

Guidelines for Achieving a Compliant Query Practice (2019 Update)

Editor's Note: This Practice Brief supersedes the January 2016 Practice Brief titled "Guidelines for Achieving a Compliant Query Practice (2016 Update)."

THIS AMERICAN HEALTH Information Management Association – Association of Clinical Documentation Improvement Specialists (AHIMA-ACDIS) Practice Brief should serve as an essential resource for coding and clinical documentation improvement (CDI) professionals in all healthcare settings who participate in query processes and/or functions. It should also be shared and discussed with other healthcare professionals, such as quality, compliance, revenue cycle, patient financial services, physician groups, facility leaders, and any others who work with health record documentation, clinical coding, and/or coded data.

This Practice Brief's purpose is to establish and support industry-wide best practices for the function of clinical documentation querying. Its intent is to integrate best practices into the healthcare industry's business and workflow processes and the overall function of querying. This Practice Brief should be used to guide organizational policy and process development for a compliant query practice that implements the directives of the ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting and official advice in the American Hospital Association's (AHA's) *Coding Clinic*® for ICD-10-CM/PCS promoting the legible, consistent, complete, precise, nonconflicting, and clinically valid documentation essential to the integrity of the ICD-10-CM/PCS code sets. It is also intended to provide a resource for external reviewers (i.e., the Office of Inspector General (OIG), government contractors, payer review agencies, etc.) in their evaluation of provider queries and the documentation they provide.

Some specific use examples include:

- Orient new employees and educate current staff
- Assist with query audits
- Review of query policies and procedures annually
- Utilize during coding and CDI education and training
- Standardize query practices across the organization
- Provide data analytics and information governance
- Compliance and legal assistance
- Share with external or third-party staff and/or consultants

The distribution of this Practice Brief should enhance the importance of adherence to its contents and guidance while improving results, outcomes, and compliance with ethical practice.

This is an abridged version of this Practice Brief. For the full ver-

sion, including an expanded discussion of the tenets of a compliant query practice, a discussion of the particulars of verbal queries and written queries, a discussion of query policies and procedures, a discussion on query retention policy, and a full list of authors for previous versions of this Practice Brief, view the online version in AHIMA's HIM Body of Knowledge at <http://bok.ahima.org>.

Who Should Follow This Brief?

With the evolution of reimbursement methodologies that move beyond resource use and instead focus on severity of illness, medical necessity, risk adjustment, and value-based measures, specific documentation related to diagnosis capture, acuity, and clinical validity have become even more important. The need for clear and accurate documentation and how it is translated into claims data impacts healthcare roles such as case management, quality management professionals, infection control clinicians, and others. In support of organizational objectives, these professionals actively engage in educating providers to document a certain way. These individuals may not understand that their interactions meet the definition of a query, but because their practices could alter coded data, they must ensure that their practices meet compliance standards.

Examples of noncompliant queries include: directing a provider to document a diagnosis that is not clinically supported but serves as an exclusion for a patient safety indicator, adding a non-reportable diagnosis, or encouraging a provider to neutralize documentation suggestive of a post-surgical complication. Although open communication between members of the healthcare team and providers is necessary and important, when it can impact claims data these discussions should be memorialized as queries. Organizations should educate all relevant professionals in compliant query practices through collaboration with health information management, coding, and CDI professionals before engaging in these interactions. Regardless of the credential, role, title, or use of technology, all healthcare professionals (whether or not they are AHIMA or ACDIS members) seeking to clarify provider documentation must follow compliant query guidelines.

What is a Query?

A query is a communication tool or process used to clarify documentation in the health record for documentation integrity and accurate code assignment for an individual encounter

in any healthcare setting. Synonymous terms for “query” include: clarification, clinical clarification, and documentation clarification. Documentation queries (referred to as “queries” in this Practice Brief) are used by coding professionals, CDI professionals, and all professionals responsible for documentation clarification or who have oversight and/or involvement in the query process. As healthcare reimbursement methodologies evolve and reliance on claims data as a risk-adjustment and quality of care tool increases, so does the importance and complexity of the query process. Queries continue to be a mechanism that increases the precision of clinical documentation, which translates into accurate clinical data, reflecting a provider’s intent and clinical thought process in a manner that results in an accurate depiction of patient complexity within each episode of care.

All queries, including verbal queries, should be memorialized to demonstrate compliance with all query requirements to validate the essence of the query (see below). Regardless of how the query is communicated, it needs to meet all of the following criteria:

- Be clear and concise
- Contain clinical indicators from the health record
- Present only the facts identifying why the clarification is required
- Be compliant with the practices outlined in this brief
- Never include impact on reimbursement or quality measures

As query templates are now increasingly embedded in the electronic health record (EHR) or workflow software, query professionals must ensure relevant clinical indicator(s) specific to the particular patient as cited within the health record are applied and referenced appropriately. Additionally, the choices provided as part of the query must reflect reasonable conclusions specific to the clinical scenario of the individual patient.

Why Query?

Queries are utilized to support the ability to accurately assign a code and can be initiated by either coding or CDI professionals. Queries may be necessary in (but are not limited to) the following instances:

- To support documentation of medical diagnoses or conditions that are clinically evident and meet Uniform Hospital Discharge Data Set (UHDDS) requirements but without the corresponding diagnoses or conditions stated
- To resolve conflicting documentation between the attending provider and other treating providers (whether diagnostic or procedural)
- To clarify the reason for inpatient admission
- To seek clarification when it appears a documented diagnosis is not clinically supported
- To establish a diagnostic cause-and-effect relationship between medical conditions

- To establish the acuity or specificity of a documented diagnosis to avoid reporting a default or unspecified code
- To establish the relevance of a condition documented as a “history of” to determine if the condition is active and not resolved
- To support appropriate present on admission (POA) indicator assignment
- To clarify if a diagnosis is ruled in or out
- To clarify the objective and extent of a procedure

Although specific query formats will be discussed later in this Practice Brief, issuing clinical validation queries can be more challenging than other query types. These challenges have initiated the development of a separate Practice Brief to address these concerns. Please refer to the AHIMA Practice Brief titled “Clinical Validation: The Next Level of CDI” to learn more about the process of clinical validation, available in the AHIMA HIM Body of Knowledge at <http://bok.ahima.org>.

What to Query?

A health record contains documentation authored by a variety of healthcare professionals. Increasingly, the electronic health record also contains information whose origin and accuracy cannot always be easily verified. While it is important to note the overall accuracy of the health record and how well it meets industry and regulatory standards, it is outside the scope of querying professionals to manage provider documentation practices.

When coding and CDI professionals identify that the health record fails to meet one of the following seven criteria identified below, and after education and query efforts have been exhausted, it should be reported to the appropriate facility and/or organizational authority:

- Legibility
- Completeness
- Clarity
- Consistency
- Precision
- Reliability
- Timeliness

Facilities and organizations are encouraged to have robust guidelines in place that define the contents of the health record and outline documentation expectations, including the use of copy and paste functionality, automatically populated fields (i.e., problem lists, diagnostic results, etc.), and document templates that are included within the health record.

The focus of CDI professionals is to review the health record to ensure clear, high-quality clinical documentation. Ambiguous documentation fails to reflect the provider’s intent, impacts the clinical scenario (i.e., complications, quality of care issues), the accuracy of code assignment, and the ability to assign a code. It is important to note that 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 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, such as the reporting of A41.9, Sepsis, unspecified organism.

Queries are not necessary for every discrepancy or unaddressed documentation issue. When determining the need to query, the query professional must consider if the provider can offer clarification based on the present health record documentation or resolve/seek clarification on conflicting documentation.

Organizational query policies and procedures should provide direction to guide staff when multiple opportunities exist. Specifically, organizations need to determine if there is a limit to how many questions may be issued at one time and how many queries may be communicated during the same encounter.

In a situation when multiple queries are required regarding the same set of clinical indicators or ambiguous documentation, querying professionals may need to utilize verbal queries to discuss these complex circumstances. For example, if both a diagnosis and additional specificity must be established for accurate code assignment (i.e., the presence of CHF and its type), a verbal query or two separate written queries may be necessary. Trying to obtain too much information in one query may result in a non-compliant query.

There may be times when a second query is needed to obtain further clarification of a previously answered query as additional information becomes available or as the clinical picture evolves. However, it is considered non-compliant to continue asking the same query to the same or multiple providers until a desired response is received.

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.

Role of Prior Encounters in Queries

There has been much discussion and confusion regarding the use of information from prior encounters in a current clinical documentation query. Some major developments require taking another look at this:

- The field of Clinical Documentation Improvement continues to mature and develop beyond clarifying for reimbursement purposes and is striving for health record integrity
- Implementation of the EHR brings information that was once buried in storage and hard to access to the fingertips of physicians and querying professionals, leading to a more detailed reference and a richer picture of a patient's

medical history

- Recent Centers for Medicare and Medicaid Services (CMS) initiatives such as bundled payments and value-based measures expand the "episode of care" across settings, transitioning to a patient or disease focus instead of a setting of care focus
- CMS and many commercial payers regularly aggregate healthcare data across settings on an annual basis

Coding Clinic's Third Quarter 2013 section "Assigning codes using prior encounters" states: "[When] reporting recurring conditions and the recurring condition is still valid for the outpatient encounter or inpatient admission, the recurring condition should be documented in the medical record with each encounter/admission. However, if the condition is not documented in the current health record it would be inappropriate to go back to previous encounters to retrieve a diagnosis without physician confirmation."

This statement speaks to code assignment, not construction of a documentation query. A query may be initiated to clinically validate a diagnosis that a prior health record provided evidence to support, particularly when clarifying specificity or the presence of a condition which is clinically pertinent to the present encounter supporting accuracy of care provided across the healthcare continuum. Prior encounter information may be referenced in queries for clinical clarification and/or validation *if* it is clinically pertinent to the present encounter. However, it is inappropriate to "mine" a previous encounter's documentation to generate queries not related to the current encounter.

Situations in which queries using information from prior encounters may be utilized when relevant include, but are not limited to:

- Diagnostic criteria allowing for the presence and/or further specificity of a currently documented diagnosis (i.e., to ascertain the type of CHF, specific type of arrhythmia)
- Treatment/clinical criteria or diagnosis relevant to 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
- Determine the etiology when only signs, symptoms, or treatment are documented
- Verify POA indicator status
- Clarify a prior history of a disease that is no longer present (i.e., 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. 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.

Clinical Indicators

“Clinical indicators” is a broad term encompassing documentation that supports a diagnosis as reportable and/or establishes the presence of a condition. Examples of clinical indicators include: provider observations (physical exam and assessment), diagnostic findings, treatments, etc. provided by providers and ancillary professionals. There is not a required number of clinical indicators 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 indicators for a diagnosis, providers make the final determination as to what clinical indicators define a diagnosis. AHA’s *Coding Clinic* similarly affirms that in its first quarter 2014 issue, stating:

Clinical information previously published in *Coding Clinic* whether for ICD-9-CM or ICD-10-CM/PCS does not constitute clinical criteria for establishing a diagnosis, substitute for the provider’s clinical judgment, or eliminate the need for provider documentation regarding the clinical significance of a patient’s medical condition. It may still be useful to understand clinical clues regarding signs or symptoms that may be integral (or not) to a condition. However, care should be exercised as ICD-10-CM has new combination codes as well as instructional notes that may or may not be consistent with ICD-9-CM.

The purpose or type of query will also impact how much clinical support is necessary to justify the query and, when applicable, reasonable option(s). When the purpose of the query is to add a diagnosis, clinical indicators should clearly support the condition, allowing the provider to identify the most appropriate medical condition or procedure. The quality of clinical indicators—how well they relate to the condition being clarified—is more important than the quantity of clinical indicators.

Clinical indicators can be identified from sources within the entirety of the patient’s health record including emergency services, diagnostic findings, and provider impressions as well as relevant prior visits, if the documentation is clinically pertinent to the present encounter. For example, there is care being provided in the current encounter that necessitated the review of a previous encounter to identify the undocumented condition. Compliant query practice always requires the individualization of each query to reflect the specifics of the current circumstance.

Who is Queried?

Healthcare data is obtained primarily from diagnosis and procedures codes. In particular, diagnosis codes are only assigned based on the documentation of those licensed independent providers who render direct patient care. The 2019 ICD-10-CM Official Guidelines for Coding and Reporting define the term “providers” as: “physician or any qualified healthcare practitioner who is legally accountable for establishing the patient’s diagnosis.” Independent providers include physicians, consulting physicians, nurse practitioners, physician assistants, and medical residents. Code assignment may be based on other physicians’ (i.e., consultants, residents, anesthesiologist, etc.) documentation if there is no conflicting information from the attending physician. Refer to section I.B.14. “Documentation by Clinicians Other than the Patient’s Provider” in the ICD-10-CM Official Guidelines for Coding and Reporting’s for additional guidance. When conflicting documentation is present, it is the attending physician who should be queried to resolve the discrepancy.

There are occurrences for which queries are applied to individuals who are not classified as a provider. *Coding Clinic* first quarter 2014 states that, “It is appropriate to assign a procedure code based on documentation by a non-physician professional when that professional provides the service.” For example, infusions may be carried out by a nurse, wound care may be provided by a nurse or physical therapist, mechanical ventilation may be provided by a respiratory therapist, or a medication may be ordered by the physician and administered by a nurse. In these instances, clarification may be needed from a non-physician professional and queries should be assigned as appropriate. 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

Verbal, written paper, and electronic queries serve the purpose of supporting clear and consistent documentation of diagnoses being monitored and treated during a patient’s healthcare encounter. Regardless of the method, a query must adhere to compliant, non-leading standards, permitting the provider of record 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.

Regardless of the format and technology used, a query should not direct the provider to document a specific response. Best practice dictates that, whenever possible, query responses be consistently documented within the health record as part of the progress notes and discharge summary or as an addendum as appropriate. If a compliant query has been properly answered and authenticated by a responsible provider and

is part of the permanent health record, absence of the documented answer in a progress note, discharge summary, or addendum should not prohibit code assignment.

Follow Best Practices

Healthcare professionals who work alongside practitioners to ensure accuracy in health record documentation should follow established facility and organization processes, policies, 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. ●

Appendices Available Online

There are three appendices in the online version of this Practice Brief, available in AHIMA's HIM Body of Knowledge:

- Appendix A: Use of Templates in the Query Process
- Appendix B: Query Examples
- Appendix C: AHIMA and ACDIS Resources

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