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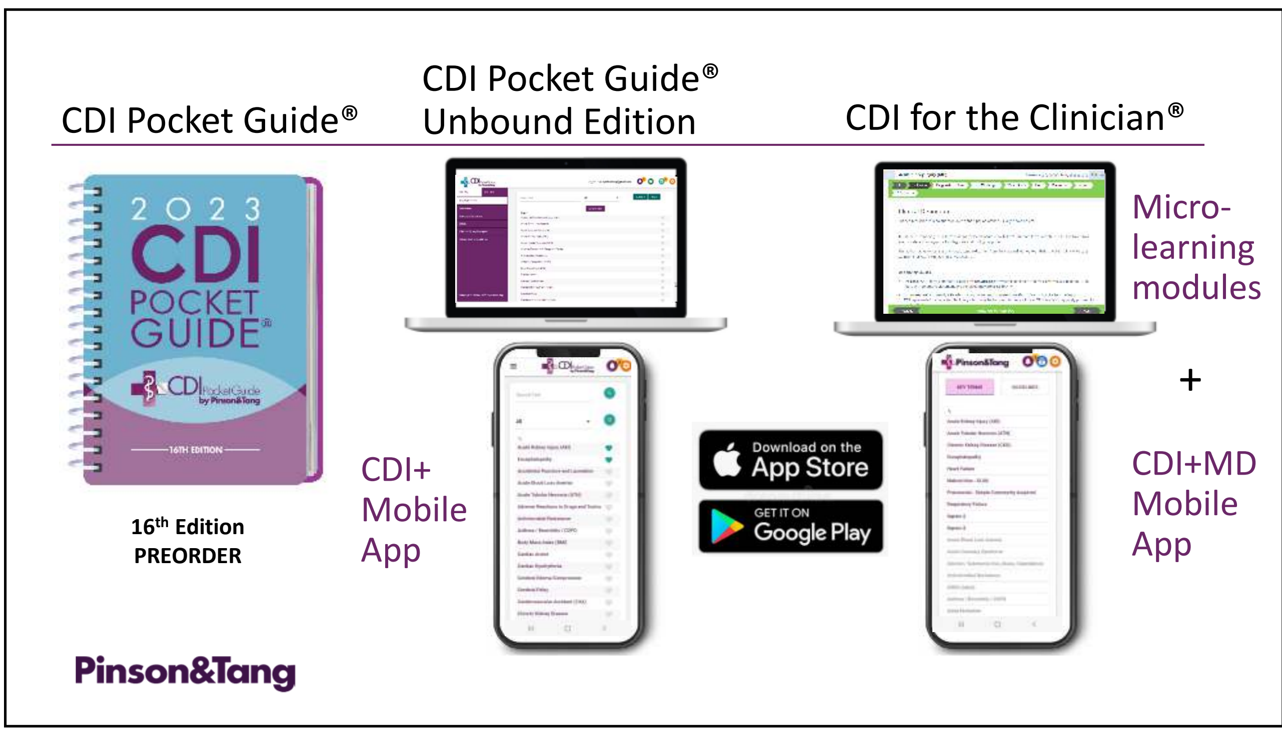

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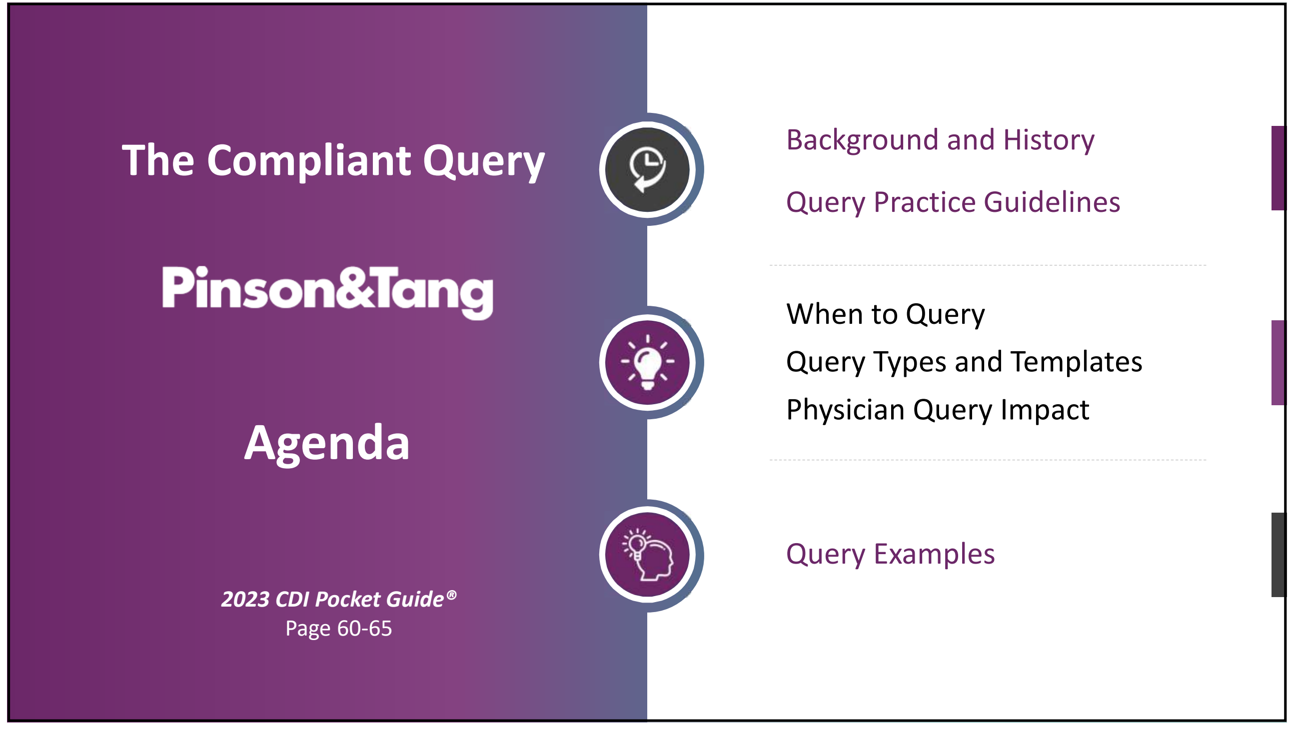

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Background and History

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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 (2022 Update)

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Guidelines for Achieving a Compliant Query Practice

AHIMA/ACDIS Query Practice Brief: 2022 Update

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Query Policies and Procedures

"The practice brief should be used to guide organizational policy and process development for a compliant query practice." "Organizations should develop policies and procedures to" address: query practice and compliance, creating addendums, query retention, recording verbal queries, query escalation.

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.

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Guidelines for Achieving a Compliant Query Practice

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AHIMA/ACDIS Query Practice Brief: 2022 Update

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

a. Clinical indicators of a diagnosis but no documentation of the condition
b. Conflicting documentation between the attending provider and other providers
c. Clarify the reason for inpatient/outpatient encounter
d. Appears a documented diagnosis is not clinically supported
e. Confirm a diagnosis by a non-provider
f. Cause-and-effect relationship between medical conditions
g. Acuity or specificity of a documented diagnosis
h. Condition documented as a "history of" to determine if active and not resolved
i. POA indicator assignment
j. Diagnosis is ruled in or out
k. Objective and extent of a procedure
l. Clarify presence or absence of a complication
m. Clarify a diagnosis on an ancillary note signed by the provider.

"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

The 2022 Guidelines provide general query requirements including:

- Be **clear and concise**
- Contain **applicable clinical indicators** from the health record **citing the location** found within the health record.
- Present only the **objective data** from the health record identifying why the clarification is required
- **Avoid** using query question and answer options that indicate an uncertain diagnosis unless an uncertain diagnosis is documented
- **Never** include impact on reimbursement, quality measures or other reportable data
- Be **compliant** with the practices outlined in this brief

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Guidelines for Achieving a Compliant Query Practice

Multiple Choice Queries

"**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).

Other "answer options that may be used (but are not required) include unknown, unable to determine, not clinically significant, unable to rule out, inherent 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 maximum or minimum number of diagnosis/ procedure answer options 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

Multiple Choice Queries

EXAMPLE from Query Practice Brief (2022 Update)

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:

- Myelophthisic pancytopenia
- Pancytopenia due to chemotherapy
- Pancytopenia due to other cause (please specify):_______
- Pancytopenia, etiology unknown

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; 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 **<u>underlying cause of a symptom</u>** 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

H&P (7/8) indicates the patient was admitted and diagnosed with a UTI and also has a urinary catheter.

Based on this documentation, can you please clarify in the medical record whether the:

- UTI is related to or caused by the urinary catheter

Conflicting Documentation

H&P (7/10) indicates this patient was admitted with:

- Cough, fever, sputum, WBC 12K.
- CXR (7/9) unremarkable. CT chest (7/10) 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?

Substantiating a Diagnosis in Diagnostic Reports

H&P states the patient was admitted with a metastatic brain cancer. CT scan (6/10) also shows "significant cerebral edema". Treatment: High dose IV steroids per progress note (6/11).

Based on these clinical indicators, can you please indicate in the medical record if the patient has significant cerebral edema?

Present on Admission

Wound care nurse note (5/10) states patient was admitted with a Stage 3 sacral pressure ulcer. 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.

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." (2019)

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

Clinical Validation Query Example for Sepsis

Sepsis was documented on the H&P (6/11) and first progress note (6/12).

Documentation in the ED record (6/10) includes: *[include actual criteria that support and do not support]*

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

Based on the clinical indicators above, 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** (please document additional supporting information or mitigating factors)

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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." (2019 Practice Brief).

"Template format should include: patient identification; editable or customizable information; clear, concise wording that is efficient for the provider to review; 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." (2022 Practice Brief).

"Three-Legged Stool"

1. Clinical indicators
2. Risk
3. Treatment

Not all three categories are necessary to submit a compliant query according to the 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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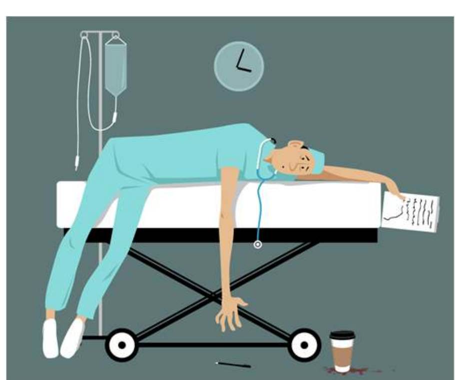
How do you feel about documentation queries?

- 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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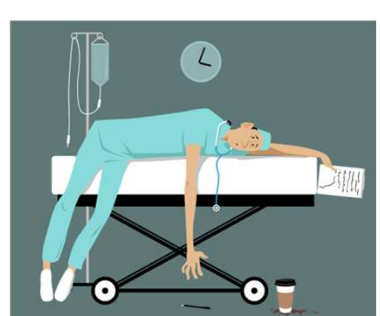
"Queries are not necessary for every discrepancy or unaddressed documentation issue… Circumstances include lack of business need, risk of query fatigue, or does not add to the clarity of the clinical picture."

"Queries should only be generated when the clinical data fully supports the answer choice(s)."

"Code accuracy is not the same as code specificity. The [OCG 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."



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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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H&P (2/11) states patient was admitted with COPD exacerbation and systolic heart failure.

Clinical Indicators from the H&P and ED (2/10):

- “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)

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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H&P (11/7) states patient was admitted with PID. AKI and ATN was also documented in progress notes (11/10-11/12):

Creatinine levels on lab:

- 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 the above 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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Protein Calorie Malnutrition was documented on the H&P addendum (8/1)

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** (please add additional supporting information or mitigating factors)

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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

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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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H&P on 3/21 states the patient was admitted with sepsis and diagnosed with bacterial pneumonia.

Clinical Indicators:

- Aerobic Culture (3/23): 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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