LaVerne Romberger MSN, CCDS.
Clinical Operations Manager- CDIP

Query Process for CDI Specialists

Purpose: To establish guidelines for the Clinical Documentation Improvement (CDI) Physician Query process. The appropriate querying process will improve the accuracy, integrity and quality of the documentation in the clinical record and minimize variation in the query process.

Policy:

1. The overall goal of query activities is to clarify ambiguous, conflicting, or incomplete documentation regarding any significant reportable condition or procedure. The query process is meant to ensure complete and accurate documentation that supports the principal diagnosis, all relevant secondary conditions, the severity of illness, the risk of mortality and resources utilized during the patient's hospital stay.
    a) A reportable condition is defined by *Official Coding Guidelines* as those that affect patient care in the terms of the following:
        i. Clinical evaluation, or
        ii. Therapeutic treatment, or
        iii. Diagnostic procedures, or
        iv. Extended length of hospital stay, or
        v. Increase nursing care and/or monitoring.
2. It is appropriate to query for documentation clarification in the following situations per *The AHIMA Practice Brief:*
    a) When there are clinical indicators of a diagnosis, but no documentation of that diagnosis
    b) Clinical evidence for a higher degree of specificity or severity
    c) A cause and effect relationship between two conditions or organisms
    d) An underlying cause when documenting symptoms only
    e) Present on admissions status of a diagnosis
3. It may be appropriate to query the physician when the documentation in the medical record fails to meet any one of the following criteria:
    a) Legibility
    b) Completeness
    c) Clarity
    d) Consistency
    e) Precision

1. Written queries will be generated, in *AHIMA* compliant manner, utilizing the approved standard SHC query forms.

2. The query will be placed in the progress notes section of the medical record for physician review.
3. The query's relevant clinical indicators and the format in which the query clarification was posed will be entered into the query section of cdis.
4. (query escalation process)The Clinical Documentation Specialist will perform a follow up review of the medical record within the next business day, when possible, to determine if the query was answered by the physician.
5. (query escalation process) If the query is unanswered within 48 hr business hours of posting, the Clinical Documentation Specialist will contact the contracted hospitalist and document the courtesy reminder in CDIS.
6. Verbal queries will be entered into the CDIS system, to include the relevant clinical indicators and the format in which the query clarification was posed.
7. Written queries will include the following information:
    a) Patient name
    b) Admission date
    c) Account number
    d) Date query was initiated
    e) Name and contact information of the CDI initiating the query
    f) Provider information

8. A compliant query:
    a) Contains relevant clinical indicators that show why a more complete or accurate diagnosis or procedure is being sought,
    b) Uses precise language,
    c) Preferably uses an open ended question format,
    d) Yes/no query format includes:
        i. Substantiating or further specifying a diagnosis that is already present in the medical record
        ii. Establishing a cause and effect relationship between two documented conditions/diagnostic findings
        iii. Conflicting documentation from two or more providers
        iv. Present on admission status
    e) The multiple choice format needs to include clinically significant and reasonable options that are supported by the medical record. Including a new diagnosis in the multiple choice list that is clinically supported by the medical record, is not considered introducing new information. Multiple choice queries should also include options of clinically undetermined, not clinically significant or other.

9. If the query is answered on the query form and/or in the progress notes the Clinical Documentation Specialist will update the CDIS Query section.
10. If the query remains unanswered at the time of discharge the Clinical Documentation Specialist will retrospectively review the medical record and discharge summary to determine if the query was answered. If answered will update the query section inCDIS, if not will follow the No Response Query Policy.

References:

- AHIMA. "Managing an Effective Query Process" Journal of AHIMA 79, NO. 10 (October 2008): 83-88
- AHIMA. "Guidance for Clinical Documentation Improvement Programs" Journal of AHIMA 81 No. 5 (May 2010): 45-50
- AHIMA. "Guidelines for Achieving a Compliant Query Practice" Journal of AHIMA 84 No. 2 (February 2013): 50-53
- ICD-9-CM Official Guidelines for Coding and Reporting, Effective October 1, 2012
- Physician Queries Hand Book-Second edition HCPro, Inc copyright 2013