
 <p>HAWAII HEALTH SYSTEMS CORPORATION <i>"Quality Healthcare For All"</i></p> <p>PROCEDURE</p>	<p>Department:</p> <p>Administration</p>	<p>Procedure No.:</p> <p>HIM 1010B</p>
	<p>Issued by:</p> <p>Finance & Information Systems Committee</p>	<p>Revision No.:</p>
<p>Subject:</p> <p>Medical Records: Query</p>	<p>Approved by:</p>  <p>By: Linda Rosen, MD Its: HHSC CEO</p>	<p>Effective Date:</p> <p>October 25, 2018</p>
		<p>Supersedes Policy:</p> <p>PAT 1010B</p>
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Last Review: August 14, 2018; Next Review: August 14, 2021

I. PURPOSE: To establish guidelines to improve the quality of the physician documentation within the body of the medical record to support code assignments and patient care. This procedure defines when a query should be initiated and outlines the appropriate process to be used. Following the procedure below shall help to ensure complete, consistent, and accurate coding practices and improve quality of care.

II. PROCEDURES:

A. Query Process:

1. Query the physician once a diagnosis or procedure has been determined to meet the guidelines for reporting, but has not been clearly or completely stated within the medical record by a physician participating in the care of the patient or when ambiguous or conflicting documentation is present.
2. Common situations in which queries are necessary include:
 - a. To clarify the present on admission indicators.
 - b. A culture lab report indicating an infectious organism and no documentation substantiating the clinical significance.
 - c. A diagnosis of urosepsis with symptoms of systemic inflammatory response (septicemia).
 - d. A diagnosis of anemia without etiology.
 - e. A clarification or respiratory failure when documentation indicates respiratory distress but arterial blood gas analysis meets or exceeds established thresholds for respiratory failure.
3. Physicians are to be queried during the hospital stay (concurrently) or after discharge. The earlier the query is initiated improves the opportunity to include the information into the documentation.
 - a. Queries may be generated by the coder, or clinical documentation specialist as appropriate.
 - b. Queries are posed in writing (on paper or electronically).
 - c. Queries are not leading in nature and include the following:

- (1) Patient name
 - (2) Admission date/service date
 - (3) Medical record number or patient account number
 - (4) Date of query
 - (5) Name and contact information for individual initiating the query
 - (6) Statement of the issue along with clinical indicators as appropriately specified in the clinical documentation
- d. Queries should never indicate a particular response is favorable or unfavorable with respect to reimbursement or quality reporting.
4. Queries are generated using approved templates specific to the disease process or a generic template. The determination of the most appropriate query is based on whether:
- a. A specific query template has been developed for the disease process, or
 - b. No specific query template has been developed.
5. The documentation of the coder's query to the physician shall comply with one of the following formats:
- a. The physician can add a dated and signed addendum to the medical record. The addendum must be dated and signed.
 - b. The query can be documented on a separate query form.
 - c. This documentation must be kept as a permanent part of the medical record and must include the patient's name, the patient's medical record number, the name of the individual submitting the query, the date the query was submitted, a statement of the issue in the form of a question, and the physician's response to the query. It must be signed and dated by the physician.
 - d. If the query process is documented in this format, a second signature is not required on the coding summary.
6. The query process may be documented on the coding summary.
- a. This documentation must be kept as a permanent part of the medical record and must include the name of the individual submitting the query, the date the query was submitted, a statement of the issue in the form of a question, and the physician's response to the query. The query must be signed and dated by the physician.
 - b. A statement that shall read, "I have reviewed the narrative descriptions of the diagnosis and procedure codes listed above and agree they accurately reflect the clinical picture of this episode of care", indicating physician agreement with the diagnoses and procedures reported must be included as part of the coding summary.
 - c. A notation that this form will be included as a permanent part of the medical record should also be included.

- d. The query process can be documented on a concurrent or retrospective basis. It is not necessary to maintain the concurrent query for diagnoses or procedures that the physician includes in the body of the medical record. If, however, the physician does not update the medical record documentation, this query must be maintained as a permanent part of the medical record to support code assignments.
7. The retention of the query documentation is related to codes reported at the time of final billing.

B. Compliance

1. All facilities shall educate their physicians on the importance of concurrent documentation within the body of the medical record to support complete, accurate and consistent coding.
2. All facilities shall communicate to their medical staff that coders shall query physicians when there are questions regarding documentation for code assignment. This query shall be documented and shall require physician signature.
3. All facilities' administration and medical staff leadership shall support this process to ensure its success.
4. Queries will be responded to within 3 days of submission by coding or Clinical Documentation Improvement staff as appropriate.
5. Queries not responded to within the 3 days will be escalated to the Physician Advisor or to the designated medical director.
6. Completion of queries is required to close a discharged medical record.
7. Any query requiring a physician response must be included in the incomplete/delinquent medical record count.

C. Monitoring the Process

1. Queries are tracked to
 - a. Facilitate support of documentation improvements.
 - b. Monitor release of claims for billing purposes.
 - c. Improve the query process.
 - d. Improve the coding process.
 - e. Educate physicians, coders, and other clinical staff.
2. Test reliability of queries by randomly electing a different coder to review the case that is queried.

3. Capture response rates for consideration in provider OPPE.

III. APPLICABILITY: All HHSC operations in all HHSC facilities.

IV. AUTHORITY: All applicable federal and state statutes and regulations that pertain to coding and health care reimbursement. Third party payor contracts, as applicable.

V. REFERENCE:

- CMS ICD-10 Official Coding Guidelines for Coding and Reporting
- American Health Information Management Association Standards of Ethical Coding
- AHA Coding Clinic for ICD-10-CM Guidelines (most current guidelines)
- CMS memorandum to the Peer Review Organization entitled "Use of the Physician Query Forms", January 22, 2001
- Medical Staff Bylaws

VI. ATTACHMENTS:

- HHSC Policy HIM 1010A Query Process