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MDS Alert

ICD-10 Focus: Perfect Your Physician Query Skills With 6 FAQs

A comprehensive querying program can save you headaches now and in the future, too.

With the Patient-Driven Payment Model (PDPM) on the way and more and more focus on ICD-10 fluency, you may find yourself, from time to time, needing clarification about a physician's diagnosis before you feel confident figuring out the appropriate ICD-10 code. Medical coders and billers know this process as "physician queries" and understand it as a regular part of their job. Becoming comfortable with querying physicians will also give your facility a boost in improving your clinical documentation - especially if you have a formal clinical documentation improvement program.

Understanding the process of querying physicians and keeping track of all involved components can go a long way in providing your facility with excellent data - and maybe give you another line of defense for spotless documentation when surveyors come knocking.

Here are some basics about physician querying. Different facilities - including hospitals and outpatient facilities - have different rules on the appropriate timeline for querying physicians, but the process basics hold across facility specialties.

Leonta Williams, RHIT, CPCO, CPC, CEMC, CHONC, CCS, CCDS, director of medical coding at Georgia Cancer Specialists, taught a class at the American Academy of Professional Coders Regional Conference in Salt Lake City and schooled attendees on the art and science of writing facility queries.

Here are some frequently asked questions and answers to help eliminate confusion on the querying process.

1. What is a query?

Answer: You write a query when something about the physician's documentation is confusing to you. However, before you submit a query, make sure you've brushed up enough on your clinical skills to understand what you're reading, Williams stressed. If you submit a query about clinical information you should know, "that lessens your credibility in your facility."

You might write a query when the documentation seems to be missing a key fact. For example, the note might contain signs and symptoms, but not a documented condition. Or, the note may contain what appears to be conflicting information. Or, perhaps you need additional information to assign the correct ICD-10 code. For example, if the provider documents simply congestive heart failure (CHF) you need to know what kind of CHF in order to code to the highest level of specificity.

You might even be dealing with a paper record that contains illegible handwriting.

"A query is a routine communication and education tool used to advocate complete and compliant documentation," according to the **American Health Information Management Association** (AHIMA). "The desired outcome is an update of the health record to better reflect the provider's intent and clinical thought process," AHIMA adds. "A proper query ensures that appropriate documentation appears in the health record."

Resource: To read AHIMA's guidelines on queries, go to: https://acdis.org/sites/acdis/files/resources/Guidelines for Achieving a Compliant Query Practice - 2016 Update.pdf.

2. Are there CMS guidelines for queries?

Answer: Yes, Williams said. Your query forms **should**:

- Be clearly and concisely written
- Present the facts and identify why the clarification is needed
- Present the scenario.

Query forms should **not:**

- Be designed so that the only thing needed is a physician's signature
- Indicate any financial impact.

Some physicians are asking coders to mention reimbursement dollar amounts in their queries, Williams noted. Make sure you steer away from that practice and follow CMS guidelines to remain compliant. Never mention dollar amounts in your queries.

3. Must the query be in writing?

Answer: Written queries are best, but they can be verbal as long as you document the verbal exchange.

4. Can a query happen over email?

Answer: Yes, as long as your facility's email system is secure and HIPAA-compliant.

5. What should a query form contain?

Answer: The form should list the patient's [resident's] name, date of service, Medicare Redetermination Notice number (MRN#), provider's name, name and contact of the individual sending the query, date of the query, and the statement of the issue in the form of a question.

Word your query carefully so that you "don't box the provider in," Williams instructed conference attendees. Steer clear of "leading" queries that give providers only one way to answer the question. Williams provided the following examples of leading queries:

- Was the dysphasia caused by the previous transient ischemic attack (TIA) in the patient's pure motor hemiparesis (PMH)?
- Was the patient given intravenous (IV) fluids because she was dehydrated?

Queries should be "non-leading," even if you think you know what the provider meant to document. You might ask for an addendum or provide some multiple-choice options that include an "other" option to help the provider articulate their thinking in the medical note. Pay close attention to the headings you use for queries, Williams cautioned, because sometimes headings can cause the query to be leading.

Tip: "Avoid the words 'you' and 'but' in your queries," Williams advised. Such language can sometimes provoke a defensive reaction.

6. Queries take a lot of staff time and cost my facility money. How can we educate providers so that we don't have to query them as often?

Answer: Most providers dislike queries, too, so you and the coding team should communicate to them that the ultimate goal of your query program is to reduce the need for queries in the first place. Williams recommends your facility's coding team set up a query-tracking form in Excel that records:

- Most common reasons for queries
- Providers with a high query percentage
- Providers with a low query rate
- Query themes that reoccur over and over again: Where might you focus your physician education efforts?
- Provider response turn-around time
- Provider agreement rate - "Be wary of the provider who agrees with the coder's query 100 percent of the time,"

Williams cautioned.

Understanding the query process means giving yourself another tool in clarifying potentially tricky situations in both documentation and care. With the increasing significance of ICD-10 in long-term care, it's important (and smart!) to try and pick up tips and tricks that medical coders in other situations and facilities utilize all the time now. With the proper preparation, including a solid foundation in the ins and outs of flushing out the proper code, you can face PDPM with more confidence.