June 2022

Topic: Querying Tips and Compliant Queries: Back to Basics

When should a query be issued any why?

- Documentation in the medical record is conflicting, ambiguous, or inconsistent
- Clinical indicators are present without a definitive diagnosis documented
- Clarification if the diagnosis is POA if unclear

Example:

▶Patient presented w/history of SOB, cough, fever & malaise x 2 days, family members recently diagnosed with pneumonia, Emergency department starts patient on Levofloxacin, chest x-ray shows "lobar consolidation". Blood cultures x2 are pending.

▶Physician documents diagnosis as: Fever of Unknown Origin

Dr. Jones,

▶**Documentation**: Patient was admitted w/SOB, Cough, Fever, Malaise per your H&P. ER physician documents FUO.

▶**Diagnostics**: CXR 3/21 documents "lobar consolidation", blood cultures x2 drawn on admission are still pending.

▶**Treatment:** Levofloxacin, Tessalon, Perles, are ordered.

Can the known or suspected condition(s)being treated be identified as:
__community acquired pneumonia
__aspiration pneumonia
__bacterial pneumonia
__reactive airway disease
__bronchitis
__other more appropriate diagnosis?

Goals of your query.

1. To make the record clearer and not to educate the physician. We should not include ICD-10-CM/PCS codes, code details, or coding guidelines that we follow unless the physician requests a reason for the query.
2. Make sure your question is clear. Be direct in what you are asking without being leading. Make queries simple and to the point, without too much "clutter."
3. Offer response options. Never tell the physician what to write, no matter how clear the clinical picture appears. Be sure to ask clear questions and always provide the physicians with multiple answer options – and always include an "out" such as "unable to be determined."
4. Avoid Yes/No questions. Writing a query in such a way that a physician can answer simple "yes" will leave you asking yourself "yes, what?" Was the condition ruled out? Does the patient still have that condition? Again, always offer response options if you can.
5. Quote the medical record word-for-word. When you quote word-for-word what was stated in the documentation that was in question, you avoid the risk of introducing information that was never there, to begin with. Which leads to the next tip…

Happy Coding!

References

- ICD-10-CM Official Guidelines for Coding and Reporting
- ICD-10-CM Monitor.com
- AHIMA query suggestions

Note: While the above education will assist the coder with accuracy each encounter may have specific variations of documentation for both diagnosis coding and/or procedure coding. Please note all encounters should be reviewed for possible query for clarification of **documentation in the health record for accurate code assignment.**