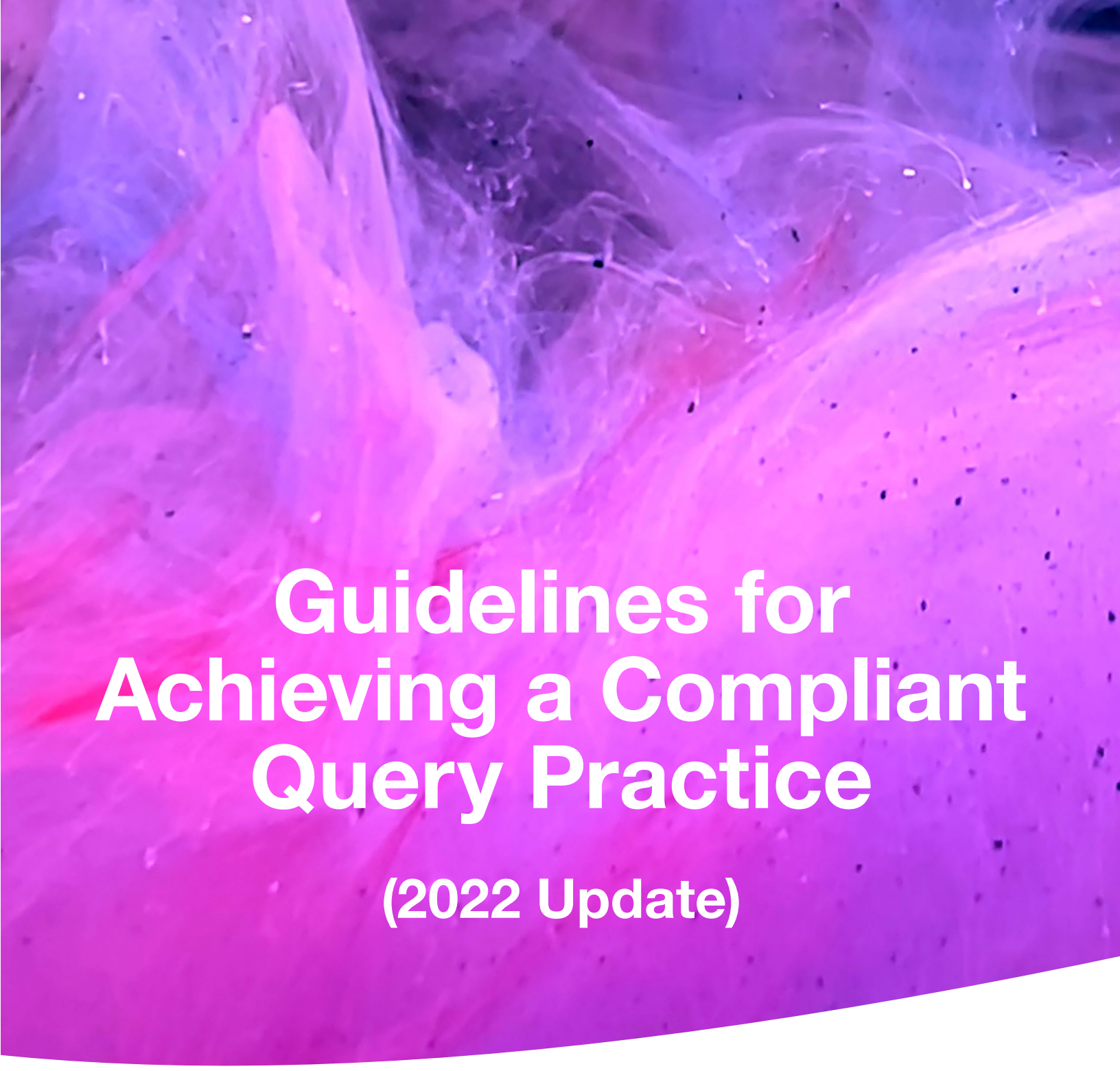

Guidelines for Achieving a Compliant Query Practice

(2022 Update)

AHIMA®

acdis
Association of Clinical Documentation Integrity Specialists

Guidelines for Achieving a Compliant Query Practice (2022 Update)

POSITION PAPER

FEATURES

Summary: This industry practice brief supersedes all previous versions of this practice brief.

Disclaimer: This practice brief is intended to provide best practice standards for the clinical documentation integrity query process that is driven by the underlying goal of validating the clinical documentation within the health record accurately represent the clinical status of the patient.

The American Health Information Management Association – Association of Clinical Documentation Integrity Specialists (AHIMA-ACDIS) Practice Brief should serve as an essential resource for coding and clinical documentation integrity (CDI), and other professionals in all healthcare settings (e.g., inpatient, outpatient, etc.), who participate in query (documentation clarification) processes and/or functions. This Practice Brief should also be shared and discussed with other healthcare professionals, such as quality, compliance, revenue cycle, patient financial services, physician groups, facility leaders, care management and any others who work with health record documentation. These disciplines work to impact the health record regarding reimbursement, medical necessity, professional billing, and quality to include complications, mortalities, clinical coding, and/or coded data. The guidance is to be used by payers, auditors and compliance agencies in health record reviews impacting Diagnosis Related Group (DRG) re-assignment, claim denials, post-payment findings, risk adjustment, medical necessity of care, and code assignment (Current Procedural Terminology® [CPT], International Classification of Diseases (tenth ed.)-Clinical Modification/ Procedural Coding System [ICD-10-CM/PCS]).

The practice brief's purpose is to establish and support industry-wide best practices for the clinical documentation query process (documentation clarification). The practice brief should be used to guide organizational policy and process development for a compliant query practice. The practice brief implements the directives of the International Classification of Diseases, tenth ed., Clinical Modification (ICD-10-CM) and International Classification of Diseases, Procedure Coding System (ICD-10-PCS), Official Guidelines for Coding and Reporting and official advice in the American Hospital Association (AHA) Coding Clinic® for ICD-10-CM/PCS. The intent is to provide a resource for all stakeholders including external reviewers (e.g., the Office of Inspector General (OIG), government contractors, payer review agencies) in the evaluation of provider queries and the documentation they provide.

The FY 2023 ICD-10-CM Official Guidelines for Coding and Reporting define a provider as, "physician or any qualified healthcare practitioner who is legally accountable for establishing the patient's diagnosis." (p. 1).[2] The term "provider"

will be utilized within this brief to refer to any treating clinician who meets this definition.

Specific use examples of the practice brief include (but are not limited to):

- Orienting new employees and educate current staff
- Assisting with development of query audit standards
- Reviewing and updating query policies and procedures for compliant practices
- Utilization in compliant query education and training
- Standardizing query practices across the industry
- Providing a reference tool for compliance and legal matters
- Informing external or third-party stakeholders and/or consultants
- Educating team members regarding the impact compliant query practices have on organizational and professional billing

The practice brief should be used to guide organizational policy and process development for a compliant query practice.

Who Should Follow This Brief?

Claims data are impacted by healthcare roles that include not only CDI and coding professionals but also physician advisors, case management/utilization review, quality management professionals, infection control clinicians, information technology professionals and any others working to clarify healthcare documentation/information. The documentation query process is used for several initiatives which may include reimbursement methodologies, data stewardship and collection, quality measures, medical necessity, denial prevention, and so forth. Regardless of organizational objectives, professionals seeking documentation clarification need to follow this practice brief.

General Query Standards

The following information establishes basic guidelines to ensure all queries are developed compliantly:

General Query Conventions

I. Query definition: a communication tool or process used to clarify documentation in the health record for documentation integrity and accuracy of diagnosis/procedure/service code(s) assignment for an individual encounter in any healthcare setting. A query may be developed by a healthcare professional or through a computer autogenerated query process.

   a. Possible terms which may meet the definition of a query (not all inclusive): clarification, clinical clarification, documentation clarification, prompt, nudge, alert, and so forth. Regardless of the term used the key is if it meets the above definition of a query, it is considered a query.

II. The remainder of this practice brief will reference code assignment when referring to a diagnosis/procedure/service code.

III. The remainder of this practice brief will reference the term encounter to describe all patient encounter types for both inpatient and outpatient settings.

   a. Synonymous terms (not all inclusive): admission, hospital stay, office visit, inpatient stay, outpatient stay, and so forth.

IV. Ambiguous documentation definition: documentation that fails to reflect the provider's intent, impacts the clinical scenario (e.g., diagnoses, complications, quality of care issues), the accuracy of code assignment, and/or the ability to assign a code.

V. Query Professionals (QP)

   a. Those who use the query to pose questions to resolve documentation issues and/or those who have oversight and/or involvement in the query process.

   b. QP include coding professionals, CDI professionals, physician/provider advisors, and all professionals who initiate communication that meets the definition of a query to clarify clinical documentation.

   c. Any QP can initiate a query following these compliant guidelines.

All multiple choice query answer options should only include clinically relevant options (meaning those options that are supported by the clinical indicators within the health record) and exclude clinically irrelevant options.

General Query Guidelines:

I. Query Requirements

   a. Be compliant with the practices outlined in this brief

   b. Be clear and concise

   c. When specific information is pulled from the health record to support the query, quotations may be used to identify direct sourcing of clinical information with identification of where the information was pulled.

   d. Contain applicable clinical indicators from the health record (See, clinical indicator section)

   e. All multiple choice query answer options should only include clinically relevant options (meaning those options that are supported by the clinical indicators within the health record) and exclude clinically irrelevant options (e.g., sodium level is 122 and a query is sent to determine if a diagnosis can be provided; hypernatremia would not be an appropriate answer option).

   f. Multiple choice answer options are to include the answer option of "other" (or similar terminology) to allow the provider to customize their response

   g. In addition to the choice of other there is no mandatory maximum or minimum number of diagnosis/procedure answer options necessary to constitute a compliant multiple choice query.

h. The multiple choice answer options are not required to be in any particular order

i. Answer options that may be used (but are not required) include, unknown, not clinically significant, integral to, unable to rule out, inherent to, or other similar wording.

j. "Unable to Determine" requires specific consideration to determine if needed as a multiple choice option.

i. "Unable to determine" is defined as the provider being clinically unable to determine if a diagnosis or further clarity can be provided in the documentation. This terminology does not equate to an "unable to rule out" option and does not represent an uncertain diagnosis (e.g., possible, probable, unlikely). See Official Guidelines for Coding and Reporting ICD-10-CM, Section II.H., Section III.C, and Section IV.H for more information in uncertain diagnosis.[2]

i. The options of "unable to determine," "possible," and "unable to rule out" are NOT synonymous terms.

iii. The option of "unable to determine" is required in POA and yes/no queries.

iv. "Unable to determine" options may be reviewed on a case-by-case basis to determine if further escalation of the query should be performed.

k. Present only the documentation or data from the health record, without subjective interpretation from the QP, identifying why the clarification is required.

l. Never include impact on reimbursement, quality measures, or other reportable data

Ambiguous documentation fails to reflect the provider's intent, impacts the clinical scenario, the accuracy of code assignment, and the ability to assign a code.

II. When to Query

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

a. To support documentation of medical diagnoses or conditions that are clinically evident and meet the Uniform Hospital Discharge Data Set (UHDDS) requirements but without the corresponding diagnoses or conditions stated

b. To resolve conflicting diagnostic or procedural documentation between providers

c. To clarify the reason for the inpatient/outpatient encounter

d. To seek clarification when it appears a documented diagnosis is not clinically supported or conflicting with the medical record documentation[2] (clinical validation).

e. To confirm a diagnosis documented by an independent licensed practitioner who does not meet the definition of a provider in the inpatient setting. (e.g., confirmation of a pathology finding)

f. To establish a cause-and-effect relationship between medical conditions

g. To establish clinically supported acuity or specificity of a documented diagnosis to avoid reporting a default or unspecified code

h. To establish the relevance of a condition documented as a "history of" to determine if the condition is active

i. To support appropriate Present on Admission (POA) indicator assignment

It is considered non-compliant to continue asking the same query to the same or multiple providers until a desired response is received.

j. To determine if a diagnosis is ruled in or out

k. To clarify the objective and/or extent of a procedure

l. To clarify the presence or absence of a complication

m. To clarify a diagnosis on an ancillary note that has been signed but not addressed by a provider. For example, if the nutrition note states, "severe malnutrition" and the notes is signed by the provider, but the provider does not address the diagnosis within their documentation.

III. When Not to Query

a. Queries are not necessary for every discrepancy or unaddressed documentation issue in accordance with an organization's policy and procedure. Circumstances may include lack of business need, or does not add to the clarity of the clinical picture. Queries sent in these circumstances can promote query fatigue.

b. Do not query if the provider cannot offer clarification based on the present health record documentation.

c. When there is sufficient documentation to assign a valid code and no indicators that the code can be specified to a higher degree. Code accuracy is not the same as code specificity. The ICD-10-CM Official Guidelines for Coding and Reporting's General Guidelines B.2 only requires diagnosis codes to be reported to the highest number of characters supported by the documentation, not to the most specific code available within the code set.

d. Queries should only be generated when the clinical data (present and relative historical data) fully supports the answer choice(s).

IV. Sending Multiple Queries

a. Verbal queries may be used when multiple queries are required regarding the same set of clinical indicators or documentation in complex cases is ambiguous. For example, when both a diagnosis and additional specificity must be established, such as clarification of the presence and the type of heart failure. A second query may be needed to obtain further clarification of a previously answered query as additional information became available or as the clinical picture evolves.

b. Organizations should develop policies to identify the number of queries that should be simultaneously placed, and directions as to how to prioritize query focus.

Compliant Query Guidelines

The objective of a query is to ensure the reported diagnoses and procedures derived from the health record documentation accurately reflect the patient's episode of care.

Organizations should develop policies and procedures related to compliant query practices and the maintenance of the problem list.

Compliant query practice should follow these tenets:

I. Provide multiple choice answer options that are supported by the clinical indicators in the health record which are also included on the query.

II. Diagnosis answer options that are not already documented in the health record must be supported by clinical indicators sourced from the medical record. These clinical indicators must be included within the query.

III. Include a non-leading query statement (e.g., please clarify the diagnoses, can a diagnosis be provided) that is clear, concise, and specific to the necessity of the query supported by the clinical scenario. See query examples in Appendix A.

IV. Titles of queries, that are viewed by providers, should be non-leading in nature and not include impactful information (e.g., reimbursement, quality indicators, specific diagnoses, new information that is not included in the health record, the desired response). See query examples in Appendix A.

V. Queries must be accompanied by clinical indicator(s)/evidence that:

   a. Are specific to the patient and episode of care

   b. Support a more complete or accurate diagnosis or procedure

   c. c. Require clinical validation of a reported diagnosis not supported by the health record, please reference the latest update to the practice brief, *Clinical Validation: The Next Level of CDI*, to learn more about clinical validation.

   d. May be acquired from the current or previous health record, if clinically pertinent to the present encounter (Please reference Previous Encounter section for more information)

VI. In the inpatient setting, using query questions/statements and answer options that indicate an uncertain diagnosis as defined by the Official Guidelines for Coding and Reporting and Coding Clinic®, should rarely be used, unless the provider has documented a diagnosis using a term of uncertainty (e.g., "likely," "probable," and so forth). There are some circumstances when they may be incorporated to allow the provider the opportunity to confirm their thought process in the absence of concrete data needed for confirmation of a diagnosis (e.g., Acute tubular necrosis (ATN) without a kidney biopsy, type of pneumonia without a sputum culture).

Problem Lists

A problem list includes a list of active diagnoses that are relevant to the current episode of care.[3] Below are some guidelines regarding the problem list.

- Organizations should develop policies and procedures related to compliant query practices and the maintenance of the problem list. For example, determine who can update a problem list post query response.
- When choosing a diagnosis and updating the problem list, elements that reflect financial reimbursement or quality impact should not be identifiable (e.g., relative weights, complications, Patient Safety Indicators (PSIs), Hospital Acquired Conditions (HACs), Major Complications and Comorbidities (MCCs), Complications and Comorbidities (CCs), Hierarchical Condition Categories (HCCs), mortality variables, and so forth).

A query cannot be based soley on the information from a prior encounter, there must be relevant information within the current encounter to substantiate the query.

Query Template Guidelines

I. Standards of use
   a. Establish policies and procedures for
      i. Creating query templates
         1. Obtaining input/feedback on templates from providers and/or other disciplines, as appropriate
      ii. Reviewing and updating query templates on a regular schedule is recommended (e.g., annually, when changes to a process occurs)
      iii. Instructions on the use of templates
   b. Templates must align with other standards and criteria identified in this practice brief

II. Template format should include:
   a. Patient identification, if not auto-populated in the EHR
   b. Editable or customizable information
   c. Clear, concise wording that is efficient for the provider to review
   d. A topic title that is not visible to a provider or is non-descript, and does not identify a diagnosis that is not already documented

III. Template elements should allow for inclusion of relevant clinical indicator(s) and evidence to support the query. Clinical indicators should include a citation of the location found within the health record.

IV. Template answer option(s) should include:
   a. Only offer multiple choice answer options that are clinically credible
      i. Remove imbedded answer options that are not clinically credible or relevant

ii. There is no mandatory or minimum number of diagnosis/procedure answer options necessary to constitute a compliant multiple choice query.

b. Choices offered should be worded in such a manner that allows for accurate code assignment

Provider Education

I. Provider education is a vital component of query efforts. Queries alone may not be enough to provide the needed information to inform the provider of ways to deliver clinical documentation integrity.

II. Offer education and examples to providers on a regular schedule so they are comfortable with reading and responding to queries. This allows them to better understand their role and the query process.

III. Provider education may utilize case studies with actual queries; however, patient identifiers should be removed.

There is no required number of clinical indicator(s) that must accompany a query because what is a "relevant" clinical indicator will vary by diagnosis, patient, and clinical scenario.

Role of Prior Encounters in Queries

Code assignment is not determined by documentation from previous encounters. However, sending a query to clarify documentation using evidence from a previous encounter may be appropriate when relevant to the current encounter. When clinically pertinent to the present encounter, information from a prior health record can be used to support a query. This process reinforces the accuracy of information across the healthcare continuum. However, it is inappropriate to "mine" a previous encounter's documentation to generate queries not related to the current encounter. Mining would be reviewing a previous health record encounter without a related trigger found in the current encounter. For example, a compliant reason to review previous information (e.g., non-mining), CKD has been documented in the current encounter triggering the need to review previous encounter information to gain further specificity of the CKD.

Queries using information from prior encounters may be utilized when relevant in (but not limited to) the following situations:

- Diagnostic criteria allowing for the presence and/or further specificity of a currently documented diagnosis (e.g., to ascertain the type of heart failure, specific type of arrhythmia, stage of chronic kidney disease [CKD] etc.)
- Treatment/clinical criteria or diagnosis referenced in the current encounter that may have been documented in a prior encounter
- Determine the prior patient baseline allowing for comparison to the current presentation
- Establish a cause-and-effect relationship (e.g., clarifying a postoperative complication, exposure to causative organism)
- Determine the etiology, when documentation indicates signs, symptoms, or treatment that appear to be related to a previous encounter

- Verify POA indicator status
- Clarify a prior history of a disease that is no longer present (e.g., history of a neoplasm)

When considering whether a query could be issued using information in the prior record, carefully consider the "General Rules for Other (Additional) Diagnoses" that states: "For reporting purposes the definition for 'other diagnoses' is interpreted as additional conditions that affect patient care in terms of requiring: clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring," according to ICD-10-CM Official Guidelines for Coding and Reporting, Section III.[2] It would be inappropriate to query for a diagnosis that, if documented, would not satisfy this criteria. A query cannot be based solely on the information from a prior encounter. There must be relevant information within the current encounter to substantiate the query.

When multiple providers, from different specialties, are involved in the patient's care, the most appropriate provider related to the query subject should be queried.

Clinical Indicator(s)

"Clinical indicator(s)" is a broad term encompassing documentation that supports a diagnosis as reportable and/or establishes the presence of a condition.[5] Examples of clinical indicators include (but are not limited to): provider observations (physical exam and assessment), diagnostic tests, treatments, medications, trends, and consultant documentation authored by providers and ancillary professionals documented throughout the health record. There is no required number of clinical indicator(s) that must accompany a query because what is a "relevant" clinical indicator will vary by diagnosis, patient, and clinical scenario.

While organizations, payers, and other entities may establish guidelines for clinical indicator(s) for a diagnosis, providers make the final determination as to what clinical indicator(s) define a diagnosis.[4]

Clinical indicators should:

- Be clear and concise
- Directly support the condition requiring clarification
- Allow the provider to clinically determine the most appropriate medical condition or procedure
- Paint the clinical picture of the diagnosis queried to be added or clinically validated
- Be specific or directly related to, but not necessarily from, the current encounter (see *Role of Prior Encounters in Queries*, above)
- Support documentation that will translate to the most accurate code

Clinical indicator(s) may be sourced from the entirety of the patient's health record, including but not limited to:

- Emergency services documentation (e.g., emergency service transport, ED provider, ED nursing)

- Diagnostic findings (e.g., laboratory, imaging)
- Provider impressions (e.g. history and physical, progress notes, consultations)
- Relevant prior visits (if the documentation is clinically pertinent to present encounter)
- Ancillary professional documentation and assessments (e.g., nursing, nutritionist, wound care, physical, occupational, speech, and respiratory therapist)
- Procedure/operative notes
- Care management/social services

If a compliant query has been properly answered and authenticated by a responsible provider and is part of the permanent health record, it is sufficient for code assignment.

Who Is Queried?

- Queries should be sent to and responded to by provider(s) that are delivering direct care to the patient during the specific encounter. It would be inappropriate to query a provider who is not providing direct care, for example sending a query to the physician advisor for a response. It is up to the organization to determine the procedure that will be followed if the treating provider is no longer on service or available to respond to the query.
- When multiple providers, from different specialties, are involved in the patient's care, the most appropriate provider related to the query subject should be queried. For example, a query should not be sent to the nephrologist for skin ulcer etiology or the hospitalist for extent of excisional debridement performed by the surgeon.
- When conflicting documentation is present, the attending provider should be queried to resolve any discrepancies. Refer to ICD-10-CM Official Guidelines for Coding and Reporting's I.B.14. "Documentation by Clinicians Other than the Patient's Provider" section for additional guidance, as this guidance has been expanded and updated as of 2022.[2]
- There are occurrences for which it is appropriate to query clinicians who are not classified as a provider for additional information (other than a diagnosis). It is up to the individual organization to determine in their policies and procedures if they will query clinicians who are not classified as a provider. For example (this is not an all-inclusive list):
  - Nurse administering infusions
  - Clinicians providing wound care
  - Respiratory therapist for mechanical ventilation
  - Nurse administering medication that has been ordered by the provider
  - Dietitian to provide body mass index (BMI)
  - Social worker, community health workers, case managers, or nurses for any clarification for social determinants of health (SDOH)

- All individuals who are likely to receive a query should be educated about the reason(s) for the query, the process, and the expectations for completion and documentation.

How to Query

Regardless of format, method, or technology used, queries serve the purpose of supporting clear and consistent documentation of diagnoses being monitored and treated during a patient's healthcare encounter or the specific procedure performed. A query must adhere to compliant, non-leading standards, permitting the provider to unbiasedly respond with a specific diagnosis or procedure. References to reimbursement must not occur. All relevant diagnoses, lab findings, diagnostic studies, procedures, etc. which illuminate the need for a query should be noted and cited as to the location within the medical record.

A query should not direct (lead) the provider to document a specific response (e.g., highlighting, bolding, underlining, italics, using a yes/no format to obtain a new diagnosis). It is non-compliant to continue sending the same query to the same or multiple providers until a desired response is received.

If a compliant query has been properly answered and authenticated by a responsible provider and is part of the permanent health record, it is sufficient for code assignment. The response to the query is not required to be repeated elsewhere in the health record. However, if subsequent information is conflicting with the query response, additional clarification may be needed.

Verbal Queries

When verbal queries are utilized, they should be recorded per organizational policy including documentation of the conversations that occur regarding documentation of reportable conditions/procedures. Conversations should be non-leading, including all appropriate clinical indicator(s) and all plausible options. In capturing the essence of the verbal discussion, timely notation of the reason for the query (exact date/time and signature), clinical indicator(s), and options provided should be recorded and tracked in the same manner as written queries. This would allow verbal queries to be discoverable to other departments and external agencies. A response to a verbal query must be documented in the permanent health record in order to be coded.

Written Queries

All queries are to be constructed in a clear and concise manner citing relevant clinical indicator(s) and identify applicable diagnoses. Queries should be legible and grammatically correct. All clinically supported option(s) should be included as well as the opportunity for the provider to craft an alternate response (e.g., "other, please specify").

Written queries can have the following formats (see sample queries in Appendix A):

- Open-ended: Allows provider to add free text query responses based on their clinical judgement which may or may not align with documentation needed to support code assignment

- Multiple choice: Multiple choice query formats 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. Providing a new diagnosis as an option in a multiple-choice list—as supported and substantiated by referenced clinical indicator(s) from the health record—is not introducing new information. There is no mandatory or minimum number of choices necessary to constitute a compliant multiple-choice query.
- Yes/no: Yes/no queries should only be employed to clarify documented diagnoses that need further specification. Yes/no queries may not be used in circumstances where only clinical indicators of a condition are present, and the condition/diagnosis has not been documented in the health record. The query should include the documentation in question with relevant clinical indicator(s) and be constructed so that it can be answered with a "yes" or "no" response. Below are some examples for when a yes/no query may be applicable:
  - Determining POA status
  - Substantiating a diagnosis that is already present in the current health record (e.g., findings in pathology, radiology, other diagnostic reports) with interpretation by a provider (inpatient setting)
  - Establishing or negating a cause-and-effect relationship between documented conditions such as:
    - Manifestation/etiology, complications, and conditions/diagnostic findings
    - Resolving conflicting documentation from multiple providers

A query response should be documented in the health record even if the patient has been discharged (e.g., in the form of an amendment or the query form itself). The response to the query is not required to be repeated elsewhere in the health record; however, if subsequent information conflicts with the query response, additional clarification may be needed. If the health record has been completed, then an addendum should be created and authenticated according to organizational policy.

While organizations are free to determine the specifics of their query process, compliant practice requires that all queries (i.e., actual queries) either be a permanent part of the health record or be retrievable in the business record.

Query Policies and Procedures

Organizations should develop policies and procedures to manage and monitor query practice compliance. All documentation queries are to be retained according to state regulations and organizational policies (e.g., written, verbal, computer generated). Below are some examples of information that may be included within the policies and procedures (not all inclusive):

- Query Compliance
  - Template approval process
  - Query validity
  - Query audit processes
    - Frequency
    - Staff
      - ☐ Internal
      - ☐ External
    - Audit tool and purpose
      - ☐ Qualitative and quantitative data
- Multiple Queries
  - How many topics and questions may be issued on one query
  - How many queries may be communicated during the same encounter
- Clinical Criteria
  - Organizations may define what clinical criteria they will use to support specific diagnoses (e.g., Sepsis 2, Sepsis 3, Kidney Disease Improving Global Outcomes [KDIGO]), American Society for Parenteral and Enteral Nutrition (ASPEN)
- Timing of Queries
  - Organizations may define when queries can be sent in relation to the timing of the encounter (e.g., prospective, concurrent, post discharge).
  - Exact time frames may be established by organizations regarding when a query may be sent after discharge, it is best practice to send queries as close as possible to the time of the encounter.
  - If a query is placed post bill, processes should be in place allowing for rebilling of the encounter, if reimbursement is impacted.
- Query Retention
  - The query retention policy needs to specify if the completed query will be a permanent part of the health record or considered as part of the business record. If the query is deemed to be part of the health record, it will be subject to health record retention guidelines which vary from state to state.
  - Queries may be disclosed and are retained for auditing, monitoring, and compliance.
- Escalation Policy
  - Facilities should develop an escalation policy including the process and purpose

- Process
  - ☐ This policy should clearly outline expectations of each individual involved in the process, including the expected time frames in which resolution or further escalation is expected.
  - ☐ Escalation may begin with a supervisor or manager and if necessary, referred to a physician advisor, chief medical advisor, or other administrative professional until resolved. The escalation process is not meant to direct or intimidate the recipient to elicit a specific response.
- Purpose (not all inclusive)
  - ☐ Unanswered queries
  - ☐ Address any medical staff concerns regarding queries
  - ☐ Provider feedback communication process
    - o If an appropriate professional response to a query is not received
    - o Monitoring and trending should be in place to identify provider engagement; this may include positive reinforcement and implications for patterns of concern

Query Technology

Technological advancements have the potential to help query professionals operate with greater efficiency, thus improving productivity. With the evolution of healthcare technology and its impact on the industry, it remains the responsibility of the query professional to distinguish between legitimate query opportunities versus inappropriate triggers while continuing to recognize potential opportunities not identified by said technology.

The purpose and expectations of the documentation query process are to assist the provider in creating thorough and complete documentation, including specificity, treatment provided, and clinical validation. All queries must meet the same compliant standards regardless of how or when they are generated, including those autogenerated by artificial intelligence (AI) and computer-assisted coding (CAC), whether in real-time computer-assisted physician documentation (CAPD) or after the episode of care is complete.6

Any technology-generated documentation query must follow the query compliance guidance discussed above. If a query response from a technology-driven query does not yield the response desired, it is inappropriate to send a follow-up manual query, for the same diagnosis/condition/procedure, in absence of new clinical indicators.

The use of technology to generate queries is used by many organizations. To review additional information regarding the compliant use of technology, please see the AHIMA/ACDIS *Compliant CDI Technology Standards* White Paper.

Conclusion

Healthcare professionals who work alongside providers to ensure accuracy in health record documentation should follow established facility and organization policies processes, and procedures that are congruent with recognized professional guidelines. This practice brief represents the joint efforts of both AHIMA and ACDIS to provide ongoing guidance related to compliant querying. As healthcare delivery continues to evolve, it is expected that future revisions to this practice brief will be required.

References

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2. AHIMA. "Definition, History, and Use of the Problem List." *Journal of AHIMA* 90, no. 7 (Jul-Aug 2019): 44-49.
3. Clinical Validation: The Next Level of CDI. (2019). AHIMA. Retrieved from: *Clinical Validation: The Next Level of CDI (January 2019 Update) (ahima.org)*
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   See also CMS (2022). Coding. Retrieved from: *Coding | CMS*

Appendix A:

NOTE: Use the following query examples as a guide in developing queries. These are examples only. Follow your organization's policies and procedures when developing queries. Please note that the clinical indicator(s) in these examples are not all inclusive; be sure to include all pertinent clinical indicators identified in the health record in your query.

Example #1: Clinical Validation Query—diagnosis is documented but appears to lack clinical support

Below are two compliant options to consider when writing a clinical validation query.

Option 1

Acute respiratory failure on H&P dated xx/xx and progress notes dated xx/xx and xx/xx.

Clinical Indicators: H&P indicates: Underlying pneumonia, respiratory rate 12, no accessory muscles usage, arterial blood gases are pH of 7.40, pCO2 of 36, and pO2 of 75 on room air.

Based upon the clinical indicators below, please clarify the status of respiratory function?

- Acute respiratory failure ruled out
- Acute respiratory failure confirmed (please document additional supporting information or mitigating factors)
- Other explanation of clinical findings (please specify) _____

Option 2

Please clarify the diagnosis related to the respiratory failure:

- Acute respiratory failure ruled out
- Acute respiratory failure confirmed (please document additional supporting information or mitigating factors)
- Other explanation of clinical findings (please specify) _____

Acute respiratory failure was documented on H&P dated xx/xx and progress notes dated xx/xx and xx/xx.

Clinical Indicators: H&P indicates: Underlying pneumonia, respiratory rate 12, no accessory muscles usage, arterial blood gases are pH of 7.40, pCO2 of 36, and pO2 of 75 on room air.

Example #2: Documentation in the present and prior health record provides evidence to support the presence of a condition

Clinical Indicators

Documentation in the progress note mm/dd/year indicates renal dosing applied to Metronidazole dosing. Current H&P mm/dd/year states CKD but no stage is documented, Previous encounter discharge summary (dated xx/xx) documents CKD stage 4, Trending eGFR (dates x/xx, x/xx, x/xx) ranging 17-20 mL/min.

Please clarify the staging of the CKD:

- CKD, stage 4
- Other explanation of clinical findings (please specify) _____
- Clinically undetermined

Example #3: Evidence in previous health record supports further specification of a condition

Acute congestive heart failure was documented on progress note dated xx/xx.

Clinical Indicators: Echo from last week's office visit indicates ejection fraction of 35% and diastolic dysfunction

Please further specify the diagnosis of heart failure:

- Acute systolic congestive heart failure
- Acute systolic and diastolic congestive heart failure (combined)
- Other explanation of clinical findings (please specify) _____

Example #4: Medical diagnosis that is clinically evident

Clinical Indicators: Respiratory therapy (dated xx/xx) notes continuous home O2 at 2L/min, which was continued this admission. H&P (dated xx/xx) indicates history of COPD, GOLD stage 4.

Please clarify the baseline respiratory function:

- Chronic respiratory failure
- Chronic respiratory insufficiency
- Other explanation of clinical findings (please specify) _____

Example #5: Uncertainty of a cause-and-effect relationship between related conditions

Clinical Indicators: H&P (dated xx/xx) states lung cancer with bone metastasis, undergoing chemotherapy. Pancytopenia was documented on progress note (dated xx/xx).

Please clarify etiology of pancytopenia:

- Pancytopenia due to chemotherapy
- Pancytopenia due to other cause (please specify): _____
- Pancytopenia, etiology unknown

Appendix B: AHIMA and ACDIS Resources

AHIMA Resources

- *AHIMA Inpatient Query Toolkit*
- *AHIMA Outpatient Query Toolkit*
- *Clinical Documentation Integrity (CDI) Toolkit Beginners' Guide (ahima.org)*
- *Clinical Validation: The Next Level of CDI (January 2019 Update)*

ACDIS Resources

- *ACDIS Code of Ethics*
- *Clinical Validation and the Role of the CDI Professional*
- *Queries in Outpatient CDI: Developing a Compliant, Effective Process*

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What is an ACDIS Position Paper?

An ACDIS Position Paper sets a recommended standard for the CDI industry to follow. It advocates on behalf of a certain position or offers concrete solutions for a particular problem. All current members of the ACDIS Advisory Board must review/approve a Position Paper and are encouraged to materially contribute to its creation.

CR-6918

Question

The Practice Brief uses the term *"query professional"* with the definition of:

> **"a. Those who use the query to pose questions to resolve documentation issues and/or those who have oversight and/or involvement in the query process.**
>
> **b. QP include coding professionals, CDI professionals, physician/provider advisors, and all professionals who initiate communication that meets the definition of a query to clarify clinical documentation."**

This direction appears to apply to other roles such as utilization review or quality reporting. Are you stating that CDI or coding professionals are to "police" the query activities of other departments when they are seeking documentation clarifications?

Answer

The writers of the brief wished to draw attention to the fact many disciplines work with providers to clarify documentation with a goal of accuracy and/or code assignment. Such roles include those in utilization review, quality reporting, and physician advisors. If their activities fit the definition of query, the Guidelines for Achieving a Compliant Query Practice should apply.

We do not feel that those in the role of CDI/coding should be the "query police" but do suggest that organizational compliance departments apply the guidance in evaluating such communications and identifying those for which the guideline should apply. Individuals who perform functions that meet the definition of a query should receive ongoing guidance and education related to compliant practice, and processes to audit for compliance should be implemented.

Question

Is it allowable to include definitions within a query? For instance, a query for afib specification including definitions for the type of atrial fib? Or a query for CKD staging including the ranges of stage differentiation?

Answer

Including such information on a query is common. This practice allows providers ease in access to organizationally developed diagnostic criteria or industry evidence-based guidelines. This practice is not thought to be leading. The information should be provided without any indication of choice, meaning the information should not highlight, bold, or indicate a desired answer.

Question

On page 3, citing when a query may be needed, the brief states:

"To clarify a diagnosis on an ancillary note that has been signed but not addressed by a provider. For example, if the nutrition note states, 'severe malnutrition' and the note is signed by the provider, but the provider does not address the diagnosis within their documentation".

We went on electronic records to reduce providers' documentation of burden, yet this guideline is stating we need to query as if the physician signature is not valid. Does this mean we are saying the co-signature on other documents should be considered invalid?

Answer

AHA Coding Clinic, First Quarter 2020, page 4 indicates that organizations should develop a policy to address when to code from documentation that is signed by a physician.

The Practice Brief states that *"Queries **may** be necessary"* in describing the example illustrated in the question above. Best practice is for providers to incorporate query answers within their documentation, speaking to the significance and relevance of diagnoses described. If there is any question as to the meaning of the provider's co-signature, a query is likely needed.

Organizations are encouraged to develop facility-based policies related to this issue.

Question

Is the diagnostic statement on a query alone good enough to be able to code, or does the diagnosis need to be stated elsewhere? What about retro-queries?

Answer

The purpose of a provider query is to seek clarification of an otherwise unclear record. In order for the query response to be utilized to support code assignment, the query and response must be incorporated as part of the health record; otherwise the provider must incorporate the answer within their documentation (progress notes, discharge summary, etc.) or apply an addendum to the existing health record if the query is applied retrospectively. Organizations should have a policy in place to define approved locations for query responses.

Section III of the *Official Guidelines for Coding and Reporting* states:

> For reporting purposes, the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring:
>
> clinical evaluation;
>
> or therapeutic treatment;
>
> or diagnostic procedures;
>
> or extended length of hospital stay;
>
> or increased nursing care and/or monitoring.

The UHDDS item #11-b defines Other Diagnoses as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded." UHDDS definitions apply to inpatients in acute care, short-term care, long-term care, and psychiatric hospital settings. The UHDDS definitions are used by acute care short-term hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, *Federal Register* (Vol. 50, No, 147), pp. 31038-40.

There is no specific direction as to where diagnoses must be documented or how often a diagnosis must be documented to allow it to be reported. Organizations may need to develop facility-based policies reflecting reportability of information that is clarified only within a query response versus elsewhere in the record.

Question **If a compliant query has been properly answered and authenticated by a responsible provider and is part of the permanent health record, is it sufficient for code assignment?**

Answer See above.

Question **Is the use of quotation marks within a query compliant? For example, if one is pulling specific information from the record as a direct quote when citing clinical indicators in support of a query?**

Answer The use of quotations within the body of a query question, to identify information pulled directly from the record, would be appropriate. For example, quoting a provider statement or a nursing assessment is compliant. All entries of clinical indicators should be accompanied by sourcing within the medical record, allowing the provider to further investigate their meaning if needed.

Question **Is it compliant to highlight or bold important information or clinical criteria in a query?**

Answer It is best practice not to highlight any information within the query that could be construed as leading, and highlighting should never be used within the option choices of a query.

Question

Is it ok to only use the options of "ruled in", "ruled out", and "other" as options for a query? Would it be non-compliant to not offer the answer "unable to determine" in this instance?

Answer

In essence, a query to confirm a stated differential diagnosis is a "yes/no" query, asking if the aforementioned diagnosis has been ruled in or ruled out. The brief states, "Yes/No queries should only be employed to clarify documented diagnoses that need further specification. Yes/No queries may not be used in circumstances where only clinical indicators of a condition are present, and the condition/diagnosis has not been documented in the health record." Thus, providing answers such as the diagnosis has been ruled in, ruled out, or other is compliant.

If the diagnosis you wish to "rule in" or "rule out" has not been specifically documented within the record, a multiple-choice query would likely be the best option, which should follow the guidance within the brief related to the multiple choice query format.

Question

Regarding the General Query Guidelines: 1.h.ii. "Unable to determine": Please elaborate on the query response. If a consult provider, e.g., a cardiologist, made a diagnosis of NSTEMI, the attending documented elevated troponin, and on query the attending states "Unable to determine", should the NSTEMI documented by the cardiologist be coded?

Answer

If the documentation between the attending and the cardiologist is thought to be conflicting, a query should be placed for verification. If the response to the query does not provide the clarity requested, the organization's policy for this type of discrepancy should be followed (e.g., escalation policy).

Question

Can a query be considered "non-compliant" without being "leading"?

Answer

Within the Practice Brief, the section entitled "Compliant Query Guidelines", number V states:

"Queries must be accompanied by clinical indicator(s)/evidence that:

- Are specific to the patient and episode of care
- Support a more complete or accurate diagnosis or procedure
- Require clinical validation of a reported diagnosis not supported by the health record—please reference the practice brief *Clinical Validation: The Next Level of CDI (January 2019 Update)* to learn more about clinical validation.

- May be acquired from the current or previous health record, if clinically pertinent to the present encounter (Please reference the 'Role of Prior Encounters in Queries' section for more information)"

This guidance speaks to the requirements of a query related to valid clinical indicators, specific to the encounter. If these requirements listed above are not necessarily describing differentiation of leading or non-leading queries. Thus, a query can be considered "non-compliant" without being leading.

Question **If a coder or other query professional finds that a query is non-compliant because it contains indicators or treatment for a different condition but the provider has signed it anyway to avoid issues, what course of action do you take?**

Answer Each organization should create well-defined escalation policies that guide individuals as to how to address and communicate circumstances in which queries are identified as being potentially non-compliant.

Question **Should an option be provided that allows the provider to identify their impression the query is unnecessary?**

Answer The option of "other, please specify" allows the provider an opportunity to clarify their disagreement or impression of necessity related to the intent of the query. Organizations may also choose to include options such as "no further clarification is needed" to track this occurrence. A policy should be in place to address this type of concern.

Question **For prospective chart reviews that are not associated with any encounter and are not querying providers to make changes to past encounters, do the query guidelines apply?**

Answer Yes, all queries should follow the same guidelines.

Because of the shortened time of an outpatient encounter, a concurrent review may not be practical. The need for query may be based off current and previous documentation, the problem list, and any diagnostic data available—knowing a query should not be asked unless it is relevant to the planned encounter. Such queries should be crafted with the guidance of the practice brief.

Question

The General Query Guidelines, section P states:

"Present only the documentation or data from the health record, without subjective interpretation from the query professional, identifying why the clarification is required."

What does "subjective interpretation by the query professional" mean?

Answer

The query professional should not be inserting diagnoses or offer their own interpretation or wording into the body of the query question that has not yet been identified. For example, if the documentation indicates a heart rate of 120, the clinical indicator should not state "tachycardia" or if the hemoglobin is reported at 10 g/dL, the query professional should not write "anemia" as a clinical indicator within the body of the query.

Question

Within the section "Role of Prior Encounters in Queries", the Practice Brief states:

"This process reinforces the accuracy of information across the healthcare continuum. However, it is inappropriate to 'mine' a previous encounter's documentation to generate queries not related to the current encounter."

What is meant by the word "mine"?

Answer

The goal of this statement is to guide query professionals as to when it is appropriate to source clinical indicators from previous encounters. The process of mining is when one consults health information from prior encounters without any guiding reason or focus, just reviewing to identify diagnosis or condition specificity that is not related to the present encounter.

Organizations should develop policies related to when and for what reasons prior encounters can be reviewed, to include how old the records should be.