

MDS Alert

Best Practices: Don't Be Afraid to Query a Doctor

Find out why and how clarification can matter.

A resident's medical record is a legal document, but also is a narrative of their condition and care. As reimbursement hinges more on diagnosis coding than ever before, it's important to understand all the tools available to determine and maintain accuracy.

Keep reading to learn more about using different types of queries and feel confident when reaching out to physicians.

Use Query to Seek Clarification

A resident's medical record should show what tests were ordered, what tests were performed, and the provider's thoughts as to what was wrong with the resident at the time of an encounter.

When information is unclear in medical documentation, you'll query the provider to receive clarification. Some of the reasons why you'd query a provider include, but are not limited to:

- Supporting the documentation of a medical diagnosis
- Clarifying the reason for the resident's admission or visit
- Clarifying whether a diagnosis is ruled in or ruled out
- Establishing a diagnostic cause-and-effect relationship between medical conditions

"What my providers tell me all the time is they went to school to be clinicians. They went to school to take care of residents. They didn't go to school to do documentation, and they certainly didn't go to school to do coding," said **Melissa Kirshner, MPH, CPC, CRC, CDEO, CFPC, Approved Instructor**, executive director at Olympia Medical LLC in Livonia, Michigan, during her session, "Compliant Provider Queries," during AAPC's DOCUCON 2022 conference.



Seeking clarification through a query helps you understand what the provider is attempting to tell you, so the clinical picture of the encounter and the resident's condition is complete and accurate.

Important: Queries should be a part of the resident's permanent medical record, and the answers to the queries help support your ICD-10 code selections.

Leave Clinical Judgment to Clinicians

When crafting your queries, you should take special precautions to ensure you're not leading the provider to a specific diagnosis. "We can't tell the provider what to document. We have to let the physician use their own clinical judgment," Kirshner said.

Scenario: A resident was admitted to a nursing home from a hospital after experiencing nausea and vomiting for three days. A chest X-ray at the hospital showed the resident was suffering from pneumonia in the lower lobe of their right lung. The resident then received clindamycin.

In this scenario, you would need more information regarding the cause of the resident's pneumonia to ensure you can assign an accurate ICD-10-CM diagnosis code. Instead of asking if the pneumonia is due to aspiration - which could be construed as a leading query - you could request the physician to specify the cause of the pneumonia, which is a nonleading query.

Don't Feel Like Your Query Needs to be in Writing

Verbal queries are an acceptable option for receiving clarification, but the guidelines for verbal queries are the same as written ones. "We have to present the details to the provider. We have to include all of that patient clinical information - all of those relevant facts, all of those clinical indicators that we see in the medical record," Kirshner added. The clinical indicators must be relevant to the question that you're asking.

Additionally, once you've received the clarification you need for your query, you should document the conversation you had with the provider and include it as part of the resident's medical record.

Stay Open to Provider Responses

Creating open-ended queries can pose a challenge but offer the chance to receive plenty of information. "Open-ended queries allow us to gather all of those clinical indicators that may be present in the medical record and then ask about the relevance," Kirshner said.

Scenario: A resident developed pneumonia, and their provider was called. The resident's history and physical exam revealed a white blood count (WBC) of 14,000, respiratory rate of 24, 102°F temperature, heart rate of 120 BPM, and hypotension.



Since the resident was showing a high WBC, fever, low respiratory rate, and an elevated heart rate, there's a possibility that they may have an infection in addition to the pneumonia. An open-ended query of "Please document the resident's condition and causative organism, if known, in the medical record," allows the physician to use their clinical judgment to make a determination on the resident's condition.

Consider 'Multiple Choice'

Multiple choice queries can be useful when faced with several diagnoses that are supported by the medical record. "There's not a minimum number or a maximum number of diagnoses that you should include on that list, but you need to make sure that they're all clinically viable," Kirshner said.

You should also provide choices that allow the physician to state that the resident's condition is undetermined at this time or the condition is another option that wasn't thought of originally.

The last type of query that you can use to receive clarification are Yes/No queries. Yes/No queries can be used to:

- Identify cause-and-effect relationships.
- Identify manifestation and cause.
- Clarify conditions and diagnostic findings.
- Look at conflicting documentation between providers.

At the same time, Yes/No queries cannot be used to introduce a new diagnosis - you may only ask the provider questions related to the clinical indicators.

Do Yes/No queries fall under leading queries? "Asking for clarification is not leading. We're giving the providers the options of what this would be and then letting them use their clinical knowledge to tell you 'Yes, it is' or 'No, it's not,'" Kirshner said.