialed nonmembers.
- **Values** – Summarizes the core values based on the mission of the Association.
- **Purpose** – Delineates the five purposes for the Code of Ethics.
- **Application of the Code of Ethics** – Describes how ACDIS members and credentialed nonmembers should use the Code.
- **Ethical Principles** – Describes the 12 ethical principles to which members and credentialed nonmembers should adhere.
- **How to Interpret the Code of Ethics** – Provides guidelines to help members and credentialed nonmembers interpret the 12 principles.

#### ***Preamble***

The ACDIS Code of Ethics serves as a guide for the professional behavior of its members and nonmembers who hold the certified clinical documentation specialist (CCDS) credential. This code of ethical standards for members of ACDIS strives to promote and maintain the highest standard of professional service and conduct among its members. Adherence to these standards assures public confidence in

# AHIMA CDI Ethics Standards

- This new document is coming and will be released soon.

# Awareness and education—to physicians

- Why queries are used
- Outline the process, including expectations for response (e.g., how, time frame)
- We are in the process of updating/revising a regional policy and procedure.
- Provide examples of queries that the physicians might see based on known issues in your facility
- Emphasize the documentation improvement aspect and how the query may be a learning tool for the physicians to be aware of the necessary documentation for coding in particular clinical situations

# Query/Clarification on Example – Angina

## PHYSICIAN DOCUMENTATION QUERY ANGINA DIAGNOSIS CLARIFICATION

Dear Dr: \_\_\_\_\_: Date: \_\_\_\_\_

MR #: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Admit Date: \_\_\_\_\_

**Documentation clarification is required to meet compliance, accuracy in coding and severity of illness reflection for your patient.**

*There is clinical documentation of the cardiac condition “ANGINA”, along with evidence of evaluation, monitoring and treatment in the medical record.*

*Additional documentation is necessary to identify the:*

- *Related/associated diagnosis or underlying cause of the angina, if known. (For example, caused by CAD, ASHD, CHF, Cardiac arrhythmia, GERD, etc.).*
- *Type of angina, if known. (For example, unstable, progressive, decubitus, Prinzmetal, stable, new onset angina, etc.)*

*Please document the underlying cause and type of Angina, if known, in the progress notes or on this form below as an addendum. (Sign and date all documentation)*

Note: If you are/were treating a suspected, possible or probable condition, please document it as such.

*MD Signature:* \_\_\_\_\_

*Date:* \_\_\_\_\_

*If you have any questions, please contact the HIM Department (Medical Records) at # \_\_\_\_\_ . Thank You!*

# Sample physician query form

## SAMPLE PHYSICIAN QUERY FORM

Date: \_\_\_\_\_

Patient name \_\_\_\_\_

Admit date \_\_\_\_\_ Discharge date \_\_\_\_\_

Medical record no. \_\_\_\_\_ Account no. \_\_\_\_\_

Coder name \_\_\_\_\_ Coder phone number \_\_\_\_\_

### Inquiry

Dear Dr. \_\_\_\_\_:

The documentation in this patient's record requires clarification to ensure coding compliance and accuracy. Please complete, sign, date, and return the following query.

The following information is recorded in *[state the specific location in the medical record of information contributing to the reason for query.]*

*[List the information; for example,  
"Sputum lab culture result verifying presence of {particular organism} in a patient with a documentation of pneumonia"]*

I have the following question about this record:

*[Example: "Was the patient's pneumonia caused by a specific organism?  
If yes, please specify the organism."]*

Please respond to this question in the space below.

*[allow space for written entry]*

*[If your policy requires, instruct the physician to make an addendum: "You must also add this information to the patient's medical record by an addendum to the progress notes or discharge summary."]*

\_\_\_\_\_  
Physician signature

\_\_\_\_\_  
Date

# Example of physician clarification form

## Physician Documentation Clarification Request Form

Date \_\_\_\_\_ Physician being queried: \_\_\_\_\_

Patient admitted with:

\_\_\_\_\_  
\_\_\_\_\_

At the time of discharge, please clarify *possible, probable, suspected* cause of:

\_\_\_\_\_  
\_\_\_\_\_

(unless you have already determined and documented a definitive diagnosis for this sign or symptom) in the progress notes or the discharge summary (not on this form) for appropriate classification of the patient's diagnosis. Thank you.

Please note: A physician should only document a medical condition when it is clinically appropriate. The patient's clinical signs & symptoms, physical findings, diagnostic & radiologic tests, and the physician's approach to care and management should be consistent with the physician's documentation of the patient's suspected or confirmed clinical condition.

Accurate coding ensures that the physician receives credit for all his/her efforts on behalf of the patient. A comorbid condition attests to the fact that the physician is caring for a sicker patient.

\_\_\_\_\_  
Case Manager

CDM 41205

\_\_\_\_\_  
Pager

# Steps to Take

- Perform audits
- Track and trend findings relating to Physician Queries
- Solicit feedback from CDI and HIM
- Annually review the Query Policy
- Annually review any Physician Query forms
- Provide education & feedback
- Build these steps into your compliance activities

# Summary

- Queries are an essential tool for compliance, reimbursement and quality improvement because they elicit more documentation from physicians on patient diagnosis and treatment.
- Have a QA process within your CDI and HIM Coding operations.
- Look at industry standards to help guide you and your staff or your program

# Final Thought...

- Being or having *Complacency* is NOT always being or having Compliance!

# References

- AHIMA Practice Brief—Physician Query 2001
- AHIMA Practice Brief – Managing the Physician Query Process 2008
- AHIMA Practice Brief – CDI 2010
- AHIMA Ethical Standards for Coding
- AHIMA Ethical Standards for CDI (to be published)
- ACIDS – Association of Clinical Documentation Improvement Specialists
  - ACDIS – Physician Query Handout
- Briefings on Coding Compliance Strategies, HCPro, Inc., January 2009

# Questions

Thank you