Guidelines for Physician Office Query Practice

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Documentation in the health record is a basic but critical component to every patient encounter, patient service, and setting. The provider is key to delivering detailed information regarding the patient's chief complaint, present illness/history, past medical/surgical history, family history, and physical examination. These details are all a common part of health record documentation, especially in the physician office setting.

All entries in the health record must be complete, accurate, and authenticated. Although the hospital setting has been a primary focus of attention surrounding clinical documentation improvement (CDI), it is just as important that clinical documentation in the physician office setting is complete, accurate, and authenticated.

Within the healthcare industry, reimbursement methodologies rely on capturing severity of illness, risk of mortality, acute and chronic conditions, medical necessity, quality measures, and value metrics such as the Centers for Medicare and Medicaid Services (CMS) Quality Payment Program (QPP). These are all directly or indirectly driven by clinical documentation and coding. The coding of diagnoses, signs/symptoms, procedures, and/or services in the physician office setting requires both ICD-10-CM and CPT to be coded to the highest level of accuracy, certainty, and specificity.

The process and practice of utilizing "physician querying" historically dates back in time to the hospital inpatient prospective payment system in 1983-84. CDI, facilitated through the physician query, is the healthcare industry practice and process that obtains clarification when the documentation is incomplete, nonspecific, conflicting, or not present at all. Individuals who are trained and educated about the query process, primarily CDI and coding professionals, address the provider with issues, concerns, and questions regarding the encounter documentation. This powerful communication process applies to all healthcare settings. For the physician office setting, this can be performed at the time of the encounter, immediately following the encounter, or retrospectively (post-billing/payment).

The AHIMA Practice Brief titled "Guidelines for Achieving a Compliant Query Practice" applies to all settings, including small physician offices and large physician group practices. The benefits of accurate, complete, and specific documentation is as relevant in the office setting as it is in the hospital setting. Following both the guidelines in that Practice Brief and this more focused article are good steps toward ensuring integrity and compliance are incorporated into the physician office query and CDI process.

There are three appendices with additional content published in the online version of this Practice Brief in AHIMA's HIM Body of Knowledge at http://bok.ahima.org:

- Appendix A: Query Monitoring and Auditing
- Appendix B: Query Escalation and Retention
- Appendix C: Query Examples

Role of CDI and Education in Physician Office Practices

CDI involves a thorough review of the health record documentation to ensure it's accurately reflecting the severity of illness, risk of mortality, and clinical care provided to and for the patient.

Preventable medical errors occur with alarming frequency in US hospitals. Unavailable patient information and illegible handwriting have led to diagnosing and ordering errors, which compromise patient safety and quality of care. Regulatory agencies and healthcare providers have recognized that by focusing on the integrity of clinical documentation, a traditional hospital can improve patient care, improve reimbursement, and report accurate data, which reflects the highest standards of

patient care. The implementation of a CDI program plays an important role in achieving these goals for physician office practices.1

The increased prevalence of risk-based healthcare plans and the emphasis on quality initiatives has begun to demand the need to focus across the healthcare continuum to include the clinic. A key component of this shift is the increased awareness of Risk Adjustment (RA) and Hierarchical Condition Categories (HCCs), which further emphasizes the need for CDI and physician education in concepts that will aid better documentation to capture diagnoses to the highest specificity.

It is industry standard for health plans to review medical records retrospectively (commonly referred to as chart review) for Medicare Advantage (MA) plans for risk adjustment payment accuracy. Regulations allow for submission of new diagnosis codes for up to two years after the date of service. During the chart review process, health plan coding professionals may review encounter documentation that is incomplete, nonspecific, conflicting, or not present at all. At this time, it may become necessary to initiate a physician query to ensure accuracy of the documentation and code assignment. This is particularly relevant in situations where ICD-10-CM does not provide code assignment for nonspecific terms, such as lupus. When physician queries are initiated during chart review within the regulatory window, the queries should be limited to requesting the physician to interpret or clarify their own documentation. An example of this would be documentation of "CKD, GFR 17," where a query is initiated to clarify the stage of the CKD. While the provider is clinically specific, the verbiage does not align with the correct code assignment unless the physician specifies the stage.

The Medicare Access and CHIP Reauthorization Act (MACRA) is one of the initiatives that is moving CDI to the outpatient arena. MACRA includes various payment models that allow the provider to customize their focus on care delivery and outcomes. It includes the need to show patient risk through HCC coding and justify the need for services with some old concepts such as medical necessity. Sometimes in that setting, coding professionals are called upon to wear multiple hats, including being the first line of defense for CDI. But the entire team, including scheduling, nursing, and others, can relieve some of the burden for providers by identifying gaps and needs for more specific documentation before it reaches the coding stage. Focusing on frequently treated diagnoses and chronic illnesses will be a valuable effort under value-based payment. The quality measures under MACRA are very specific, and clinical documentation will need to match or exceed that level of specificity for physicians to be successful when participating in these programs.2

CDI programs are also crucial in validating that the physician office receives appropriate and accurate reimbursement. It is a known fact that reimbursement is driven by coding and coding is driven by documentation. Compliant clinical documentation also supports accurate quality of care reporting.

Education on the linkage of clinical documentation to the many aspects of healthcare will be helpful to the physician practice. As adult learners, there are many verbal and written educational styles a CDI specialist can utilize when providing education to physicians and the office staff. Education for office staff, including physicians, will help to achieve the goals and benefits of CDI.

Education can consist of any of the following techniques and tools:

- Face-to-face education (one-on-one)
- Classroom-style education
- Webinars
- Online, self-directed style
- Privacy-compliant mobile apps

The six quality domains of healthcare quality, according to the Agency for Healthcare Research and Quality (AHRQ), can guide the development of CDI education for physicians in the office setting.3

1. **Safe:** Avoiding harm to patients from the care that is intended to help them.
2. **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
3. **Patient-centered:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.
4. **Timely:** Reducing waits and sometimes harmful delays for both those who receive and give care.

5. **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas, and energy.
6. **Equitable:** Providing care that does not vary in quality among groups of those with varying personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

It is important for physicians to know that their documentation impacts the quality of patient care reporting, physician performance profiling, and accurate payment. To improve clinical documentation, physician practices must identify deficiencies, inconsistencies, and discrepancies in current clinical documentation. It is beneficial for physician offices to adopt a CDI education program within their day-to-day practice. This model will assist in the capture of not only acute but all chronic conditions/statuses impacting patient care. Without adequate tools and procedures for accurate and complete documentation at the point of care, patients can be exposed to medical errors. A single mistake can threaten the stability of a medical institution and may even destroy the lives of the patients. Liabilities, failures, and risks can be prevented by implementing improvement programs which promote modern tools, programs, and applications for clinical documentation.

The Query Process in the Physician Office

Each physician office will vary in the structure of their query process. This process may be developed in a new department or incorporated into other roles. CDI professionals who work in a physician office setting can come from a variety of professional backgrounds, such as nurses, coding professionals, office managers, scribes, and more. Each practice should work with the practice leaders, providers, and frontline staff to determine the best structure for their query process.

Query Definition

A query is a clarification request that is sent (delivered) to the provider (physician, nurse practitioner, physician assistant, etc.) who is legally responsible for the care of the patient as well as determining a diagnosis. Synonymous terms for "query" include: clarification, clinical clarification, documentation alert, documentation clarification, and similar terminology.

Why Query?

The following are important rationale for a physician query:

- **Physician Quality.** Clinical documentation within the health record provides valuable information that is instrumental to the provision of quality care. Quality reporting is important for patients to utilize when choosing a caregiver and is now being tied to reimbursement. It is vital for providers to record high-quality documentation to reflect the appropriate quality of care they delivered.
- **Physician Payment Structure.** With the repeal of the Sustainable Growth Rate in 2015 and the initiation of MACRA, physician reimbursement is being transitioned to pay-for-performance (value-based, instead of volume-based). The performance composite for reimbursement adjustments are impacted by risk adjustment of quality and cost measures which are adjusted annually. The RA methodology standardizes the population cohort by bundling patient comorbidities and demographics, which affect healthcare outcomes (cost, mortality, complications, etc.), into CMS' HCCs in order to appropriately compensate for the differences among patients which may affect their healthcare outcomes (cost, mortality, complications, etc.). In some settings, the RA methodology requires annual documentation of conditions used for the RA, requiring the physician to continually monitor chronic conditions, thereby improving the patient's overall health. Although many chronic conditions never resolve, the documentation still needs to demonstrate that the condition remains active. Both Medicare Advantage and the CPT Evaluation and Management (E/M) code payment structure rely heavily on clinical documentation and coding to capture the complexity of the patient's medical condition(s) and complexity of decision-making. Therefore, reporting of comorbid conditions impacts the RA methodology which has a direct impact on perceived physician quality of care and payment. As such, to ensure compliance, the physician-derived "problem list" should be reviewed at the point of care to ensure all comorbid conditions are active (not resolved) to accurately depict the patient's severity of illness.
- **Medical Necessity.** Office procedures such as exercise treadmills and pulmonary function studies rely on medical diagnoses to satisfy local and national coverage determinations for reimbursement of the professional and technical component of the procedure. Many of the diagnoses require increased specificity in order to meet medical necessity and coverage. Ensuring medical necessity is also important for Bundled Payment for Care Improvement (BPCI).

- **Adverse Clinical Validation Determination.** Clinical documentation that is precise, thorough, and accurate can provide a defense from regulatory reviews. For example, a medical condition which is documented can be clinically validated through the substantiation of well-documented provider notes based on clinical criteria that is generally accepted by the medical community.
- **Third Party Audit.** It may become necessary to initiate a query in response to a third party coding audit when the encounter documentation is incomplete, nonspecific, conflicting, or not present at all. These should be limited to the physician interpreting or clarifying their own encounter note to assist the auditor in accurate code assignment. The query response would be documented as an addendum or late entry for the encounter and kept as a permanent part of the medical record.

When to Query

Queries may be made in situations such as:

- Clinical indicators of a diagnosis but no documentation of the condition
- Clinical evidence for a higher degree of specificity or severity
- Uncertainty of a cause-and-effect relationship between two conditions or organisms
- An underlying diagnosis for presenting symptoms
- An underlying diagnosis for treatment that is provided
- Clinical validation of a diagnosis in the outpatient setting when the previous health record provides evidence to support further documentation, such as further specificity or the presence of a condition that is clinically pertinent to the present encounter (those who perform "querying" should keep in mind that each encounter must stand on its own)
- When patients are receiving drugs or treatment without a diagnosis to support the therapy
- Determining the clinical significance of abnormal test results
- Establishing acuity of a condition versus past history to determine if the condition is active and not resolved
- Determining the intensity of patient evaluation, treatment, and description of the thought process and complexity of medical decision-making
- Clarifying diagnostic and therapeutic procedures, treatments, and tests ordered—including results
- Lack of any changes in the patient's condition, including psychological and physical symptoms
- Assisting in identifying any follow-up instructions or discharge planning
- Clarifying each new or active condition, the disease manifestation, severity, precipitating event/cause, and/or complication/consequence

It may be appropriate to generate a provider query when documentation in the patient's health record fails to meet one of the following seven criteria identified below:

- Legibility
- Completeness
- Clarity
- Consistency
- Precision
- Reliability
- Timeliness

Query Format

Practitioners should review previous encounter documentation that will impact direct patient care across the continuum. Some of the clinical information impacting an encounter for the physician office may come from a previous encounter or workup that was ordered in preparation for the visit and current patient care. For this reason, previous encounter information in the outpatient setting may be referenced in queries for clinical clarification and/or validation if it is clinically pertinent to the present encounter. However, it would be inappropriate to "mine" previous encounter documentation to generate queries not related to the current encounter.4 The composition and format (layout and design) of the query itself is very important in achieving a non-leading and compliant process.

Queries may be either verbal or written and may be generated in one or more of the following ways:

- Concurrent with the patient encounter
- Pre-bill (prior to the claim submission)
- Retrospective (post encounter claim submission)

Written queries, whether paper or electronic, should be made utilizing compliant query templates:

- Query format
    - Open-ended
    - Multiple choice
    - Yes/No

Yes/No queries are to be utilized in an outpatient setting under the following circumstances:

- Substantiating or further specifying a diagnosis that is already present in the health record with interpretation by a physician
- Establishing a cause-and-effect relationship between documented conditions such as manifestations/etiologies, complications, and conditions/diagnostic findings
- Resolving conflicting documentation from multiple practitioners

Use of AHIMA query templates (see the AHIMA Practice Brief "Guidelines for Achieving a Compliant Query Practice" and AHIMA's Query Toolkits) is highly encouraged, with only the following edits:

- Deletion of any part of the query form not pertinent to the query
- Add any pertinent clinical findings as documented in the health record

Verbal and telephonic queries will follow the same format and requirements as written queries. All queries will be:

- Clear, concise, and non-leading (the title of the query should not be leading, and the query should include both supporting as well as conflicting documentation)
- Simple and direct
- Itemize the clinical indicators or clues (for example, documentation found in the nursing documentation but not mentioned in the primary provider's documentation, lab findings, or radiological findings) from the health record

The query should contain all of the patient's identifying information such as name, date of service, and health record number. Queries may be initiated by professionals trained and educated in the compliant query process. The contact information (name, telephone, email) of the professional who initiated the query should be provided.

All queries should be logged for follow-up to track responses and to trend any documentation issues which may indicate additional documentation improvement educational opportunities for providers or overuse of queries by trained professionals.

The Road to Documentation Excellence

The following guidance regarding medical record documentation was included in CMS Transmittal 47:

> All entries in the medical record must be complete. A medical record is considered complete if it contains sufficient information to identify the patient; support the diagnosis/condition; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers. With these criteria in mind, an individual entry into the medical record must contain sufficient information on the matter that is the subject of the entry to permit the medical record to satisfy the completeness standard.
>
> All entries in the medical record must be dated, timed, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided.

In addition, CMS Transmittal 442, Change Request 8105, effective January 1, 2013, has given some guidance for healthcare providers:

> Providers are encouraged to enter all relevant documents and entries into the medical record at the time they are rendering the service. Occasionally, upon review a provider may discover that certain entries, related actions that were actually performed at the time of service but not properly documented, need to be amended, corrected, or entered after rendering the service.

With respect to the above, it is well known that healthcare quality and data are gaining more importance, and key elements include the coded data—which comes from the clinical documentation in any healthcare settings. This is particularly focused on the diagnoses, signs/symptoms, procedural services, and encounter details. However, when looking further at that clinical documentation for coding, one finds there are opportunities for improvement through clarification. Through partnerships, collaboration, and processes that function with the highest degree of integrity, documentation improvements can be obtained.

Utilizing the physician query in a physician office setting as a communication tool is a recommended process of asking a question in order to obtain the necessary clarity, specificity, and completeness of the clinical documentation. If the query process is followed in accordance with industry standards (such as those outlined in AHIMA's Practice Briefs), guidelines, and regulatory directives, there can be significant positive impact on the quality of the provider's documentation as well as the potential of reduced compliance risk.

Notes

1. Agency for Healthcare Research and Quality. "The Six Domains of Health Care Quality." March 2016. www.ahrq.gov/professionals/quality-patient-safety/talkingquality/create/sixdomains.html.
2. AHIMA. "Guidelines for Achieving a Compliant Query Practice (2016 Update)." HIM Body of Knowledge. January 2016. http://library.ahima.org/doc?oid=301357.
3. Agency for Healthcare Research and Quality. "The Six Domains of Health Care Quality."
4. AHIMA. "Outpatient Clinical Documentation Improvement (CDI) Toolkit." HIM Body of Knowledge. 2018. http://bok.ahima.org/PdfView?oid=302445.

References

AHIMA. "AHIMA Query Toolkit." HIM Body of Knowledge. 2017. http://bok.ahima.org/PdfView?oid=302140.

AHIMA. "Amendments in the Electronic Health Record Toolkit." HIM Body of Knowledge. 2012. http://bok.ahima.org/PdfView?oid=105672.

AHIMA. "Guidance for Clinical Documentation Improvement Programs." *Journal of AHIMA* 81, no. 5 (May 2010): expanded web version. http://bok.ahima.org/doc?oid=103352.

AHIMA. "Managing an Effective Query Process." *Journal of AHIMA* 79, no. 10 (October 2008): 83-88. http://bok.ahima.org/doc?oid=84610.

Bonner, Dari and Karen M. Fancher. "Expanding CDI to Physician Practices: Five Documentation Vulnerabilities to Address in 2016." *Journal of AHIMA* 87, no. 5 (May 2016): 22-25. http://bok.ahima.org/doc?oid=301436.

Centers for Medicare and Medicaid Services. "ICD-10-PCS Official Guidelines for Coding and Reporting." 2017. www.cms.gov/Medicare/Coding/ICD10/Downloads/2017-Official-ICD-10-PCS-Coding-Guidelines.pdf.

Centers for Medicare and Medicaid Services. "SUBJECT: Revised Appendix A, 'Interpretive Guidelines for Hospitals.'" CMS Manual System Pub. 100-07 State Operations Provider Certification, Transmittal 47. June 5, 2009, page 2. www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R47SOMA.pdf.

Florida Hospital Association. Clinical Documentation Improvement Program web page. www.fha.org/services-for-hospitals/clinical-documentation-improvement-program.aspx.

Legg, Laura. "MACRA, MIPS, and APMs: Why is CDI an Essential Ingredient to the Alphabet Soup?" ICD10Monitor.com. November 28, 2017. www.icd10monitor.com/macra-mips-and-apms-why-is-cdi-an-essential-ingredient-to-the-alphabet-soup.

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Three appendices with additional physician practice query content are included in the online version of this Practice Brief in AHIMA's HIM Body of Knowledge:

Appendix A: Query Monitoring and Auditing

Appendix B: Query Escalation and Retention

Appendix C: Query Examples

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