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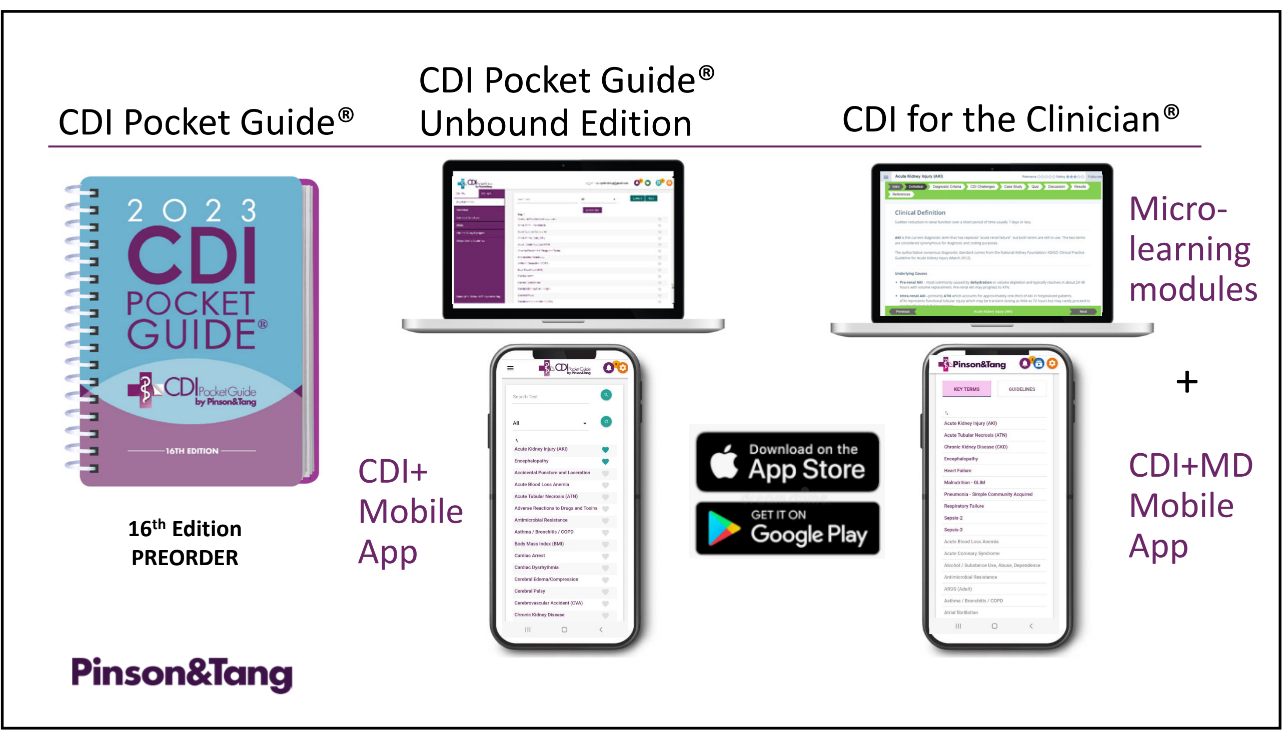

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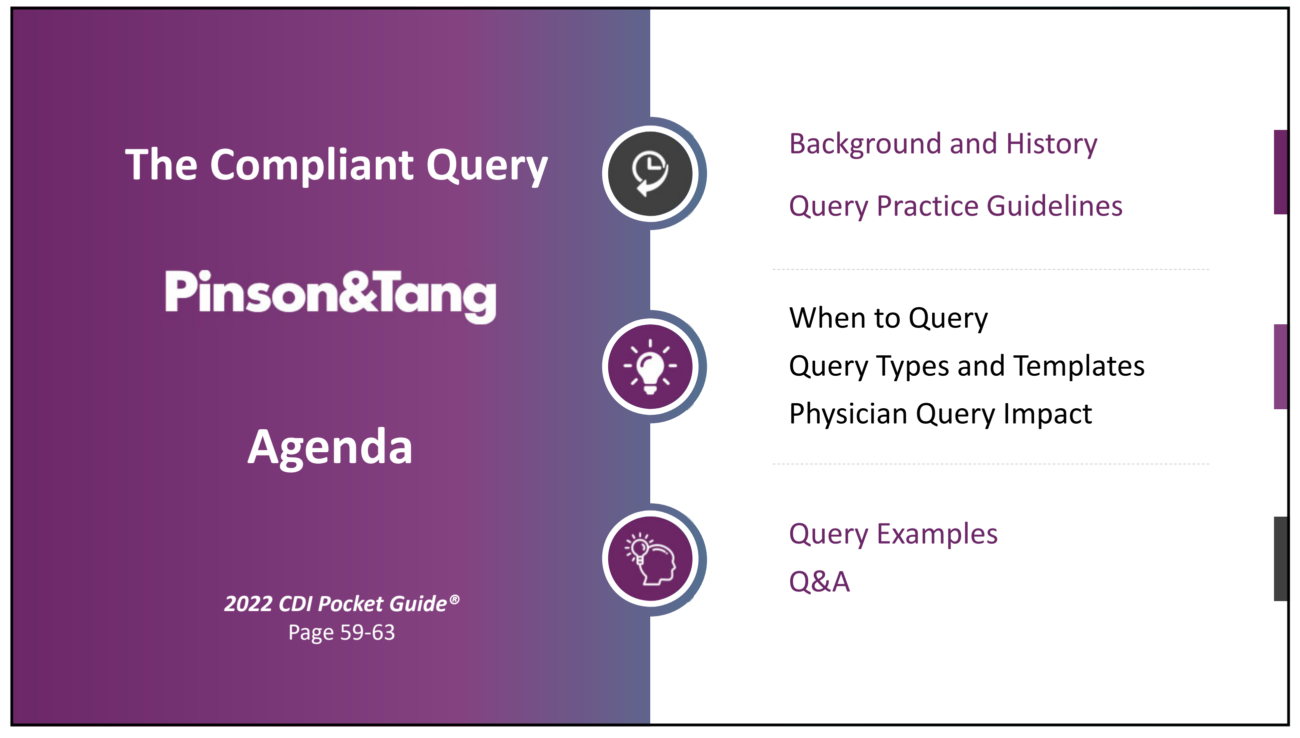

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Background and History

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Medical Record Deficiencies

Traditionally assigned to physicians to complete missing information such as discharge summaries, operative reports, and signatures on verbal orders.

Diagnosis Deficiencies

January 2001: CMS issued a directive that PROs are not to accept Physician Query Forms as a substitute for documentation in the medical record for DRG validation purposes.

October 2001: CMS allowed the use of physician documentation queries to the extent that they provided clarification of conditions that was "consistent with other medical record documentation."

CMS deferred "the promulgation of **specific guidelines** addressing these practices to health information management experts and organizations."

AHIMA/ACDIS Guidelines for Achieving a Compliant Query Practice Brief (2019 Update)

Guidelines for Achieving a Compliant Query Practice

Pinson&Tang

AHIMA/ACDIS Query Practice Brief: 2019 Update

Query Policies and Procedures

"Query practice should be managed and monitored for compliance to organizational policy. Organizations should develop pertinent query policies, including a query retention policy and escalation policy."

Facilities must balance the value of gaining marginal data quality benefits against the administrative burden of obtaining additional documentation and physician query fatigue and burnout.

Guidelines for Achieving a Compliant Query Practice

Pinson&Tang

AHIMA/ACDIS Query Practice Brief: 2019 Update

"Queries may be necessary in (but are not limited to) the following instances":

1. Clinical indicators of a diagnosis but no documentation of the condition
2. Appears a documented diagnosis is not clinically supported
3. Conflicting documentation between the attending provider and other providers
4. Clarify the reason for inpatient admission
5. Cause-and-effect relationship between medical conditions
6. Acuity or specificity of a documented diagnosis to avoid reporting a default or unspecified code
7. Condition documented as a "history of" to determine if active and not resolved
8. Present on Admission (POA) indicator assignment
9. Diagnosis is ruled in or out
10. Objective and extent of a procedure

"Queries are not necessary for every discrepancy or unaddressed issue in physician documentation."

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Guidelines for Achieving a Compliant Query Practice

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Criteria

"Regardless of how the query is communicated, it needs to meet all the following criteria:

1. Be **clear and concise**
2. Contain **clinical indicators** from the health record
3. **Present only the facts** identifying why the clarification is required
4. Be **compliant** with the practices outlined in this brief
5. Never include **impact** on reimbursement or quality measures."

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Guidelines for Achieving a Compliant Query Practice

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Multiple Choice Queries

"**All clinically supported options** should be included as well as additional options that permit the provider to craft their own alternate response. Options may include other, unknown, unable to determine, not clinically significant, integral to, or **other similar wording.”**

“Should include clinically significant and reasonable option(s) as supported by clinical indicator(s) in the health record, recognizing that **occasionally** there may be only one reasonable option.”

“There is no mandatory or minimum number of choices necessary to constitute a compliant multiple-choice query.”

- Chronic Respiratory Failure
- Other (please specify)
- Unable to determine

Only one clinical option.
Is this compliant?

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Guidelines for Achieving a Compliant Query Practice

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Multiple Choice Queries

EXAMPLE from Query Practice Brief

Dear Doctor,
Pancytopenia was documented within the progress note dated xx/xx.

Clinical Indicators: H&P identifies the presence of lung cancer with bone metastasis, undergoing chemotherapy.

Based on your judgement and review of the clinical indicators listed below, can you please select the most appropriate diagnosis?

- Myelophthisic pancytopenia
- Pancytopenia due to chemotherapy
- Pancytopenia due to other cause (please specify):______
- Pancytopenia, etiology unknown
- Other explanation of clinical findings ________________
- Clinically undetermined

1. **Clear** and **concise**
2. **Contain clinical indicators** from the record
3. **Present only the facts** identifying why the clarification is required
4. **All clinically supported options** should be included
5. **Additional options** that permit the provider to craft their own alternate response.

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Guidelines for Achieving a Compliant Query Practice

Yes/No Queries

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"Yes/No queries should only be employed to clarify documented diagnoses that need further specification." Include relevant clinical indicators and "be constructed so that it can be answered with a 'yes' or 'no' response."

"Some examples for when a yes/no query may be applicable:

1. Determining **POA** status
2. Substantiating a **diagnosis that is already present** in the current health record (i.e., findings in pathology, radiology, and other diagnostic reports) with interpretation by a physician.
3. Establishing or negating a **cause and effect** relationship between documented conditions such as manifestation/etiology, complications, and conditions/ diagnostic findings
4. Resolving **conflicting** documentation from multiple providers."

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Yes/No Queries

Present on Admission (POA)

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Official Coding Guidelines: "Present on admission" means **present at the time the order for inpatient admission** occurs." Includes any conditions that occur in the ED, observation, clinic, or outpatient surgery that **did not resolve** prior to the inpatient admission.

- **POA "Yes:** Assign POA "Yes" for "conditions diagnosed during the admission that were clearly present but not diagnosed until after admission occurred."

  "Diagnoses subsequently confirmed after admission if at the time of admission they … constitute an **underlying cause of a symptom** that is present at the time of admission."

- **POA "No":** Alternatively, assign POA "No" if there are no symptoms or clinical indicators that a condition was present at the time of admission. A query is not appropriate if there are no clinical indicators that the diagnosis was POA.

It would be unusual that POA status cannot be determined by the medical record documentation.

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Yes/No Queries

Conflicting Documentation

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Coding Clinic:

"A physician query is not necessary if a physician involved in the care and treatment of the patient has documented a diagnosis and there is no conflicting documentation from another physician. If documentation from different physicians conflicts, seek clarification from the attending physician, as he or she is ultimately responsible for the final diagnosis."

CMS MLN Matters Number SE1121:

"The failure of the attending physician to mention a consultant's diagnosis is not a conflict. So, if the consultant documents a diagnosis and the attending physician doesn't mention it at all, it is acceptable to code. A **conflict occurs when 2 physicians call the same condition 2 different things** – for example, the attending physician documents a sprained ankle and the orthopedist refers to the same injury as a fracture."

It is important to distinguish between "conflicting" and "more specific." Pneumonia vs. bronchitis is conflicting and would require a query. Pneumonia vs. aspiration pneumonia is more specific and would not.

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Yes/No Query: Examples

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Cause and Effect

This patient was admitted and diagnosed with a UTI and also has a urinary catheter.

Based on your medical judgment, can you please clarify in the medical record whether the:

- UTI is related to or caused by the urinary catheter

Substantiating a Diagnosis in Diagnostic Reports

This patient was admitted with a metastatic brain ca on CT scan.

CT scan also shows "significant cerebral edema". Treatment: High dose IV steroids.

Abnormal findings on diagnostic reports cannot be coded unless confirmed by a provider.

Based on your medical judgment, can you please indicate in the medical record if the patient has significant cerebral edema.

Conflicting Documentation

This patient was admitted with:

- Cough, fever, sputum, WBC 12K.
- CXR unremarkable. CT chest shows LLL atelectasis or infiltrate.
- Treated with IV Rocephin x 5 days.

Discharge summary states "Bronchitis," but Dr. Smith, pulmonologist, diagnosed "pneumonia."

Can you please clarify which diagnosis, bronchitis or pneumonia, is correct?

Present on Admission

Patient was admitted with a Stage 3 sacral pressure ulcer according to nursing notes. Provider documentation of the pressure ulcer did not occur until day 3.

Coding guidelines do not allow use of nursing notes for present on admission status for pressure ulcers.

Based on your medical judgment, can you please clarify in the medical record if the pressure ulcer was present on admission?

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Clinical Validation Queries

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"Issuing clinical validation queries can be more challenging than other query types."

AHIMA Clinical Validation Practice Brief (January 2019) was developed to address this issue.

Clinical Validation Query Example for Sepsis

Your assistance with confirmation/validation of a documented diagnosis is requested.

Diagnosis: **Sepsis**

Documentation in the medical record also includes: *[include actual criteria that support and do not support]*

- WBC 15.2
- Temp 99.8
- RR 18
- Pulse 75-89

Based on your medical judgment, can you please clarify in the medical record whether:

1. Sepsis is **not confirmed** and/or it has been ruled out.
2. Sepsis is **confirmed** (if confirmed, please add additional supporting information to the medical record)

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Query Templates

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"Query templates can be a useful tool for creating consistency and continuity in format and approach that simplifies work and increases efficiency."

"Templates should be editable or customizable to ensure that clinical indicators and evidence is included, and only suitable diagnostic choices are provided. Any conditions that are not appropriate to the situation should not be included in the final document that is communicated to the provider."

"Three-Legged Stool"

1. Clinical indicators
2. Risk
3. Treatment

Not all three categories are necessary to submit a compliant query according to the AHIMA/ACDIS query practice brief.

Good general template guide, but:

- One size does not fit all
- Need to be flexible for different circumstances and query purpose

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Physician Query Burnout

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Unnecessary queries can lead to overdiagnosis, overcoding, and overpayment.

The **volume** of documentation queries has increased substantially.

Queries that are vague or include so much clinical information is **difficult for the physician to discern** what needs to be clarified.

Arbitrary physician **query rates** (e.g., 35%) are used as a performance measure for documentation specialists.

Artificial intelligence applications identify large numbers of "potential conditions," prompting CDI specialists to query the clinician even if the condition has no direct (or identifiable) impact on reimbursement or quality.

Sometimes the clinical indicators do not fully support documentation of these "potential" conditions, which could lead to overdiagnosis when a clinician doesn't fully review the record to determine the validity of the condition when queried.

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Physician Query Burnout

ACP Hospitalist Reader Poll

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How do you feel about documentation queries?

- Annoying or time-consuming: 84%
- Not a problem: 16%

How has the quantity of documentation queries you get changed in recent years?

- Increased: 76%
- Decreased: 5%
- Stayed the same: 19%

Oh no, not another query!

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How Can We Reduce Physician Burnout?

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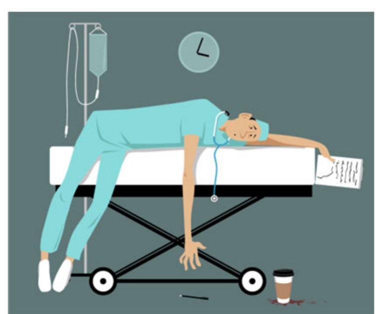
"Queries are not necessary for every discrepancy or unaddressed documentation issue."

"The ICD-10-CM Official Coding Guidelines for Coding and Reporting B.2 only requires diagnosis codes be reported to the highest number of characters available, **not to the most specific code** available within the code set. Although there has been discussion from payers and others regarding the reporting of unspecified diagnoses, there are situations where an unspecified code is accurate based on the clinical scenario."



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How Can We Reduce Physician Burnout?

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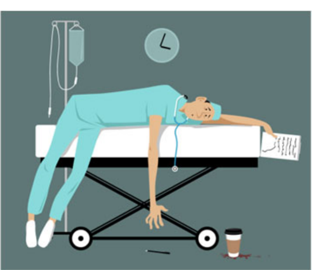
A query is not necessary when needed information can be gleaned from the medical record.

- Clinical indicators on admission will usually support that a condition is present at the time of admission (**POA**) or not.
- Diagnoses documented on admission that are **clearly ruled out or no longer valid** based on the clinical evidence in the medical record.
- Conditions that do not meet the **definition of a secondary diagnosis** (clinical evaluation, treatment, diagnostic procedures, …).
- **Laterality** can be identified from diagnostic reports. Greater specificity of established diagnoses can be based on diagnostic reports that have been interpreted by a physician.



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How Can We Reduce Physician Burnout?

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Reconsider arbitrary query rates as a performance measure for your CDI specialists or program.

After all, the goal of CDI programs should be to educate providers and reduce the volume of queries.

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Query Example #1

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The medical record reflects the following information:

50 year old female with PMH of COPD on home 2-3L NC, R sided systolic HF, pHTN, OSA/OHS with cor pulmonale on nightly BiPAP, NIDDM Type II, GERD, gout, anxiety and depression, who presented to the UED with increased SOB and cough x 3 days. Vitals on admission RR 20, Sat 96% on 2L O2 NC. 9/24 Hospital Medicine Admission H&P Respiratory: Breath sounds are equal, Symmetrical chest wall expansion, Expiratory wheezing worse on the L, Distant crackles anteriorly, iWOB with mild desat with coughing spells. She is afebrile, vitals are stable, on 3.5L NC. Her presentation is c/w COPD exacerbation with increased cough and expiratory wheezing, also likely mild HF exacerbation with pulm edema on imaging and elevated BNP.

9/27 Hospital Medicine Progress Note
SOB, cough improving
Acute on Chronic COPD
- s/p nebs, 125 mg IV solu-medrol, CTX, and AZM in ED, continue prednisone 40 mg daily x 4 days
- duonebs QID, continue budesonide BID and Spirava
- home Symbicort non-formulary, continue Advair, chest PT
- now stable on baseline 2L NC

OSA/OHS
- certainly contributing to acute on chronic hypoxia
- continue nightly BiPAP
- Counselled on importance and need for weight loss

Please respond with which of these is most appropriate in regards to the diagnosis:

Chronic hypoxic respiratory failure
Other explanation of clinical findings
Unable to determine

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Query Example #1: REVISED

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This patient has been admitted with COPD exacerbation and systolic heart failure.

Clinical Indicators:

- "COPD on home oxygen" at 2-3L NC
- OSA/OHS on nightly BiPAP
- ABG (admission): pH 7.30 / pCO2 62 / pO2 50 on oxygen 28%
- Elevated bicarbonate = 37-43
- Treatment: O2 @ 3.5 L, duonebs, IV solumedrol

← **ABG** not included in original query which supports "acute on chronic" respiratory failure = pH < 7.35 and pO2 < 60 (also pCO2 > 50)

Based on your medical judgment, can you further clarify the diagnosis related to these findings such as:

- Acute on chronic respiratory failure
- Chronic respiratory failure
- COPD exacerbation only
- Another condition (please specify)
- None of the above / Not applicable

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Query Example #2: ATN

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The medical record reflects the following information:

Risk Factors: 38 yo P2002 admitted for inpatient management of PID.

Clinical Indicators: Creatinine 1.9 on 11/8, increased to 3.8 on 11/10, decreased to 3.6 on 11/12. The 11/12 PN notes "AKI: Cr downtrending at 3.6 today from 3.8 on 11/11. Nephrology consulted on 11/11, determined likely ATN (granular casts on microscopy) due to Vanc/Zosyn, CT contrast, and NSAIDS."

The 11/11 Consult note states "urine microscopy w/ granular casts indicative of ATN, likely secondary to contrast, NSAIDS, and vancomycin (have since been discontinued)".

Treatment: Trending labs, nephrology consult, avoid nephrotoxic agents

Please respond with which of these is most appropriate in regard to this diagnosis:

ATN - Confirmed

vs. ATN ruled out, AKI only

vs. Other explanation of clinical findings

vs. Unable to determine

Date of Service: 11/7-11/12 (Post discharge query 11/15)

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Query Example #2: REVISED

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This patient was admitted 11/7 with PID. AKI and ATN was also documented in the medical record:

Creatinine levels:

- 11/7: 0.9, 1.0 (admit)
- 11/8: 1.9
- 11/9: 3.4
- 11/10: 3.8
- 11/11: 3.8
- 11/12: 3.6

Risk: IV contrast, hypotension, NSAIDS, poor po intake.

Treatment: Vancomycin discontinued, NSAIDS held, strict I&Os, PO intake encouraged.

Nephrology Consult (11/11): "Urine microscopy w/ granular casts indicative of ATN."

"She had normal Cr on admission but has had several renal insults including hypotension, poor po intake, IV contrast and NSAIDS… She has a non-oliguric AKI likely due to ATN from these insults."

Based on your medical judgment and review of the clinical indicators, can you clarify the diagnosis as:

- AKI due to ATN
- AKI only
- Other condition (please specify)
- None of the above/Not applicable

Was a query needed? Discharged on 11/12.

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Query Example #3: Malnutrition documented once

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Documentation in the record includes the following clinical indicators:

Diagnosis: Protein Calorie Malnutrition is documented in the 8/1 H&P addendum.

77 yo admitted with COVID pneumonia.

In the H&P, protein calorie malnutrition is documented. Per the admission form, her weight is 146 lbs, height 62 inches. BMI 26.7.

8/1 ED note documents that patient reports very notable diarrhea. IV fluids were held as patient was hemodynamically stable. 8/1 H&P says patient has decreased PO intake. There is no nutrition consult. Diet is regular with no nutritional supplements.

Based on the clinical evidence above and your medical judgement, can you clarify the diagnosis of Protein Calorie malnutrition:

- Protein Calorie Malnutrition is confirmed and is supported by (please provide additional documentation to support this diagnosis)
- Protein Calorie Malnutrition is ruled out
- Other (please specify)
- Unable to be determined/Unknown

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Query Example #3: REVISED

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Your assistance with confirmation/validation of a documented diagnosis is requested.

Diagnosis: **Protein Calorie Malnutrition** (documented in 8/1 H&P addendum)

Documentation in the medical record includes:

- BMI 26.7
- Decreased PO intake
- No nutrition consult
- Regular diet and no nutritional supplements

Based on your medical judgment, can you please clarify in the medical record whether:

- Malnutrition is **not confirmed** and/or has been ruled out.
- Malnutrition is **confirmed** (if confirmed, please add additional supporting information to the medical record)

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Query Example #4: Heart Failure?

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Admission details: Patient admitted 2/21 with Sepsis.

Clinical Indicators:

- EF RATIO: Echocardiogram 2/24. The left ventricular systolic function is low normal (50-54%).
- The right ventricular systolic function is normal.
- The left atrium is moderately dilated.
- The left ventricle is mildly dilated.
- Mild aortic valve regurgitation.
- Mild-to-moderate mitral valve regurgitation.
- Mild tricuspid valve regurgitation.
- No obvious vegetations on surface study
- BNP: No record
- CXR: Mild nonspecific bilateral interstitial prominence.
- There is no evidence of consolidation.

Risk Factors: ESRD, DM2, Septic shock, Hypertension, Tobacco abuse, Bacterial pneumonia, DRESS syndrome, MRSA bacteremia.

Treatment:

1. IVF
2. Continue vanc. Cipro discontinued on 2/25.
3. EKG performed at 5:06 PM. Sinus tachycardia 119.
4. Repeat CT 2/21, 2/22, 2/24, 2/25.

Query Question: Based on your medical judgment, can you please clarify the type and acuity of CHF? For example:

( ) Acute
( ) Acute on chronic
( ) Chronic
( ) Other (Please specify)

AND (adjust choices as needed)

( ) Combined
( ) Diastolic
( ) Systolic
( ) Right sided
( ) Other (Please specify)

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Query Example #5: Bacterial Pneumonia

Pinson&Tang

Admission details: Patient admitted on 3/21 with Sepsis.

Clinical Indicators:

- CXR - Mild nonspecific bilateral interstitial prominence. There is no evidence of consolidation.
- Chest CT - Significantly improved airspace opacities with minimal residual diffuse groundglass densities and right lower lobe patchy airspace opacities.
- Aerobic Culture - Value: Moderate Growth Staphylococcus aureus
- WBC 10.4
- T 97.5–98.5
- Procal of 6.71
- Bacterial pneumonia documented on 3/21/22 H&P, 3/22/2022 -- 3/25/22 PN
- PULM - no SOB, no cough
- Room air 02 sats 93–100%

Risk Factors:

- Coronary artery disease
- Vomiting (per H&P)
- Sepsis
- Volume Overload 2/2 ESRD
- Smoker - 1 pack/day
- ESRD
- Diabetes mellitus
- Normocytic anemia-hemoglobin stable at 7.8. Platelets of 122
- History of DRESS syndrome–pt with hx after transitioning antibiotics for his osteo-–Continue prednisone taper.
- Chronic OM of the right fifth metatarsal with diabetic foot ulcer

Treatment:

- IV Zyvox, Cipro per ID
- ID Consult

Query Question: Based on your medical judgement, could you further specify causative organism being treated in the documented Bacterial pneumonia?

( ) MRSA Pneumonia.
( ) Gram Negative PNA (specify organism if know)
( ) Gram Positive PNA (specify organism if know)
( ) Other PNA (specify type and/or organism)
( ) Other, please specify

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Query Example #5: REVISED

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Patient admitted on 3/21 with sepsis and diagnosed with bacterial pneumonia.

Clinical Indicators:

- Aerobic Culture: Moderate Growth Staphylococcus aureus
- “Bacterial pneumonia” documented on H&P 3/21 and 3/22-3/25 progress notes
- Risk factors: ESRD, DM foot ulcer with chronic osteo: transitioning antibiotics, prednisone taper
- ID Consult

Treatment: IV Zyvox, Cipro per ID

Based on your medical judgement, could you further specify the causative organism being treated for the bacterial pneumonia?

( ) MRSA Pneumonia
( ) Gram negative pneumonia
( ) Other PNA (specify type and/or organism)
( ) Bacterial pneumonia only
( ) None of the above/not applicable

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Question #1: Multiple Choice Queries Not Allowed

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We currently are not allowed to use a diagnosis in the query that the physician has not already documented. We can only include the clinical findings and treatments and query the physician for the diagnosis without prompting.

For example, a query for chronic respiratory failure would state "Can you please clarify why your patient is on continuous home O2?" without any diagnosis options. The clinician must come up with "chronic respiratory failure" on their own.

This directly conflicts with the AHIMA/ACDIS Compliant Query Guidelines.

Multiple choice queries are highly recommended and "Yes/No" queries are permitted in certain situations.

This would be considered an **open-ended** query. “Open-ended: The provider free texts a response which may or may not align with documentation needed to support code assignment.”

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Question #2: Coding vs. CDI Queries

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What are the differences between a compliant coding query and a compliant CDI query?

Some coders will not code a query response because they feel that CDI should have included more multiple-choice options and is not following the AHIMA/ACDIS guidelines.

We have tried to explain that CDI queries are done differently because we cannot offer a choice that is not clinically supported and that we are following guidelines within our clinical scope.

For example:

- For a CHF query, acute, chronic, acute on chronic and all types of CHF are included.
- For an ABLA query, multiple types of anemia are included.

There is no difference between a coding and CDI query and the same guidelines apply.

“Templates should be editable or customizable to ensure that clinical indicators and evidence is included, and only **suitable diagnostic choices** are provided. Any **conditions that are not appropriate to the situation should not be included** in the final document that is communicated to the provider.”

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Questions #3: Query Construction

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Are there any rules or guidelines about using **BOLD** formatting? I thought it could be considered leading to have anything other then dates in Bold. Some of our CDIs copy & paste from the medical record and some things are bolded or different fonts and not formatting them so they are not bold, and consistent fonts.

We do not recommend bolding diagnostic options which could be viewed as overly-leading. Copy and paste can result in too much query content and even if used should be edited and formatted.

When giving clinical indicators, what is a good number of days to give vitals and labs? For instance, if Sepsis is documented do we want to show a trend of vitals and labs over several days? There are many reasons we could explain away elevated vital signs.

When including vitals and labs, provide the information most pertinent to the query. If more than one, use a range such as potassium 2.0-3.1. For example with sepsis, we suggest using a range.

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Question #4: Discharge Summary

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When a patient has been at the hospital for an extended length of time, do all diagnoses need to be documented in the discharge summary?

We are often asked to clarify if the patient really had sepsis, even if documented for several days, meets criteria, but is dropped later from the documentation or doesn't make it on the discharge summary.

Does it need to be documented on the discharge summary or documented "X" number of times in the stay? How would you write this query?

No, the entire medical record is used for coding and not any particular document like the discharge summary.

If a diagnosis is documented within the stay and is clinically valid, a query would not be needed if not documented in the discharge summary or a certain number of times.

OCG: "The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated."

Coding Clinic: "Documentation [to assign codes] is not limited to the face sheet, discharge summary, progress notes, history and physical, or other report designed to capture diagnostic information."

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Question #5: Consultant's Diagnosis

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When a consultant documents a diagnosis but the attending does not pick it up, is a query necessary if it appears it meets criteria?

For instance, if the Nephrologist mentions the patient has a UTI. There is no mention by the attending, but the patient does have positive UA/CS, the patient is already on ABX for another diagnosis. Do we need to ask if they agree with the consultant?

It is not necessary to query the attending regarding a diagnosis documented by a consultant if the diagnosis meets criteria and there is no conflicting documentation.

CMS MLN Matters Number SE1121: "The failure of the attending physician to mention a consultant's diagnosis is not a conflict. So, if the consultant documents a diagnosis and the attending physician doesn't mention it at all, it is acceptable to code it."

A conflict occurs when 2 physicians call the same condition 2 different things – for example, the attending physician documents a sprained ankle and the orthopedist refers to the same injury as a fracture.

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Question #6: Conflicting Documentation

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When sending a conflicting documentation query – how much information is needed? How do you paraphrase the documentation so its not an essay.

I try to give as much information as possible so the doctor doesn't need to look at the record but sometimes this can be a very long query and my supervisor wants them cut down to just a few lines which I feel difficult to do.

Be sure the diagnoses are "conflicting", such as pneumonia vs. bronchitis, fracture vs. sprained ankle.

If a query is necessary, specifically state the conflict and include only the most pertinent supporting clinical information.

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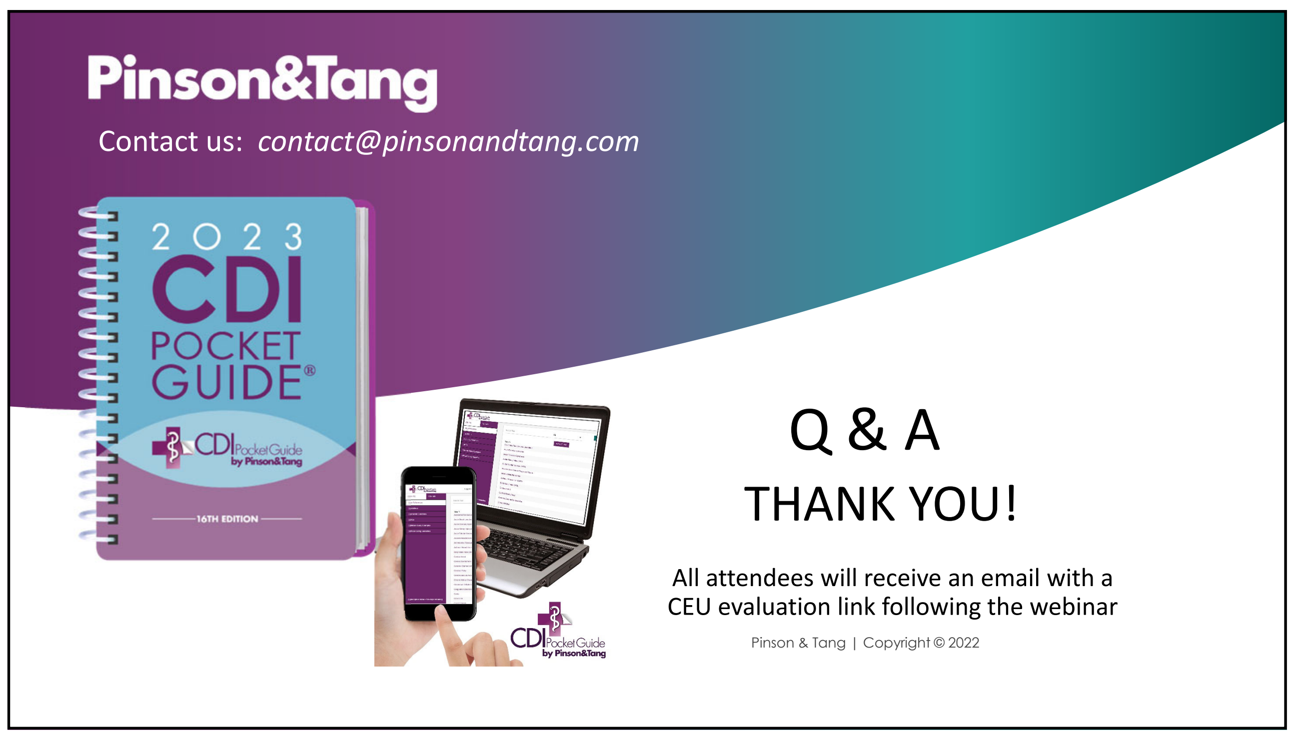

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