Guidelines for Achieving a Compliant Query Practice

IN COURT AN ATTORNEY CAN'T "lead" a witness into a statement. In hospitals, coders and clinical documentation specialists can't lead healthcare providers with queries. Therefore, appropriate etiquette must be followed when querying providers for additional health record information.

A query is a communication tool used to clarify documentation in the health record for accurate code assignment. The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment. The final coded diagnoses and procedures derived from the health record documentation should accurately reflect the patient's episode of care.

The guidance of this practice brief augments and, where applicable, supersedes prior AHIMA guidance on queries. The intent of this practice brief is not to limit clinical communication for purposes of patient care. Rather it is to maintain the integrity of the coded healthcare data. All professionals are encouraged to adhere to these compliant querying guidelines regardless of credential, role, title, or use of any technological tools involved in the query process.

A proper query process ensures that appropriate documentation appears in the health record. Personnel performing the query function should focus on a compliant query process and content reflective of appropriate clinical indicators to support the query.

When and How to Query

The generation of a query should be considered when the health record documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Provides a diagnosis without underlying clinical validation
- Is unclear for present on admission indicator assignment

Although open-ended queries are preferred, multiple choice and "yes/no" queries are also acceptable under certain circumstances.

Query Example: Clarification for Specificity of a Diagnosis

OBTUNDED PATIENT ADMITTED with three-day history of nausea and vomiting. CXR revealed right lower lobe (RLL) pneumonia. Clindamycin ordered.

Leading query:
Is the patient's pneumonia due to aspiration?

Nonleading query:
Can the etiology of the patient's pneumonia be further specified? It is noted in the admitting history and physical examination (H&P) this obtunded patient had a history of nausea and vomiting prior to admission to the hospital and is treated with clindamycin for RLL pneumonia. Based on the above, can the etiology of the pneumonia be further specified? If so, please document the type/etiology of the pneumonia in the progress notes.

Source: AHIMA. "Guidance for Clinical Documentation Improvement Programs." *Journal of AHIMA* 81, no.5 (May 2010): expanded web version.

To support why a query was initiated, all queries must be accompanied by the relevant clinical indicator(s) that show why a more complete or accurate diagnosis or procedure is requested. Although AHA's *Coding Clinic* for ICD-9-CM often references clinical indicators associated with particular diagnoses, it is not an authoritative source for establishing the clinical indicators of a given diagnosis. A recent *Coding Clinic* issue also stated that it is not intended for such a purpose. Clinical indicators should be derived from the specific medical record under review and the unique episode of care. Clinical indicators supporting the query may include elements from the entire medical record, such as diagnostic findings and provider impressions.

A query should include the clinical indicators, as discussed above, and should not indicate the impact on reimbursement. A leading query is one that is not supported by the clinical elements in the health record and/or directs a provider to a specific diagnosis or procedure. The justification (i.e., inclusion of relevant clinical indicators) for the query is more important than the query format.

Because the patient record should provide a sequence of

events, best practice is to capture the content of a verbal and/or written query, as well as any practitioner response to the query. This practice allows reviewers to account for the presence documentation that might otherwise appear out of context.

If the practitioner documents his or her query response directly into the health record and there is a lack of supporting clinical information, it is recommended the practitioner provide the clinical rationale for the diagnosis (i.e. "Patient transfused four days ago due to acute blood loss anemia") unless the query is maintained as a permanent part of the health record. Lack of clinical rationale may raise questions in the event of any secondary review. Organizations that opt to not maintain queries as part of the permanent health record are encouraged to maintain copies as part of the administrative, business record. If the practitioner documents his or her response only on the query form, then the query form should become part of the permanent health record.

Multiple choice query formats should include clinically significant and reasonable options as supported by clinical indicators in the health record, recognizing that there may be only one reasonable option. As such, providing a new diagnosis as an option in a multiple choice list—as supported and substantiated by referenced clinical indicators from the health record—is not introducing new information. Multiple choice query formats should also include additional options such as "clinically undetermined" and "other" that would allow the provider to add free text. Additional options such as "not clinically significant" and "integral to" may be included on the query form if appropriate.

The "yes/no" query format should be constructed to include the additional options associated with multiple choice queries (i.e., "other," "clinically undetermined," and "not clinically significant and integral to"). Yes/no queries may not be used in circumstances where only clinical indicators of a condition are present and the condition/diagnosis has yet to be documented in the health record. Also new diagnoses cannot be derived from a yes/no query.

In such circumstances, open-ended or multiple choice query formats must be used. It is not considered leading to include a new diagnosis as part of a multiple choice format when supported by clinical indicators (see "Query Example: Yes/No Format"). In addition to present on admission (POA) determinations, yes/no queries may be utilized under the following circumstances:

- Substantiating or further specifying a diagnosis that is already present in the health record (i.e., findings in pathology, radiology, and other diagnostic reports) with interpretation by a physician
- Establishing a cause and effect relationship between documented conditions such as manifestation/etiology, complications, and conditions/diagnostic findings (i.e., hypertension and congestive heart failure, diabetes mellitus and chronic kidney disease).
- Resolving conflicting documentation from multiple practitioners.

Query Example: Yes/No Format

Compliant Example 1

Clinical scenario: In the impression of the pathology report, ovarian cancer is documented; however, only ovarian mass is documented in the final discharge statement by the provider.

Query: Do you agree with the pathology report specifying the "ovarian mass" as an "ovarian cancer"? Please document your response in the health record or below.
Yes_____
No _____
Other _____
Clinically Undetermined _____
Name: _____ Date:_____

Rationale: This yes/no query involves confirming a diagnosis that is already present as an interpretation of a pathology specimen in the health record.

Compliant Example 2

Clinical scenario: Consulting pulmonologist documents pneumonia as an impression based on the chest X ray; however, the attending physician documents bronchitis throughout the record including in the discharge summary.

Query: Do you agree with the pulmonologist's impression that the patient has pneumonia? Please document your response in the health record or below.
Yes _____
No _____
Other _____
Clinically Undetermined_____
Name: _____ Date:_____

Rationale: This is an example of a yes/no query resolving conflicting practitioner documentation.

Unlike other qualifiers listed under the official coding guidelines for inpatient reporting of uncertain diagnoses, "possible" is a very broad term and therefore its use in a query is discouraged.

Verbal Queries and Missing Clinical Indicators

Verbal queries should contain the same clinical indicators and follow the same format as written queries to ensure compliance and consistency in policy and process. Documentation of the verbal query may be condensed to reflect the stated information, but should identify the clinical indicators that support the query as well as the actual question posed to the practitioner. Verbal queries should be documented at the time of the discus-

Query Example: Documented Conditions Without Clinical Indicators

THESE EXAMPLES PROVIDE sample wording for documentation cases that include a diagnosis without an accompanying clinical indicator.

Clinical Scenario 1

Documentation: Laboratory finding of serum sodium of 120 mmol/L and the attending physician documents hypernatremia in the final diagnostic statement.

Query: Please review the laboratory section of the present record to confirm your discharge diagnosis of hypernatremia. Laboratory findings indicate a serum sodium of 120 mmol/L.

Clinical Scenario 2

Documentation: Four-year-old child sustains a cautery injury to upper lip during maxillofacial surgery. Silvadene and dressing is applied to the affected area at the completion of the procedure and plastic surgery was consulted. The surgeon documented in the operative report that there were "no intraoperative complications."

Query: Please review the operative note notation of "a cautery lesion to the upper lip," subsequent treatment with Silvadene and clarify your documentation of "no intraoperative complications."

sion or immediately following.

The focus of external audits has expanded in recent years to include clinical validation review. The Centers for Medicare and Medicaid Services (CMS) has instructed coders to "refer to the *Coding Clinic* guidelines and query the physician when clinical validation is required."[1] The practitioner does not have to use the criteria specifically outlined by *Coding Clinic*, but reasonable support within the health record for the diagnosis must be present.

When a practitioner documents a diagnosis that does not appear to be supported by the clinical indicators in the health record, it is currently advised that a query be generated to address the conflict or that the conflict be addressed through the facility's escalation policy.

CMS recommends that each facility develop an escalation policy for unanswered queries and to address any staff concerns regarding queries. In the event that a query does not receive a professional response, the case should be referred for further review in accordance with the facility's escalation policy. The escalation process may include, but is not limited to, referral to a physician advisor, the chief medical officer, or other administrative personnel.

Develop Query Retention Policies

Each organization should develop internal policies regarding query retention. Ideally, a practitioner's response to a query is documented in the health record, which may include the progress notes or the discharge summary. If the record has been completed, this may be an addendum and should be authenticated. As noted in AHIMA's toolkit, "Amendments in the Electronic Health Record," "the addendum should be timely, bear the current date, time, and reason for the additional information being added to the health record, and be electronically signed."

Organizational policies should specifically address query retention consistent with statutory or regulatory guidelines. The policy should indicate if the query is part of the patient's permanent health record or stored as a separate business record. If the query form is not part of the health record, the policy should specify where it will be filed and the length of time it will be retained. It may be necessary to retain the query indefinitely if it contains information not documented in the health record. Auditors may request copies of any queries in order to validate query wording, even if they are not considered part of the legal health record.

An important consideration in query retention is the ability to collect data for trend analysis, which provides the opportunity for process improvement and identification of educational needs.

Always Follow Best Practices

Healthcare professionals that work alongside practitioners to ensure accuracy in health record documentation should follow established facility policies and procedures that are congruent with recognized professional guidelines. This practice brief represents the joint efforts of AHIMA and the Association for Clinical Documentation Improvement Specialists to provide ongoing guidance related to querying. It specifies updates to previous AHIMA practice briefs and provides support for an appropriate query process. As healthcare delivery continues to evolve, it is expected that future revisions will be required.

More Examples Online

View examples of different forms of queries (open ended, multiple choice, etc.) on the *Journal of AHIMA* website at http://journal.ahima.org.

These examples are also available in an appendix, "Appendix A: Query Examples," in the online version of this practice brief in the AHIMA Body of Knowledge at www.ahima.org. ○

Note

1. Centers for Medicare and Medicaid Services. "Medicare Quarterly Provider Compliance Newsletter." Volume 1, Issue 4. July 2011.

References

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Acknowledgments

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