Introduction

In today's changing healthcare environment, health information management (HIM) professionals face increased demands to produce accurate coded data. Therefore, establishing and managing an effective query process is an integral component of ensuring data integrity. A query is defined as a question posed to a provider to obtain additional, clarifying documentation to improve the specificity and completeness of the data used to assign diagnosis and procedure codes in the patient's health record. Documentation can be greatly improved by a properly functioning query process. This document will assist in the setup, understanding the process as the coder, and show how a provider will successfully sign the query from the Esign queue.

Physician Coding Query

Setup

The Physician's Header table within Patient Accounting will need to be set up prior to performing a query on a patient. Once the physician type is selected, it will be necessary to enter the physician number 999999 to set up query document formats.

Once the 999999 physician is entered, existing documents will be displayed. The system gives the option to enter **N**ew for creating a new query document format, or enter a sequence number to edit an existing format.

Select **Hospital Base Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **Phy Headers**

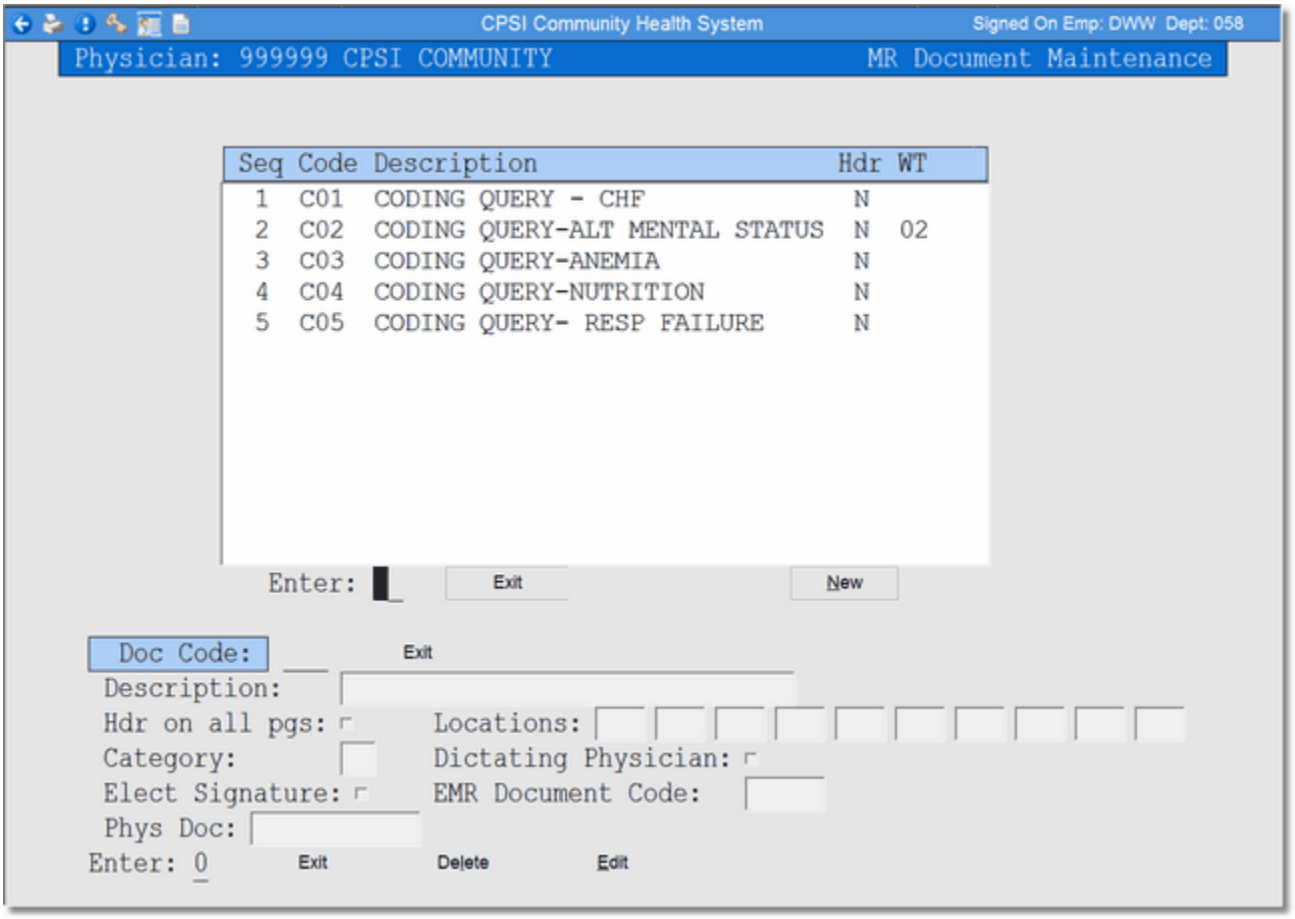


Figure 1.1 MR Document Maintenance

Select **Hospital Base Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **Phy Headers** > **Physician** > **"N"ew**

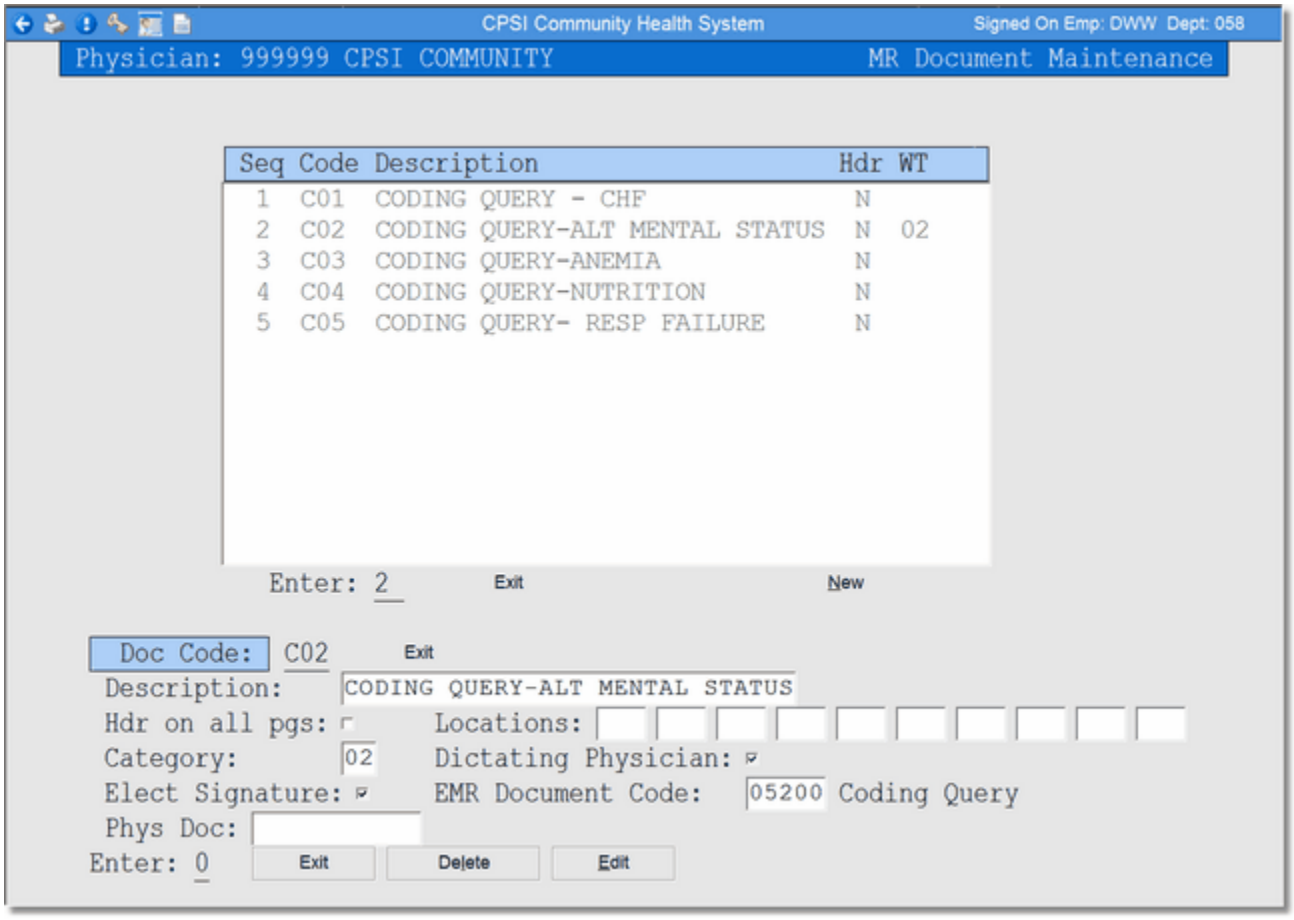


Figure 1.2 MR Document Maintenance

Below are the fields that will need to be set up for the Coding Query document.

- **Doc Code:** This code is a user-defined code and may be used as a quick indexing feature. For example, C01 could be the first Coding query for this physician.

- **Description:** Enter the name of the document, up to 30 characters in length. This will be used in various screen listings.

- **Category:** This is a required free form field for all MR transcription headers. This category code should be entered in the Transcription Workcode field in the EMR Document Table when assigning document codes to physician headers for MR transcription.

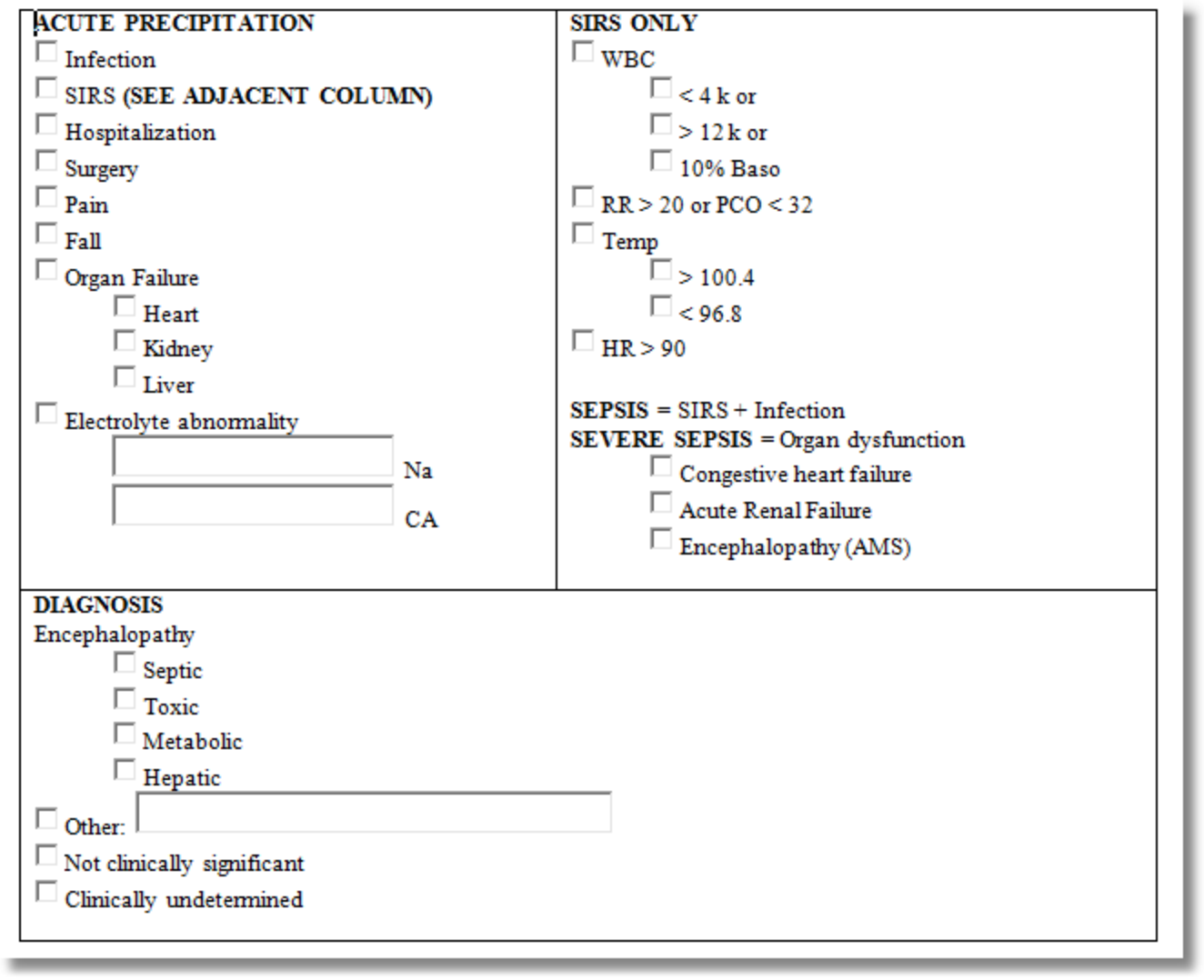
NOTE: *For the sake of consistency and in the face of future software development, CPSI recommends the use of the dictation "worktype" that the physician utilizes when dictating a report to be transcribed for this code. Since query documents are not likely dictated, CPSI recommends selecting a unique code and using it for all query documents.*

- **Elect Signature:** Select this field if this physician will electronically sign this query document.

- **EMR Document Code:** Enter the code that corresponds to this physician query. The magnifying glass provides a lookup option and connects to a table that allows the user to enter a new document code.

***NOTE**: The EMR Document Code field is not required in order for a* physician header *to be printed in the Electronic Medical Record; however, once a code is set up in the EMR Document Code table, it should be loaded here.*

Once the above prompts have been answered, the electronic physician's query document may be **E** dited using MSWord. Below is an example of a Physician's query.



ACUTE PRECIPITATION
- ☐ Infection
- ☐ SIRS **(SEE ADJACENT COLUMN)**
- ☐ Hospitalization
- ☐ Surgery
- ☐ Pain
- ☐ Fall
- ☐ Organ Failure
  - ☐ Heart
  - ☐ Kidney
  - ☐ Liver
- ☐ Electrolyte abnormality
  - _____ Na
  - _____ CA

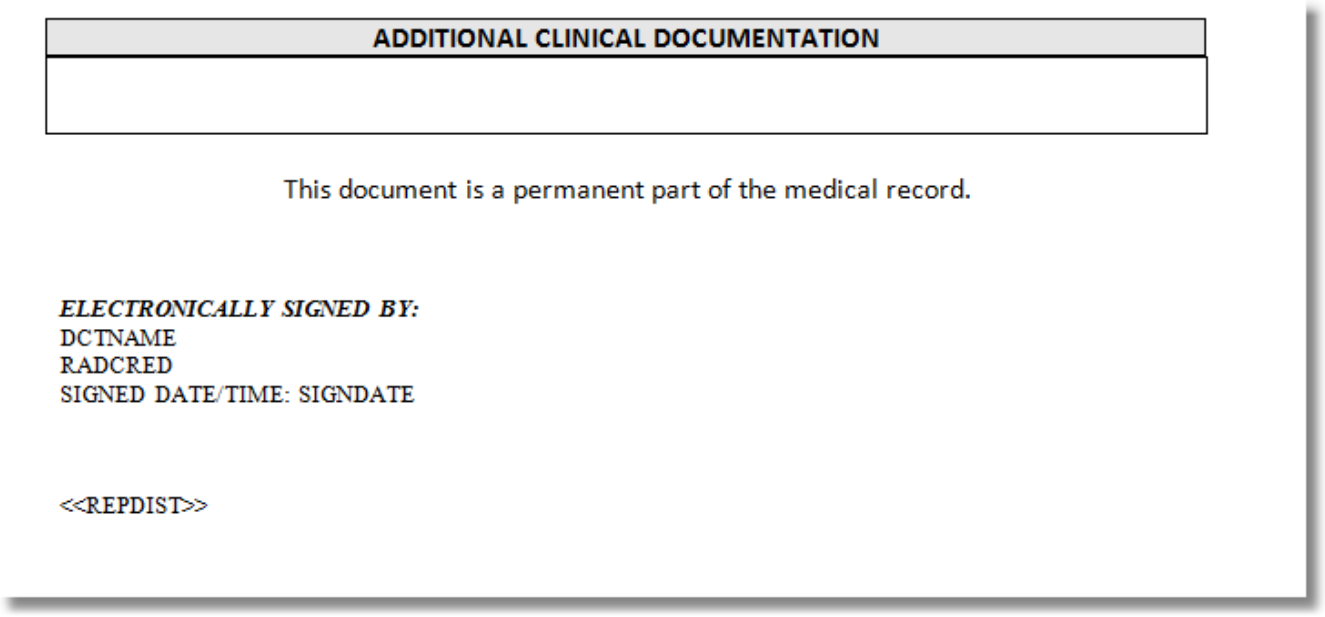
SIRS ONLY
- ☐ WBC
  - ☐ < 4 k or
  - ☐ > 12 k or
  - ☐ 10% Baso
- ☐ RR > 20 or PCO < 32
- ☐ Temp
  - ☐ > 100.4
  - ☐ < 96.8
- ☐ HR > 90

SEPSIS = SIRS + Infection
SEVERE SEPSIS = Organ dysfunction
- ☐ Congestive heart failure
- ☐ Acute Renal Failure
- ☐ Encephalopathy (AMS)

DIAGNOSIS
Encephalopathy
- ☐ Septic
- ☐ Toxic
- ☐ Metabolic
- ☐ Hepatic

☐ Other: _____
☐ Not clinically significant
☐ Clinically undetermined

Figure 1.3 Query



ADDITIONAL CLINICAL DOCUMENTATION

This document is a permanent part of the medical record.

ELECTRONICALLY SIGNED BY:
DCTNAME
RADCRED
SIGNED DATE/TIME: SIGNDATE

<<REPDIST>>

Figure 1.4 Query

Security Switches

Employees that will be performing queries on patients will need security switche 14, Medical Record Transcription Entry, set to **Y** in the Employee Security table.

Coder Process

The coder will use the same process for initiating a query as a transcriptionist uses to transcribe a document. Below are the steps for coding a query.

- Medical Records
  - Access the Transcription System for a patient
    - Phase ID: Select **Master Selection > Account Number > Medical Records > <u>Transcription System</u>**
    - No Phase ID: Select **Account Number** > **Medical Records > <u>Transcription System</u>**
  - Select **New Document**
    - Enter Physician Name or Number > Select Physician
    - Select Document or Global
    - Select Document if Global option was selected
    - Enter Dictation Date ("." Enter for today's date). This field is required for PHYSDOC
    - Enter Dictation Time (Enter for current time). This field is required for PHYSDOC
    - Select **Edit**
    - Transcribe the report. (Select F11 to utilize stop codes)
    - Upon completion select **Save/Exit** on the CPSI toolbar
    - Select back arrow
    - Select **Require Edit**

Provider Process

The Electronic Signature feature allows a physician to automatically assign an electronic signature to a physician query document within the CPSI system. To utilize Electronic Signature, Graphics and Edit Boxes must be enabled on the Client PC.

Select **Hospital Base Menu** > **Electronic Signature**

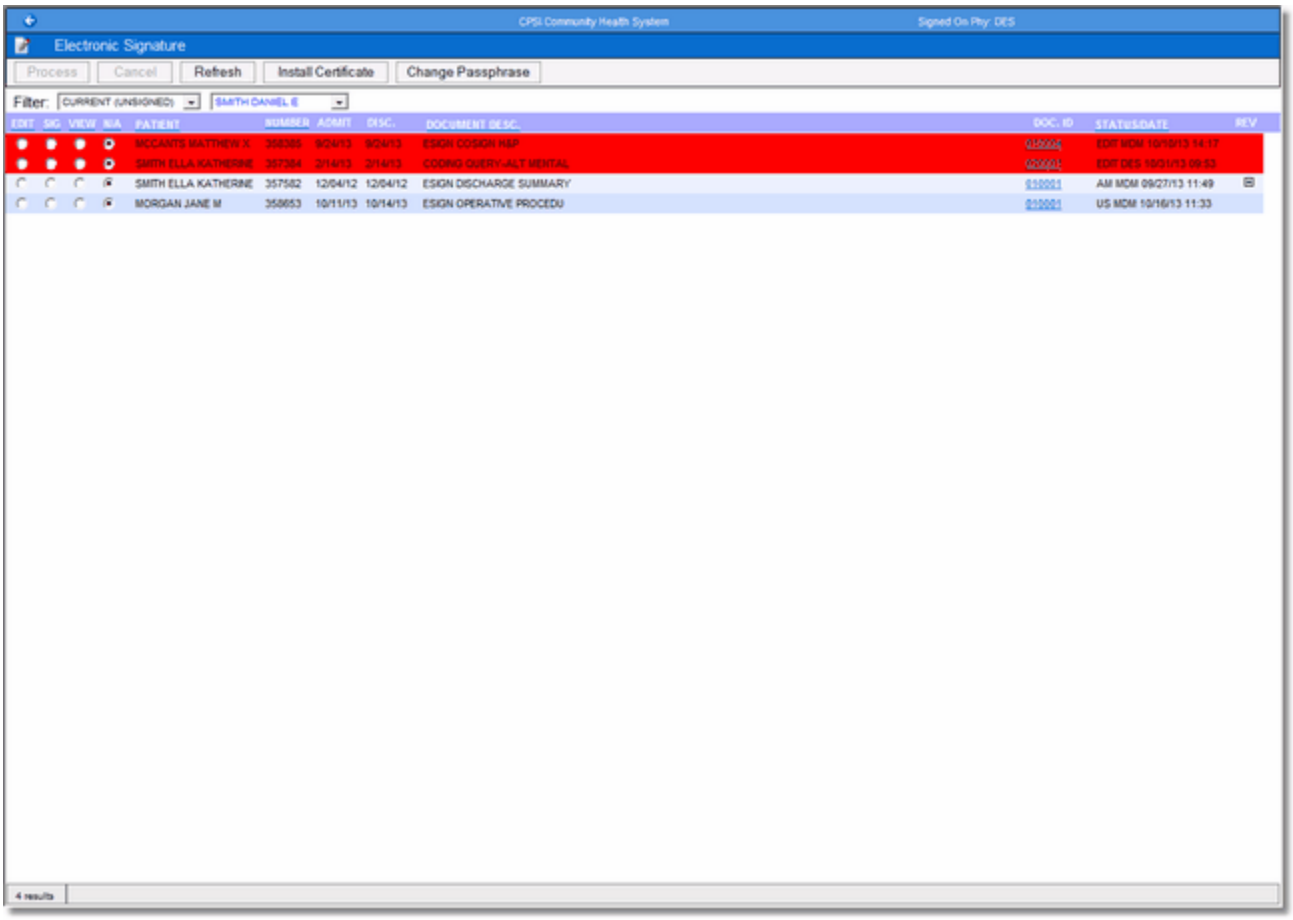


Figure 1.5 Electronic Signature

To electronically sign a document, the physician should leave the Filter set to Current (Unsigned). This option lists all unsigned, transcribed documents for the dictating physician. Also displayed will be the patient's Admit Date, Discharge Date, Account Number, Document ID, Document Description, the transcribing clerk's initials and the date and time of transcription.

Also displayed will be the Status of the document. These statuses will be:

US Unsigned
AM Amended
AD Addended
Edit Requiring Edit

- **Filter:** The options are Current (Unsigned), Last 7 Days, Last 30 Days, Last 12 Months or a date range may be selected.

The desired document should be selected to perform the following:

- **Edit:** This option will allow the physician to edit the document, whether **R**equired by the transcriptionist or not. If the transcriptionist had selected **R**equire Edit upon exiting, the completed edit box will display for the physician.

- **Sig:** The selected document will be signed and will remain in the display until the screen is refreshed or reentered. If page 1 of the Physician Table is **Y**, the following message is received when the Physician selects this option. “Are you sure you want to sign without viewing or editing document”? The Physician is given the option of **Yes** or **No**. If **Yes** is selected, the signing process may continue. If **No** is chosen, the physician may either View or Edit the Document before signing.

- **View:** This option will display the document in its printed format in Adobe Acrobat.

- **N/A:** This option will allow no action to be taken for the selected document.

The document will appear after reading the edit box instructions and selecting **Ok.**

There are several options that appear at the top of the screen:

- **Edit:** This option will allow the physician to select specific documents for editing.

- **Cancel:** Selecting this option will cancel the selections made below.

- **Refresh:** Selecting this option will refresh the screen and display more transcriptions that have been completed and sent to the physician's queue.

The physician will have several options available from the CPSI E-Sign Toolbar.

Save: Selecting this option will save any changes made and remain in the document for further editing.

Save/Sign: Selecting this option will save any changes the physician made and electronically sign the document after the passphrase is entered. The system will automatically distribute reports based on the table settings.

Save/Hold: Selecting this option will save any changes the physician has made to the document but will retain the document in the queue.

Edit/Return: Selecting this option will open a Notepad edit box, in which the physician can enter instructions to let the transcriptionist know what needs to be changed. This option will return the

document to the transcriptionist's queue to edit.

Abort/No Save: Selecting this option will not save any changes made, and will exit the document.

Exit E-Sign: Selecting this option will close the document without electronically signing.