Inpatient Physician Querying and Compliance

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ACDIS
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Speaker

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MS-DRGs . . . Remember

• With the October 1, 2007, implementation of Medicare-Severity DRGs (MS-DRG), CMS announced its anticipation of "DRG creep" - a phenomenon where hospitals may experience increased reimbursement due to clear and more specific documentation. Hospitals experienced this same trend in 1983 when CMS established CMS-DRGs, and in 2005 when Maryland put in place APR-DRGs.

• To adjust for this expected increase, CMS imposed a "behavioral adjustment" of 0.6% for fiscal year (FY) 2008. There is an additional 0.9% adjustment for FY 2009 and FY 2010.
Why Do We Need to Query The Physician?

- Lack of sufficient documentation or no documentation to support the healthcare claim/charges
- Documentation & charges did not meet medical necessity
- Documentation that is conflicting, contrasting or ambiguous
- Documentation is nonspecific

Why Do We Need to Query The Physician?

- Healthcare Compliance (Fraud & Abuse)
- OIG Audit Findings
  - DRG reports
- Recovery Audit Contractor Findings (RAC)
- AHA *Coding Clinic* guidance - direction to query
- Querying for proper documentation is crucial to patient care, risk management, coding and billing.
- MS-DRGs require greater coding specificity thus the documentation also needs to be specific and detailed… querying is needed
Hospital & Physician Report Cards and Profiles

- Coded “Data” used in physician profiling and hospital report cards comes from claims data, including ICD-9-CM & CPT codes, which comes from physician documentation (when present).
- See www.healthgrades.com

Severity of Illness and Risk of Mortality

- “My patients are sicker”, this is often said by physicians.
- How do we or how can we best demonstrate this?
- Reflect the resources used via physician documentation of the diagnostic information.
- Comorbid conditions are examples
Reportable Conditions

• Document the condition if the condition affected the hospital care in terms of any one of the following:
  – Clinical evaluation; or
  – Therapeutic treatment; or
  – Further diagnostic studies, procedures or consultation; or
  – Extended the length of stay; or
  – Increased the nursing case and/or monitoring

What is Querying the Physician?

• Asking a question . . .
• Seeking clarification . . .
  – Without “leading” the physician to a diagnosis
  – Without “suggesting” a diagnosis or procedure
  – Without . . .
CMS Guidance

- A CMS memorandum issued on January 22, 2001 instructed QIOs not to accept coding summary forms, including query forms, as documentation in the medical record when validating DRG information provided by a hospital, but this guidance was subsequently suspended in a second memorandum. Issued March 21, 2001, the second memorandum stated that CMS would continue to review the issue and would provide further direction to QIOs in October 2001.

On October 11, 2001, CMS issued policy clarification on the use of physician query forms to the QIOs. This clarification was effective immediately and supersedes previous instructions provided by CMS to QIOs.

- A query form would be considered acceptable “to the extent it provides clarification and is consistent with other medical record documentation.”

- A query form should not be leading, and it should not introduce new information not otherwise contained in the medical record.
CMS Guidance

- Per DHHS (Department of Health & Human Services) Office of Clinical Standards and Quality - PRO 2001-13

- Query forms should be:
  - Clearly and concisely written
  - Contain precise language
  - Present the facts and identify why the clarification is needed
  - Present the scenario

- The query form can/should be used “to the extent it provides clarification and is consistent with other medical record documentation.”

- The Query form should be phrased such that the physician is allowed to specify the correct diagnosis. It should not indicate the financial impact of the response.

- The form should not be designed so that the only thing required is a signature.
10/01 – HFMA memo

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

QIP TOPS CONTROL NUMBER: PRO 2001-13

DATE: October 11, 2001

FROM: Director
Quality Improvement Group
Office of Clinical Standards and Quality

SUBJECT: Coding Compliance - Use of Physician Query Forms

TO: Associate Regional Administrators, DCSQ
Regions I, VI, VII, IX
Chief Executive Officers, All PBOs

Policy Clarification
This TOPS is effective immediately and supersedes TOPS 2001-03 and TOPS 2001-06.

In conducting medical review for validating the DRG, the PBO reviewer shall use his or her
professional judgment and discretion in considering the information contained on a physician query.

CMS contact on the Query memo

- CMS contact:
- Sheila Blackstock at (410) 786-3502.
AHIMA Guidance

- A Practice Brief on physician query forms titled “Developing a Physician Query Process” was published in the October 2001 issue of the *Journal of the American Health Information Management Association* (AHIMA).

As of 2/4/08 this Practice Brief was bring rewritten

AHIMA Guidance

- Complete Documentation and coded data;
- Improve the quality and effectiveness of patient care;
- Ensure equitable healthcare reimbursement;
- Expand the body of medical knowledge;
- Make appropriate decisions regarding healthcare policies, delivery systems, funding, expansion, and education;
- Monitor resource utilization;
- Permit identification and resolution of medical errors;
- Improve clinical decision-making;
- Facilitate tracking of fraud and abuse;
- Permit valid clinical research, epidemiological studies, outcomes and statistical analyses, and provider profiling; and
- Provide comparative data to consumers regarding costs and outcomes, average charges, and outcomes by procedure
AHIMA - Physicians

- Physicians are expected to provide complete, accurate, timely, and legible documentation of pertinent facts and observations about an individual’s health history including past and present illnesses, tests, treatments, and outcomes.
- Medical record entries should be documented at the time the service is provided.
- All documentation should be legible and written in ink, typewritten, or electronically signed/stored and/or printed.
- Medical record entries should be authenticated. If subsequent additions to documentation are needed, they should be identified as such and dated. All diagnoses relevant to the care or service provided should be updated in the medical record as necessary.
- Documentation should be consistent, and any discrepancies discussed and reconciled (this reconciliation should be documented in the medical record).

Expectations of Coding Professionals

- AHIMA Code of Ethics
- AHIMA’s Standards of Ethical Coding
  - Do you have a hospital policy that addresses this??
Proper Use of Physician Queries

• Query forms have become an accepted tool for communicating with physicians on documentation issues impacting proper code assignment.

• Query forms should be used in a judicious and appropriate manner. They must be used as a communication tool to improve the accuracy of code assignment and the quality of physician documentation, not to inappropriately maximize reimbursement.

• The query process should be guided by AHIMA's Standards of Ethical Coding and the official coding guidelines.

• The goal of the query process should be to improve physician documentation and coding professionals' knowledge of disease processes, not to improve reimbursement.

AHIMA - Inappropriate Query

• Inappropriate query techniques:
  – Poorly constructed or worded
  – Asks leading questions
  – Overuse of the query process

• Can result in quality of care, legal, and ethical concerns

• No “sticky notes”, Post-its or scratch paper should be allowed.
• “Open-ended” questions that allow the physician to document the specific diagnosis are preferable to multiple-choice questions or questions requiring only a “yes” or “no” response.

• Queries that appear to lead the physician to provide a particular response could lead to allegations of inappropriate upcoding.

What does Coding Clinic say?

• More than 50 times in AHA Coding Clinic - coders are instructed to query the physician
  – Coding Clinic is a publication of AHA
  – Coding Clinic opinion, information and guidance is from the four cooperating parties:
    • AHA
    • AHIMA
    • CMS
    • NCHS

Focus on “inpatient” querying for today’s program
• Chronic airway obstruction documentation

  * AHA Coding Clinic, Second Quarter 2000 Page: 15

• Pneumonia with yeast cultured from sputum

  * Coding Clinic, Second Quarter 1998 Page: 7
• Clarification - Abnormal findings on radiology reports, inpatient

*Coding Clinic*, Second Quarter 2002 Page: 17

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Query the MD regarding cultures when Dx is pneumonia

• All code assignments should be based upon the physician’s documentation. If the documentation is vague or not available, **query the physician** to confirm whether the culture findings identify the causative organism or identify a contaminant.

• Per AHA *Coding Clinic*
Query Forms

• Include:
  – Patient Name
    • Admission or Discharge date
    • MR #
    • Name and contact information of coding professional
    • Specific question and rationale (relevant documentation or clinical findings)
    • Place for physician to document his/her response
    • Place for the physician to sign, date his/her response

Query Forms Should Not…

• “Lead” the physician
• Sound presumptive, directing, prodding, probing, or as though the physician is being led to make an assumption
• Ask questions that can be responded to in a “yes or no” fashion; with a few exceptions, e.g., chronology
• Indicate the financial impact of the response to the query
• Be designed in a manner so that all that is required is a physician signature.
What is “leading”?

- “Leading” is implied when the expected answer is in the question.
- Examples:
  - Was the chest pain caused by unstable angina?
  - Was the patient on Lasix to treat CHF?
  - The patient was dehydrated, correct?

Example of Poorly Worded Query

Documentation of education is required to aid in patient(s) recovery in caring and severity of illness reflection. Please respond to the query below on the progress notes or on this form as an addendum.

Because there is documentation of medical treatment present in the medical record, clarification is needed. Additional documentation is necessary to identify the related diagnosis for the treatment ordered. Please answer the question:

You have documented “sepsis resolved” on your prog. note dated 09/17/02. By this, do you mean appendicitis with peritonitis? Something else?

Please document the diagnosis or sign and symptoms to justify medical necessity on the progress notes or on this form as an addendum. Be as specific as possible.

Example: Appendicitis with peritonitis (specific diagnosis condition)

The Coder worded the query which lead the physician to the answer and suggested a “YES” or “NO” response.
Example of Poorly Worded Query

In #1, a question was never asked, but rather a statement was made.
In #2, question was not left open ended for the physician to respond.

Example of "Good" Query

Documentation clarification is required to meet compliance, accuracy in coding and severity of illness reflection. Please respond to the query below on the progress notes or on this form as an addendum.

1. Patient was admitted for questionable aspiration after having a seizure. Per your discharge summary, there is some evidence of pneumonitis on his chest x-rays and pt. was discharged on Levaquin. It is not clear if the aspiration pneumoni was ruled-out or not.

2. Is this pt. etoh dependent or abusive only?

(specific diagnosis/condition)

In #1, a question was never asked, but rather a statement was made.
In #2, question was not left open ended for the physician to respond.
Example of “Good” Query

Because there is documentation of medical treatment present in the medical record, clarification is needed. Additional documentation is necessary to identify the related diagnosis for the treatment ordered. There are orders for __________.

After study what is the principal diagnosis?

Pneumonia, which left

Please document the diagnosis or sign and symptoms to justify medical necessity on the progress notes or on this form as an addendum, be as specific as possible.

(Sign and date all documentation)

(Specific diagnosis/condition)

Query Forms

- Development of common documentation scenarios (input from coding staff). Seeking clarification!
- Review of query language by legal and/or compliance
- Distribution to all HIM Department Coding Staff and Case Management.
Physician Query Forms . . .

• If there are multiple questions for one case ensure that:
  – (1) it is clear to the physician that he/she has more than one to respond to
  – (2) ensure that there is sufficient room to write a response (if it is required on the form).

Awareness and Education – to Physicians

• Why queries are used
• Outline the process, including expectations for response (how, timeframe etc.)
• Provide examples of queries that the physicians might see based on known issues in your facility
• Emphasize the documentation improvement aspect and how the query may be a learning tool for the physicians to be aware of the necessary documentation for coding in particular clinical situations.
• Clinical definitions to know:
  – Infection = invasion by organisms in a normally sterile area with resulting local inflammation.
  – Bacteremia = the presence of viable bacteria in the blood stream. This is **NOT** synonymous with “sepsis”.
  – Sepsis = the body’s systemic inflammatory response to an infectious process.

• **Urosepsis** per AHA Coding Clinic
  
  **Urosepsis**: Although the Alphabetic Index assigns urosepsis to urinary tract infection, 599.0, this classification may or may not be what the physician intended……..Coding Clinic 1st Quarter 1988
**Septicemia Tips/Hints**

- Fever, chills, malaise, hypotension, tachycardia, tachypnea, confusion, ALOC
- IV broad spectrum antibiotic and large volume IV fluids
- Administration of Xigris
- Leukopenia or leukocytosis (WBC less than 3,000 or more than 12,000)
- Blood cultures + or -
- LOS is often > 3 days but not necessarily
- Review AHA Coding Clinic, Fourth Quarter 2003 Page: 79-81

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**Physician Query = Physician Communication**

- When the documented diagnosis is “UTI”, but there is presence of a indwelling Foley (urinary catheter) or other recent instrumentation…

- You should query to clarify whether there is a relationship or association between the infection and the medical device.
**Physician Query = Physician Communication**

- When the documentation of “Urosepsis” is made but there are clinical signs of Sepsis (see AHA *Coding Clinic*)…

- You should query the physician for clarification of the diagnosis (meaning urinary tract infection or “sepsis from a urinary source.”)

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**To Query or Not to Query?**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

- 80 year old patient admitted from the MD office after being seen for cough and fever for three days. Patient was seen prior that week for bronchitis and received antibiotics.

- Patient has a history of a CVA with residual dysphagia in the past and history of vomiting 2 days ago. Chest exam positive for congestion with rales. X-ray shows an infiltrate in both lungs. Sputum is productive.

- Admitting diagnosis is “pneumonia”, progress notes state “acute pneumonia”, discharge summary states “acute pneumonia now resolved after 6 days”

- Would you query the MD? Yes or No

- If Yes, what would you query the MD for and why?
To Query or Not to Query?

• Patient seen in the ED/ER feeling weak, mentally not clear and fever. UA shows bacteria. ED/ER MD documents “Urosepsis” as the admitting diagnosis. H&P reports the patient is also hypotensive and is taken to ICU for 32 hours with IV antibiotics. Diagnosis is “Urosepsis” on the H&P and Discharge Summary after 5 days.

• Would you query the MD? Yes or No

• If Yes, what would you query the MD for and why?

To Query or Not to Query?

• Chart documentation (labwork) shows lowered Hgb and a packed cell blood transfusion is given. There is no physician documentation of “anemia” anywhere in the record.

• Would you query the MD? Yes or No

• If Yes, which query form would you use, and why?
To Query or Not to Query?

1. You are coding a case that needs a MCC/CC and you notice “altered mental status” documented as a secondary diagnosis.
   - Would you query the MD? Yes or No
   - If Yes, what would you query the MD for and why?

To Query or Not to Query?

1. You are coding a case that needs a CC and “CHF” is documented on the Discharge Summary.
   - Is this a CC?
   - Would you query the MD? Yes or No
   - If Yes, what would you query the MD for and why?
To Query or Not to Query?

• If coding a TIA case with a secondary diagnosis of known A-fib, should you query the MD? Yes or No

• If Yes, what would you query the MD for and why?

To Query or Not to Query?

• A very elderly patient has a rather lengthy hospital stay for pneumonia and you find that none of the secondary conditions coded so far count as an MCC or CC. On a Progress Note from day 5 of the hospital stay, you notice documentation of a urinary tract infection (UTI) due to an indwelling foley catheter.

• Would you query the MD? Yes or No

• If Yes, what would you query the MD for and why?
Everybody is using Physician Query forms…

PHYSICIAN DOCUMENTATION QUERY

SIMPLE VS COMPLEX PNEUMONIA CLARIFICATION

Date: ____________________________

Patient Name: ____________________________
Admit Date: ____________________________

Documentation clarification is required to meet compliance, accuracy in coding and severity of illness reflection for your patient.

Please document, if known, the appropriate specific pneumonia diagnosis on the progress notes or on this form as an attachment. (Sign and date all documentation)

Note: If any relevant treatment was received or problem noted, please document it as well.

Note: Physician or licensed advanced practice providers may not include a diagnosis of a specific bacterial pneumonia in patients with the clinical evidence of this condition. (MMWR Cough Coins)

MD Signature: ____________________________
Date: ____________________________

If you have any questions, please contact the HIM Department (Medical Records) at (949) 756-4444.

Everybody is using Physician Query forms…

PHYSICIAN Query

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Medical Form

Free Medical Form info
Find what you are looking for

www.medical31.net
PHYSICIAN DOCUMENTATION QUERY
ANGINA DIAGNOSIS CLARIFICATION

Date Dr.: ___________________  Date: ___________________

MR #: ___________________  Patient Name: ___________________  Admit Date: ___________________

Documentation clarification is required to meet compliance, accuracy in coding and severity of illness reflecting for your patient.

There is clinical documentation of the cardiac condition "ANGINA", along with evidence of evaluation, monitoring and treatment in the medical record.

Additional documentation is necessary to identify that:

- Related/diagnosed disease or underlying cause of the angina, if known. (For example, caused by CAD, ASMR, CCF, Congestive heart failure, GESD, etc.)

- Type of angina (if known. (For example, unstable, new onset angina, etc.)

Please document the underlying cause and type of angina, if known, in the progress notes or on this form below as an subsection. (Sign and date all documentation)

Note: If you are unsure or a suspected, possible or improbable condition, please document as such.

MD Signature: ___________________

Date: ___________________

If you have any questions, please contact the HIM Department (Medical Records) at 888-785-1000. Thank You!

PHYSICIAN DOCUMENTATION QUERY
CARDIAC ARRYTHMIA and CONDUCTION DISORDERS

Date Dr.: ___________________  Date: ___________________

MR #: ___________________  Patient Name: ___________________  Admit Date: ___________________

Documentation clarification is required to meet compliance, accuracy in coding and severity of illness reflecting for your patient.

There is clinical documentation of a "Cardiac arrhythmia" with treatment and/or monitoring present in the medical record. Additional documentation is necessary to identify the specific type of arrhythmia or conduction disorder. (For example, atrial flutter, atrial fibrillation, premature atrial contractions, bundle branch block, etc.).

Please document the specific type of arrhythmia and/or conduction disorder diagnosis, if known, in the progress notes or on this form as an subsection. (Sign and date all documentation)

Note: If you are unsure or a suspected, possible or improbable condition, please document as such.

MD Signature: ___________________

Date: ___________________

If you have any questions, please contact the HIM Department (Medical Records) at 888-785-1000. Thank You!
Sample Physician Query Form

SAMPLE PHYSICIAN QUERY FORM

Date: ____________________________

Patient name: ____________________________

Admit date: ____________________________ Discharge date: ____________________________

Medical record no. ____________________________ Account no. ____________________________

Clerk name: ____________________________ Clerk phone number: ____________________________

Property

Dear Dr. ____________________________

The documentation in this patient’s record requires clarification to ensure coding compliance and accuracy. Please complete, sign, date, and return the following query:

The following information is recorded in [state the specific location in the medical record of information contributing to the reason for query].

[Add the information, for example, "Gastroesophageal reflux disease (GERD) in a patient with a documented peptic ulcer disease"]

I have the following question about this record:

[Example: "Was the patient’s pneumonia caused by a specific organism? If yes, please specify the organism."]

Please respond to this question in the space below:

[allow space for written entry]

[If your policy requires, instruct the physician to make an addition: “You must also add this information to the patient’s medical record by an addition to the progress notes or discharge summary.”]

Physician signature: ____________________________ Date: ____________________________

This material was prepared by Physicians Health, Inc., a Medicare Quality Improvement Organization for Colorado, under contract with the Centers for Medicare & Medicaid Services. This material is not a Medicare or Medicaid benefit. This material may be used for quality improvement purposes only.
POA (Present on Admission) Query

Can Diagnoses Be Coded From MD Orders?

- Can Coders assign codes based on diagnoses listed on MD Orders?
- Coders can code from other diagnostic documentation within the MD orders.
- It has been proven that patients whose MD Orders contain the diagnosis (clinical indication) have less medication errors.
Capturing Co-Morbid Conditions

• Documenting the clinical indication or diagnosis when writing an order (even a telephone order) will improve physician documentation and decrease medication errors. Examples:
  – 40 mg Lasix IVP now, for CHF
  – Change IV to D5W/.45NS @ 80cc/hr, for hypernatremia
  – 500mg Bactrin DS for probable UTI
  – In & Out Cath for Urinary Retention

The Joint Commission Pharmacy Standard

Physician Query Forms

• Queries should improve understanding of unique clinical situations and provide assurance that if codes are assigned, the documentation in the record supports them.

• Excessive use of queries may indicate trends of poor documentation
How Can We Decrease Retrospective MD Queries?

• Awareness and Education to the Medical Staff (physicians)
• Appoint a suitable liaison to assist with physician communication and awareness
• MD Orders that contain a diagnosis matched to each drug
• Nursing and Ancillary staff assistance – concurrently
• Case Managers’ assistance - concurrently
• Improved documentation forms and templates
• Administrative Support

What else can help?...

• Standard abbreviation
• Correcting errors in documentation should be standard
• Improve forms
**Verbal Query Process**

- Follow the same guidelines when verbally querying the physician for clarification
  - Non-leading, etc.

- However, clinical documentation specialist may have more of an “open dialog with physicians
  - No formal guidelines have been established

**Tracking Your Physician Querying Concurrent, Prebill or Retro**

- Track query usage by physician, coder, positive/negative responses, diagnoses or DRG, etc. for trends.

- Review queries for content and appropriateness in terms of the medical record documentation, and to

- Identify leading questions or otherwise poorly constructed queries. Also, review for legibility.

- Follow up on trends by determining the cause and addressing it through system improvement and/or education.
MD Query Log – rationale

- Medicare is concerned about leading queries, not the fact that we query. Everyone, including CMS and the OIG understand that we under document in healthcare.

- Keeping data on the outcome of the query process does not infer impermissible upcoding, in fact, it is consistent with our obligation to maintain accurate data and submit accurate claims.
Physician Query Policy … A Must

- Development of a *policy* for use of Query Forms
- Your policy should be clear that the query procedure is *not limited* to situations where reimbursement is an issue.
- The purpose of the physician query form is to address all clinical documentation and data quality issues.
- Physician Query procedures should support Medicare Conditions of Participation documentation requirements and Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) requirements for completeness and accuracy
- Establish retention policies for query forms

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Physician Query Policy

- Your policy should include a mechanism for placing the response to the Query form or addendum in the medical record where it will be obvious
- The policy should be approved by the organizational entity, such as the Medical Record Committee, that determines and approves medical record documentation practices.

Catholic Healthcare West
Physician Queries...

• “Greater specificity in a chart translates not only into more correct coding and payment—the improved information enables better care by everyone who treats the patient—severity of illness and risk of mortality can be reported more accurately due to increased detail on diseases and procedures, and subsequent encounters will have more medical history from which to make new treatment decisions.”

For the Record – January 2008

Audit the quality of the documentation … give it a “SCORE!”

**Physician Documentation Scorecard: Cardiology**

<table>
<thead>
<tr>
<th>Description</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation Meets All Requirements</td>
<td>0</td>
</tr>
<tr>
<td>Cardiac Arrhythmias Unspecified</td>
<td>3</td>
</tr>
<tr>
<td>Cardiac Conditions Not Clearly Documented</td>
<td>4</td>
</tr>
<tr>
<td>Missing Detail on Myocardial Infarction</td>
<td>2</td>
</tr>
<tr>
<td>Pacemaker Removals Not Documented</td>
<td>6</td>
</tr>
<tr>
<td>Components of Echocardiogram Missing</td>
<td>3</td>
</tr>
<tr>
<td>Missing Documentation of Specific Vessel Treated</td>
<td>9</td>
</tr>
<tr>
<td>Revision of Pacemaker Skin Pocket Not Documented</td>
<td>2</td>
</tr>
<tr>
<td>Insufficient Documentation of Physician Presence/Services Provided in Cardiac Rehabilitation Exercise Area</td>
<td>1</td>
</tr>
<tr>
<td>Medical Necessity Denial</td>
<td>10</td>
</tr>
</tbody>
</table>

A physician scoring 11 points or higher in a record review needs documentation therapy.
Query Form Not Allowed?

- Disallowing the use of the query form or disallowing its acceptance in the medical record complicates the process of obtaining supplemental documentation from the physician, results in an increased burden on health information departments, accurate clinical data and delaying coding and billing.

Summary

- Check all documentation before querying
- Coders should ask open-ended questions whenever possible
- Physician Query form usage and Documentation improvement programs for physicians must have the support of hospital administrators
- Key stakeholders must understand that proper documentation is crucial to patient care, risk management, and billing.
Questions

• Are there any questions?

References and Resources

• For the Record – January 2008
• Just Coding.com (Physician Queries – January 2008
• "Improve Documentation of Patient Records", SLMDA GOOD PRACTICE FORUM – June 2006
• AHIMA Practice Brief – Physician Query
• CMS Communications – QIO/Lumetra
• CHW Physician Query Policy
• CHW Physician Query Forms
• AHA Coding Clinic for ICD-9-CM
• TMF, Texas Quality Improvement Organization (QIO)
Thank You

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