AHIMA Advocates for Physician Query Forms

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by Dan Rode, MBA, FHFMA

The Medicare program's reluctance to accept physician query forms has been fermenting for several years. Recently, the Health Care Financing Administration (HCFA) and the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) have argued that facilities using physician query forms (forms that allow physicians to fill in or check off responses to an inquiry) were at risk of potential fraud and abuse. This opinion persists today, despite AHIMA's efforts to mitigate the situation.

HCFA and the OIG believe physician query forms lead a physician to respond in a way that allows the facility to code the encounter for a higher DRG than might be warranted. An example of this concern arose in recent years with the coding process behind some organizations' coding of pneumonia. Unfortunately, these situations validated the government's concern about query forms because some led physicians to approve coding to a higher level.

"A Variety of Means"

HCFA began taking steps to invalidate physician query forms as documentation for Medicare claims in fall 2000. AHIMA then learned that HFCA was planning to cite a portion of AHIMA's *Health Information Management Compliance: A Model Program for Health Care Organizations* that discourages the use of query forms as a substitute for documentation in the medical record.

AHIMA's coding policy and strategy committee (CPSC) discussed this issue and as a result, the AHIMA policy and government relations (P&GR) team sent a letter to HCFA expressing concern as well as AHIMA's willingness to work with HCFA to resolve the situation. The letter also indicated that while "members strive continually to assemble and ensure a complete medical record and accurate coding for their institutions" similar to the book's recommendations, the recommendations represented "the ideal case and not one that is found in very many institutions."

The letter continued: "Often to ensure a complete record and accurate coding, the medical records department must contact the physician to complete the record and/or explain an entry or gap in information. Physicians in many institutions are difficult to contact and have limited time, and in some cases, concern, for the task of completing the record. Again, to meet the demands of their role, members of the medical records department have had to resort to a variety of means to obtain the information and approval they need from the physician. Out of this need various types of query forms and query processes have been developed in most institutions to meet the obligations of the medical record department and the compliance obligations of the entire institutions."

AHIMA also offered to work with HCFA to identify and educate all parties concerned about best practices that could be mutually acceptable. AHIMA noted that "An instruction to PROs not to accept query forms will not resolve the problem that you have identified. It will only make it much more difficult [for professionals] to do their job and remain compliant with the real need to have complete records and information on which to base patient care, and yes, to validate reimbursement." The letter continued: "Hospitals and other institutions have little leverage to get physicians to complete the records and provide the input we would all like to see. Requiring physicians to, in some cases, duplicate their time and effort to complete the medical record will fail until...they accept the need for complete and accurate records."

HCFA's First Mandate to PROs

HCFA rejected AHIMA's offer. In January 2001, the director of the Division of Program Management and Evaluation-Quality Improvement Group released the *QIP TOPs Control Number: PRO 2001-03* to a variety of regional officers and PROs. The QIP (quality improvement projects) document stated: "Effective immediately, PROs are not to accept coding summary forms (e.g., physician query forms) as documentation in the medical record when following DRG validation procedures specified in

Section 4130 of the PRO Manual. PROs are directed to educate and inform providers within their jurisdiction as necessary to ensure proper documentation within the medical record."

The HCFA notice continued: "Hospitals have requested that PROs accept boilerplate coding summary forms (e.g., physician query forms) as a substitute for physician documentation in the medical record..." The notice added that additional instructions to the PRO Manual would be issued shortly. (At press time, no instructions had been issued.)

AHIMA Redoubles Its Efforts

The CPSC again conferred with AHIMA's P&GR team about the HCFA QIP. Members of the CPSC were concerned that the QIP, besides being disappointing, left too many unanswered questions. AHIMA sent a second letter that listed a number of questions and concerns including:

- a request for identification of the actual effective date that would be used by HCFA relative to the QIP and whether it would vary by PRO, noting the problems that variations create
- concern that there might be some form of retrospective implementation or review
- concern about how to handle discharges that might occur between the effective date and the date of notification
- concern for how providers would be educated and informed and that "...this memorandum is effectively mandating a systems and cultural change among approximately 6,000 hospitals and hundreds of thousands of physicians and, like the proverbial oil tanker, these entities and professionals cannot have their systems and culture turned or changed on a date that has already past." AHIMA suggest that a grace period be extended
- a request that "best practice" be established to define query processes and documentation that are acceptable to HCFA and examples that demonstrate what is not acceptable

The second AHIMA letter also noted that it is difficult to work without some sort of query process, especially given the interface problems between physicians and staff involved in record completion and coding. The letter noted that having the query as part of a record is itself a very clear indication if there is an attempt of fraud. Once again, AHIMA volunteered to work with HCFA to resolve the issues at hand.

In response to AHIMA's letter, HCFA representatives indicated that AHIMA's questions would serve as the basis of HCFA's instructions and potential FAQ release. However, in late March, the agency issued a second QIP TOPs (PRO 2001-06) retracting the first and indicating that it would be working with the industry to come up with a better solution by October 1, 2001.

As the correspondence and discussion demonstrate, the query form issue is a challenge for many AHIMA members and it appears that a satisfactory resolution will not appear overnight. Situations like this highlight the importance of members alerting AHIMA volunteer leaders and staff of government and other policy makers' actions. Often, changes in policy or procedure begin at the local level long before they surface in the national arena. This situation also underscores the value of volunteer committees and task forces who can, in collaboration with staff, take action and make changes. While the outcome of this situation is unknown, as long as the industry practice is inconsistent with expectations, there is an opportunity for dialogue and resolution.

As more information on this topic becomes available, it will be posted on the AHIMA Web site at www.ahima.org/.

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