East Jefferson General Hospital

Documentation Tip: Physician Queries

October 2020

Did you know?

- ICD-10 was created by WHO intended to serve as an epidemiologic classification tool – this is why clinical and ICD-10 coding language differs.
- Queries are not meant to second guess or question a provider's judgement. The objective of a query is to ensure that the medical record documentation translates to accurate ICD-10 coding reflecting the complexity of care involved in managing your patient's acute and chronic comorbidities.

Reason for queries

1. Payers continuously find ways to avoid paying claims. They often site lack of clinical validation in denying payment for diagnoses resulting in higher reimbursement.
2. Clarification for accurate ICD-10 reporting. Examples of clarification queries may include:
   - Conflicting documentation between providers
   - Complications of medical management
   - Rule in/out for possible diagnoses
   - Present on admit status
   - Consistency of a documented condition
   - Specificity of a condition
   - Chronic vs active condition
   - Clinical validity or significance

How CDI can help you:

- We are available by phone or email to assist with queries. CDI contact information is at the top of each query or we can be reached by contacting HIM department at 503-4961.
- Tip sheets like this one are sent out every month. If you have a specific topic you would like further information about please let us know.
- **You will start receiving monthly emails from CDI with your top queries. Included will be specific tips on how you can reduce future queries.**

Tips:

- Include clinical rationale when diagnosing conditions. This will ensure accurate reporting of SOI/ROM, quality measures, and help to prevent denials
- Document the daily status of each condition you are managing and treating.
- It is acceptable to note a multidisciplinary approach for treatment such as WOCT recommendations for wound care or RD recommendations for malnutrition
- The DC summary is the most important document because it is considered the final diagnostic statement for the entire hospitalization.
- Document every diagnosis that affects your patients care.
- Remember to check your message Center Priority inbox for outstanding queries daily

From your Clinical Documentation Improvement Team

Kathy Green, RN, CCDS	(410) 259-3636
Karen Hebert, RN	503-5681
Melissa Imhoff, RN, BSN	503-4970
Tammy Carter RN, CCDSS	503-5186
Suzanne Snider, RN, BSN	503-4943
CDI Manager: Collette Zeiour	503-6187
Clinical Documentation Integrity Coordinator:	
Nicole Newman, RN, MSN, CCDS	(216) 379-1679