Physician Queries: The Dos and Don’ts When Querying for Specificity

Stephanie Johnson, CCS
Senior HIM Coding Specialist
Uniform Data System for Medical Rehabilitation
Disclosure

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Objectives

- Introduction
  - Demands of the industry
- Documentation expectations for providers
- Electronic health record
  - Copy forward
- Auditing and monitoring
- The medical record
- The what, how, when, and why of a query
- Implementation and content
- Misleading acronyms
- Leading and misleading query scenarios
- IRF-specific documentation
What Is a Query?

• A **query** is a communication tool used to clarify documentation in the medical record for accurate and complete code assignment.

• A proper query process ensures that appropriate detailed documentation appears in the medical record.

• The person performing this function should focus on a compliant process and content that reflects clinical indicators that support the query.
The Industry’s Ongoing Demands

- The healthcare industry is an ever-changing environment, and the demands on health information management (HIM) professionals to produce accurate coded data is at the top of the list.
- Developing and managing an effective query process are vital components of ensuring data integrity.
- Putting a formal process in place is not mandatory, but it is highly recommended.
Why Would You Need to Query?

• Because of a lack of good documentation practices by physicians, the query has become a common communication and educational tool to assist the physician in better practices

• Most facilities have a standard policy and procedure in place based on medical staff bylaws
  • These may include a timely response to queries and the consequences for noncompliance

• Physicians are expected to follow the bylaws and may help in developing a policy and procedure for a solid query process
MAC/RAC

• Both overcoding and undercoding can lead to MAC/RAC reviews

• Physicians need to understand how good documentation can help improve the outcome of an audit
What Are the Documentation Expectations for Providers?

- CMS expects physicians to provide reliable documentation that is:
  - Legible and complete
  - Clear and precise
- UDSMR recommends that all clinicians (nursing, therapy, dieticians, etc.) be educated on documentation standards
What Are the Documentation Expectations for Providers?

• The physician’s documentation should identify the following:
  • Etiologic diagnosis
  • Comorbid conditions
  • Complications (conditions that develop after admission)
  • Test results
  • Severity of illness
  • Specificity of anatomical sites/types of injuries
The Electronic Health Record

• The electronic health record (EHR) creates new challenges in clinical documentation with the use of templates and how well the physician responds to electronic queries

• Establishing a functional query process can greatly improve documentation, whether electronic or paper
The Results of Nonspecific Documentation

• A lack of specificity in documentation can result in the use of *unspecified* ICD codes that impact the following:
  • Coding compliance
  • 60% rule compliance
  • Tiered comorbidities
• In some instances, reimbursement depends on more precise documentation
Query Auditing and Monitoring

- Querying is important, but making sure your process is effective is equally important.
- Auditing and monitoring should be conducted on a regular basis and will assist in determining whether a query was necessary.
- Auditing and monitoring should include a review of the total queries, both by physician and by querist.
- Review the negative and positive responses.
  - High negative responses could indicate an overused process.
  - A high positive response rate may indicate incomplete documentation by your physicians.
“My Patient Is Sick”

- A lack of documentation that includes assigned ICD codes states otherwise
- Physicians should be reminded that:
  - Copying forward the previous day’s documentation into the current day’s documentation could obscure the severity of the patient’s conditions and related deficits
  - Complete and precise documentation will help support medical necessity
  - Connect the relationship between the condition and any related manifestations
What, How, When, and Why
What Is the Medical Record?

- The **medical record** is the vessel that should carry the most specific information allowed for each condition, for an individual patient, from one level of service to the next.
The Medical Record

- Medical record documentation provides continuity and communication among all physicians and clinicians involved in a patient’s care.
- It should include, but is not limited to, the following:
  - The reason for admission (the etiologic diagnosis), described to the highest degree of detail that supports the admission IGC.
  - Active comorbid conditions and their treatments.
  - Diagnostic testing results and the course of treatment.
  - Functional deficits.
When to Query

• Query the physician when:
  • Documentation in the medical record is conflicting and ambiguous
  • Clinical indicators support a particular diagnosis, but only symptoms are documented
  • Positive clinical reports (lab, radiology) support a degree of specificity higher than that of the physician’s documentation
  • Treatment is rendered without documentation of a specific diagnosis
What Are Reportable Conditions?

• Coders possess the knowledge to read clinical documentation and assign the appropriate ICD code based solely on physician documentation

• Report conditions that:
  • Represent the specific etiology
  • Affect the rehabilitation stay
  • Require nursing care
  • Extend the length of stay
  • Require further diagnostic studies
Have We Forgotten the Term “Continuum of Care”?

• Clinical documentation in the medical record should be completed with the understanding that someone else will likely look at the same record down the road
  • That person should be able to examine the documentation and know the patient’s exact status at the time and the course of treatment
• As a result, the assigned ICD codes should match the clinical documentation and tell a complete, accurate story
Tip

• Functional deficits should be well documented and coded
  • Even if they do not result in a tier, they will help *support medical necessity*

• What does *coding* have to do with medical necessity?
  • *Everything!*
  • ICD codes tell the story
What Not to Code

• Do not code a condition that *resolved* in the previous level of care
  • The physician’s documentation should clearly indicate whether a condition is resolved
• When in doubt, query!
Why You Should Never Assume

• Do not assume an acronym means one thing or the other
  • For example, AKI can mean one of two things:
    1. Acute kidney injury (tier D)
    2. Acute kidney insufficiency (no tier)
• When in doubt, query!
What Are the Contents of a Query Form?

- Content should include, but is not limited to, the following:
  - The patient’s name
  - The admission date
  - Account number
  - Medical record number
  - The date on which the query was initiated
  - The querist’s name and contact information
  - A statement of clarification that lead to the query (lab, radiology, medication, etc.)
  - The physician’s response, either in documented form or as a checkbox with initials
  - The physician’s attestation
When to Query: An Example

• The physician orders a urinalysis that comes back positive for *E. coli* and orders a ten-day dosage of antibiotic

• The coder cannot assume the patient has a urinary tract infection and assigns the code

• The physician must be queried for additional documentation based on his clinical judgment
Suspected Conditions

• Even if a coder suspects a diagnosis based on clinical indicators, the coder should not lead the physician to a specific conclusion

• A query that appears to lead to a particular isolated response could lead to allegations of “upcoding”
An Example of a Leading Query

Dr. Yellow,
Your documentation does not support the level of consciousness for this patient. Please document the etiologic diagnosis exactly the way it appears below.
Thank you,
Medical Records

852.26, Subdural hemorrhage following injury, closed, with loss of consciousness of unspecified duration.

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1/15/2015

1. Traumatic Brain Injury, s/p MVA
2. Oral Dysphagia: We will have SLP evaluate regarding diet consistency.
3. UTI-Ecoli: On Levaquin and has 4 more days of treatment. We will complete the course.
4. Impulsivity/agitation: We will place him in a right facing room near the nursing station. We will maintain a low-stimulation environment. We will provide a sitter for safety.
5. Diabetes: The patient is on Lantus and sliding scale insulin. We will continue to monitor blood sugars and adjust prn. His needs may change as his caloric intake improves.
What Is a Verbal Query?

• A verbal query is simply a query asked face-to-face, over the phone, etc.
• The team conference provides an ideal time for such queries
• Like written queries, verbal queries cannot lead the physician to a specific conclusion
• Although verbal queries have become more common in concurrent query processes, the physician must provide documentation that supports his medical diagnosis—simply documenting “per the physician” is not sufficient
Concurrent vs. Retrospective Query

• A concurrent query is an ongoing process in which the physician is queried for clarification or additional information while the patient is still in-house.

• A retrospective query is performed after discharge.

• Do not add comorbid conditions from retrospective queries post-discharge to the IRF-PAI.

• Let’s take a look at page 18 of *The IRF-PAI Training Manual*:

> 47. Complications during rehabilitation stay: Enter up to six (6) ICD codes reflecting complications. The ICD codes entered here, including E-codes, represent complications or comorbidities that began after the rehabilitation stay started. To clarify the instructions on the IRF-PAI, the word "began" means any condition recognized or identified during the rehabilitation stay. These codes must not include the complications and/or comorbidities recognized on the day of discharge or the day prior to the day of discharge. These data will be used by CMS as part of its ongoing research and to determine what, if any, refinements should be made to the IRF-PPS payment rates. These ICD codes identify complications and/or comorbid conditions which delayed or compromised the effectiveness of the rehabilitation program or represent high-risk medical disorders.

> Relationship Between Complications and Comorbid Conditions: All ICD codes listed as Complications (Item 47) may also appear in Item 24 as Comorbid Conditions. Coding
SECTION 2: ITEM-BY-ITEM IRF-PAI CODING INSTRUCTIONS

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Relationship Between Complications and Comorbid Conditions: All ICD codes listed as Complications (Item 47) may also appear in Item 24 as Comorbid Conditions. Coding
Leading Query Example

- Do not use:
  - Leading examples
  - Post-it notes

428.20 - 428.23, Systolic heart failure
  - Acute/Chronic/Acute on Chronic
    - 428.30 – 428.33, Diastolic heart failure
      - Acute/Chronic/Acute on chronic
    - 428.40 – 428.43, Combined Systolic and Diastolic

Dr. Blue, Please document diastolic heart failure, tier d.

Thank you,
Medical Records
How to Query

- Don’t query the physician to change the content of the medical record—instead, query for additional information
  - Add to what is already written based solely on clinical support and the physician’s clinical knowledge
- “Based on the patient’s past history, present condition, test results, and current medication, as well as your clinical judgment . . .”
UDSMR® Physician Query Forms

- The UDSMR® Physician Query Forms are a collection of thirty-two forms that deal with IRF-specific issues:
  - Tiers
  - 60% compliance
  - ICD-9-CM codes vs. ICD-10-CM codes
UDSMR® Physician Query Forms

• The hip fracture form to the right is available for free from the UDSPRO Central™ website under Clinical ➔ Documents/Forms

• To access the order form for all the forms, log in to the UDSPRO Central™ website and go to Clinical ➔ Education and Training Resources
UDSMR® Physician Query Forms

• Available electronically as Word documents or PDF files
  • If you order the Word documents:
    • Add your facility name
    • Add a form number
Querying for Specificity and Compliance: Fractures

• For compliance review periods beginning on or after October 1, 2015, a record with an IGC of 08.11, Status post-unilateral hip fracture, will fail if item 22, Etiologic diagnosis, matches either of the following codes:
  • 820.8, Closed fracture of unspecified part of neck of femur
  • 820.9, Open fracture of unspecified part of neck of femur
Fractures

• Queries for specific documentation of fractures should include the following:
  • The specific bone site
  • Laterality
  • Traumatic/nontraumatic
  • Pathologic due to osteoporosis, neoplasm, or another disorder
  • Displaced or nondisplaced
  • Closed or open
  • Type of fracture (oblique, segmental, spiral, transverse, compression, burst, etc.)
Querying for Specificity: Stroke

- **Cause:**
  - Hemorrhage, embolism, thrombosis, occlusion, stenosis, infarction, intraoperative

- **Acute vs. old**
  - If old and new, the physician should document specific deficits related to each stroke

- **Deficits:**
  - Spastic hemiplegia
  - Flaccid hemiplegia
  - Expressive aphasia
  - Dysphagia, oral phase, etc.
  - Cognition, etc.

- **Hand dominance**
Querying for Specificity and Compliance: TBD

- Queries for TBD specificity should include the following:
  - Cause of injury
  - Level of consciousness:
    - Whether the patient lost consciousness
    - The length of time, if known
  - Any associated injuries:
    - Skull fracture (location and laterality)
    - Intracranial injury
    - The portion of the brain involved, including the specific artery/vessel
    - Cerebral edema
Querying for Specificity and Compliance: TBD

- A seventy-year-old female is admitted with a traumatic subdural hemorrhage with concussion
  - 852.29, closed traumatic subdural hemorrhage following injury, closed, with concussion, *unspecified*—noncompliant
  - Unspecified state of consciousness

For more information about specificity, review the UDSMR® Subscriber Document “ICD-9 Codes That Meet Presumptive Compliance Criteria.”
DON’T OVERDO IT!

1. Traumatic Brain Injury, s/p MVA
2. Oral Dysphagia: We will have SLP evaluate regarding diet consistency.
3. Hypertension: She is on Lisinopril and her pressures are still somewhat elevated. We will monitor closely and adjust medications to get him near goal by discharge.
4. Dyslipidemia: He is not on a lipid lowering agent at this time. We will begin simvastatin as he has no contraindication. We discussed risks, benefits, and alternatives.
5. UTI: He has been placed on Levaquin and has 4 more days of treatment. We will complete the course.
6. Impulsivity/agitation: We will place him in a right facing room near the nursing station. We will maintain a low-stimulation environment. We will provide a sitter for safety.

Subjective: Ms. Brown states that she feels reasonably well. She participated well in her therapy evaluations. She continues to have some shortness of breath and wheezing. It has not worsened.

Medications: Ms. reviewed.

Objective: Labs/imaging: WBC 10.2, Hgb 9.4, Hct 30.9, Na 137, K 4.4, Cl 103, CO2 25, BUN 13, Cr 0.88

Physical Exam:
Vitals: At rest: BP 117/79, HR 72, RR 19, Temp 36.9, SpO2 93% 2L per minute.
Gen: The patient is awake and cooperative. She is in no acute distress.
HEENT: The pupils are equal and round. EOMI. She has lens implants. No rhinorrhea or oral lesion. No

Las Vegas User Group

PROGRESS NOTE
1/15/2015

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4. Impulsivity/agitation: We will place him in a right facing room near the nursing station. We will maintain a low-stimulation environment. We will provide a sitter for safety.
5. Diabetes: The patient is on Lantus and sliding scale insulin. We will continue to monitor blood sugars and adjust prn. His needs may change as his caloric intake improves.
In Summary

- All clinicians are responsible for providing documentation that:
  - Supports the presence and impact of comorbid conditions
  - Supports the condition as a current condition
  - Justifies the coding on the IRF-PAI
  - Complies with CMS’s requirements
  - Meets medical necessity requirements
In Summary

• HIM coding professionals are consistently challenged to improve the accuracy of coded data to meet regulatory requirements

• The quality of coding depends directly on the documentation in the medical record

• Establishing an effective query process with an appropriate format will enable your facility to obtain critically needed documentation without compromising coding ethics and compliance standards
Real-time Documentation

• Acquire clarification in a timely manner
• Avoid wasting time on after-the-fact documentation
• Querying will:
  • Ensure greater accuracy in assigning ICD codes
  • Assist with 60% compliance
• *Tell the true story of each individual patient’s conditions!*
Query, Query, Query!

• Develop a solid process, and start advertising!
• Start with posters
  • *New query forms to assist with ICD-10 documentation!*
• Be optimistic
• Have an open house to introduce the new tool
• As always, if you feed them, they will come!
• Lastly, *share what you have learned this week!*
Any Questions?

Thank You!
Contact Information

- Stephanie Johnson, Senior HIM Coding Specialist:
  - 716-817-7819
  - sjohnson@udsmr.org
- Clinical and coding support:
  - 716-817-7844
  - clinicalsupport@udsmr.org