Sample Physician Query Policy and Procedures

A **physician query** is a method of communication used by coders to request clarification of patient diagnoses or procedures from the physician.

Scope: This policy applies to all queries initiated for inpatient services provided in [*Hospital Name*], and to all individuals and departments involved in the query process, including, but not limited to

- Administration
- Ethics and Compliance Officer
- Physician Advisors
- Facility Health Information Management
- Internal Audit & Consulting Services
- Case Management /Quality Resource Management
- Business Office/Central Business Office/Medicare Service Center/Financial Service

The purpose of this policy is to improve physician documentation and coders understanding of unique clinical situations. This policy defines when a query should be initiated and outlines the appropriate process to be used. Following the policy guidelines will help ensure complete, consistent, and accurate coding practices among all coders.

Policy

When an inpatient medical record has incomplete, inconsistent, unclear, or ambiguous documentation for assigning ICD-9-CM diagnoses or procedure codes, a physician query is recommended.

Hospital medical record departments use the following references to assign diagnoses and procedure codes:

- The Official Guidelines for Coding and Reporting Diagnosis and Procedures published in *Coding Clinic* 1990 2nd Qtr and/or the most current *Coding Clinic for ICD-9-CM guidelines.*
- AHIMA Code of Ethics
- Joint Commission on Accreditation of Healthcare Organizations Standards (IM 7.2, 7.6, and 7.10)
- Medicare Conditions of Participation
- *The International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM), volumes 1–3.

Procedure for the Query Process

[Define the query process with the following points in mind:]

- **Establish** facility-specific guidelines for when it is appropriate to query. Common situations in which queries are necessary include
  - a culture lab report indicating an infectious organism and no documentation substantiating the significance of the organism in the disease process
  - a diagnosis of urosepsis with symptoms of systemic inflammatory response (septicemia)
  - documentation of anemia without etiology
  - clarification of respiratory failure when documentation indicates respiratory distress but arterial blood gas analysis meets or exceeds established thresholds for respiratory failure

- **Determine** if physicians will be queried during the patient's hospital stay (concurrently) or after discharge. A concurrent query has the advantage of allowing the information to be incorporated directly into the medical record before the patient is discharged.

- **Designate** a person to initiate the query process—coder, lead coder, supervisor.

- **Use** a generic query form to request more information from the physician. (Facilities may determine that they need condition-specific query forms in addition to a generic query form.) **Do not use "sticky notes," scrap paper, or other miscellaneous forms for a query.**

- **Consider** various approaches to bring the query to the physician's attention:
  - Request that the physician come to the Medical Record department to complete the query (physician has access to the complete medical record).
  - Fax the query to the physician with the pertinent chart information and a return fax form. Include instructions on how to complete the form.
  - Reinforce doctors who complete their records on a timely basis.

- **Establish** a method for incorporating the query information into the medical record by using either
  - the actual form
  - a late entry progress note
  - a discharge summary addendum
  - an inclusion in the dictated discharge summary

  Note: If your procedures allow the physician to complete query forms outside the Medical Record department, a medical record progress note with all appropriate patient identifiers may be attached to the query for physician documentation and inclusion in the medical record.

- **Determine** the official document status of the query form. Consider whether the query should be an official part of the record to be photocopied for record requests. Obtain required medical staff approvals to include the query form as an official component of the medical record. Consult medical staff to be sure coders are allowed to add to the medical record.

Monitoring the Quality of the Query Process

Establish procedures for monitoring the effectiveness of the query process

- Track queries to
    - facilitate support of documentation improvement efforts
    - monitor release of the claims for billing purposes
    - assess timeliness of query process
    - improve the query process
    - improve the coding process
    - improve documentation
    - educate physicians, coding staff, and other clinical staff
- Look for problems in the implementation and use of queries that need modification or improvement.
- If physicians are being queried frequently, investigate the reasons for the queries.
- Consider designing quality improvement projects related to physician queries to provide feedback on the query process.
    - Look for patterns of queries (i.e., are there repeated queries on the same topic, such as anemia or pneumonia?) and plan to educate coders and physicians on the query process and documentation issues.
    - Review responses to the query to reveal discerning use by the coding staff and/or poor physician documentation practices.
      This review can also reveal whether necessary reports (discharge summary, operative report) are included in the medical record before coding.
- To develop consistency, consider testing reliability between coders by using blinded checks by different coders to see whether the same codes and queries are generated.