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Physician Queries Done Right

How to ask a physician to clarify inconsistent or vague documentation.

While most surgeons document the surgical procedures they perform in your facility with the utmost precision, there may be times when your coder needs clarification or additional documentation from the surgeon before she can assign the proper codes. When there's conflicting, incomplete or ambiguous information in the operative report, you must ask the physician to verify the procedure performed and to get any written clarification in the form of an addendum. The official name for this is a *"physician query."* What it really means is, *"Doc, we need you to clarify exactly what you did."*

Before You Query

The physician query process is triggered when there's a problem with documentation quality. But before you implement a physician query process, check your state's requirements for documentation and reporting, quality improvement organization guidelines and your facility's policy and procedures. Keep in mind that some queries become part of the formal medical record.

Don't lead physicians

Coders don't want to query a physician any more than the physician wants to receive a query, but when the surgeon's documentation leaves more questions than answers, you risk overcoding or undercoding if you don't ask for clarification. Here are some tips on handling physician queries.

- Formulate queries from the clinical documentation that the physician provided in the patient chart.
- Questions that appear to show preference for a particular response are not acceptable.
- Don't try to *lead* a physician to respond the way you'd like him to simply to increase reimbursement. A coder's role is to translate the physician's documentation, not dictate for him. Queries that appear to lead the provider to document a particular response could result in allegations of inappropriate upcoding.

The query format shouldn't sound presumptive, directing or as though the physician is being led toward a certain response, as in this example.

Based on the operative report, this Medicare patient had an open rotator cuff tear repair. There is a discrepancy between the "pre-operative diagnosis" and the "post-operative diagnosis and the "indications" section of the operative report for this account. Please indicate "chronic tear," since reimbursement for this diagnosis is greater than that of an "acute rotator cuff tear."

The intent of this query is to lead the physician to provide an addendum or response based on reimbursement impact. This is unacceptable. Your coders should follow your facility's policies related to documentation, querying and coding while ensuring that ethical and legal coding practices are maintained.

A better alternative

You may use the multiple-choice format in your queries as long as you list all clinically reasonable choices, regardless of the impact on reimbursement. The multiple-choice format should include an "other" option, with a line that lets the provider document additional comments. You should also give providers the choice of "unable to determine." This format is designed to make multiple-choice questions as open-ended as possible. Here's a look at an

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acceptable excerpt from a physician query:

Based on the operative report, this patient had an open rotator cuff tear repair. There is a discrepancy between the " pre-operative diagnosis" and the "post-operative diagnosis" that state "acute rotator cuff tear" and the "indications" section of the operative report that states, "This patient sustained a tear of his rotator cuff tear about 1 year ago. Conservative methods have failed and now he presents for an open rotator cuff repair in hopes of alleviating his ongoing chronic pain." Please confirm the patient's condition/diagnosis.

❑ *Acute rotator cuff tear*

❑ *Chronic rotator cuff tear*

❑ *Unable to determine:*

❑ *Other (please specify)* _____

Physician education

Show physicians how they can improve their documentation practices using both acceptable and unacceptable documentation examples from their own dictation. Provide the financial impact for operative report examples when specific information was not documented versus when the additional information was provided after physician query. With detailed operative documentation, code selection isn't a challenge. When accurate code selection is based on the most specific clinical documentation, you ensure your facility the maximum appropriate reimbursement for services rendered. **OSM**

ON THE WEB

"ICD-9-CM Official Guidelines for Coding and Reporting" from the Centers for Medicare and Medicaid Services and the National Center for Health Statistics are available at **www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guidelines.**

"Standards of Ethical Coding" from the American Health Information Management Association are available online at **www.ahima.org**.

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