

January 31, 2013 · Revenue Cycle

Physician Query Examples

By **AHIMA**

A query can be a powerful communication tool used to clarify documentation in the health record and achieve accurate code assignments. This Practice Brief In Addition provides examples of the different forms of queries available to HIM professionals.

Example Verbal Query Documentation

The documentation of verbal queries should follow a standard format to include all necessary information.

Spoke with Dr. X regarding the documentation of _(condition/procedure)_ based upon the clinical indicator(s) found in the health record _(list what was found and where)_.

Example Open-Ended Query

A patient is admitted with pneumonia. The admitting H&P examination reveals WBC of 14,000; a respiratory rate of 24; a temperature of 102 degrees; heart rate of 120; hypotension; and altered mental status. The patient is administered an IV antibiotic and IV fluid resuscitation.

Leading: The patient has elevated WBCs, tachycardia, and is given an IV antibiotic for Pseudomonas cultured from the blood. Are you treating for sepsis?

Nonleading: Based on your clinical judgment, can you provide a diagnosis that represents the below-listed clinical indicators?

In this patient admitted with pneumonia, the admitting history and physical examination reveals the following:

WBC 14,000
Respiratory rate 24
Temperature 102° F
Heart rate 120
Hypotension
Altered mental status
IV antibiotic administration
IV fluid resuscitation

Please document the condition and the causative organism (if known) in the medical record.

Source: AHIMA. "Guidance for Clinical Documentation Improvement Programs." *Journal of AHIMA* 81, no.5 (May 2010): expanded web version.

Example Multiple Choice Query

A patient is admitted for a right hip fracture. The H&P notes that the patient has a history of chronic congestive heart failure. A recent echocardiogram showed left ventricular ejection fraction (EF) of 25 percent. The patient's home medications include metoprolol XL, lisinopril, and Lasix.

Leading: Please document if you agree the patient has chronic diastolic heart failure.

Nonleading: It is noted in the impression of the H&P that the patient has chronic congestive heart failure and a recent echocardiogram noted under the cardiac review of systems reveals an EF of 25 percent. Can the chronic heart failure be further specified as:

Chronic systolic heart failure_____

Chronic diastolic heart failure_____

Chronic systolic and diastolic heart failure_____

Some other type of heart failure _____

Undetermined_____

Source: AHIMA. "Guidance for Clinical Documentation Improvement Programs." *Journal of AHIMA* 81, no.5 (May 2010): expanded web version.

Example Yes/No Queries

Compliant Example 1

Clinical Scenario: A patient is admitted with cellulitis around a recent operative wound site, and only cellulitis is documented without any relationship to the recent surgical procedure.

Query: Is the cellulitis due to or the result of the surgical procedure? Please document your response in the health record or below.

Yes _____

No _____

Other _____

Clinically Undetermined _____

Name: _____ Date: _____

Rationale: This is an example of a yes/no query involving a documented condition potentially resulting from a procedure.

Compliant Example 2

Clinical scenario: Congestive heart failure is documented in the final discharge statement in a patient who is noted to have an echocardiographic interpretation of systolic dysfunction and is maintained on lisinopril, Lasix, and Lanoxin.

Query: Based on the echocardiographic interpretation of systolic dysfunction in this patient maintained on lisinopril, Lasix, and Lanoxin can your documentation of “congestive heart failure” be further specified as systolic congestive heart failure? Please document your response in the health record or below.

Yes _____

No _____

Other _____

Clinically Undetermined _____

Name: _____ Date: _____

Rationale: This yes/no query provides an example of determining the specificity of a condition that is documented as an interpretation of an echocardiogram.

Compliant Example 3

Clinical scenario: During the removal of an abdominal mass, the surgeon documents, in the description of the operative procedure, a “serosal injury to the stomach was repaired with interrupted sutures.”

Query: In the description of the operative procedure a serosal injury to the stomach was noted and repaired with interrupted sutures. Was this serosal injury and repair:

A complication of the procedure _____

Integral to the above procedure _____

Not clinically significant _____

Other _____

Clinically Undetermined _____

Please document your response in the health record or below accompanied by clinical substantiation.

Name: _____ Date: _____

Rationale: This is an example of a query necessary to determine the clinical significance of a condition resulting from a procedure.

Non-Compliant Example 1

Clinical scenario: On admission bilateral lower extremity edema is noted, however, there are no other clinical indicators to support malnutrition.

Query: Do you agree that the patient's bilateral lower extremity edema is diagnostic of malnutrition? Please document your response in the health record or below.

Yes _____

No _____

Other _____

Clinically Undetermined _____

Name: _____ Date: _____

Rationale: Malnutrition is not a further specification of the isolated finding of a bilateral lower extremity edema. An open-ended or multiple choice query should be used under this circumstance to ascertain the underlying cause of the patient's edema.

Non-Compliant Example 2

Clinical scenario: A patient is admitted with an acute gastrointestinal bleed, and the hemoglobin drops from 12 g/dL to 7.5 g/dL and two units of packed red blood cells are transfused. The physician documents anemia in the final discharge statement.

Query: In this patient admitted with a gastrointestinal bleed and who underwent a blood transfusion after a drop in the hemoglobin from 12 g/dL on admission to 7.5 g /dL, can your documentation of anemia be further specified as an acute blood loss anemia? Please document your response in the health record or below accompanied by clinical substantiation.

Yes _____

No _____

Other _____

Clinically Undetermined _____

Name: _____ Date: _____

Rationale: In this example, a yes/no query is not appropriate for specifying the type of anemia. A multiple-choice or open-ended query is a better option.

Non-Compliant Example 3

Clinical Scenario: In the ED, a foley catheter was inserted for the patient with dysuria and elevated WBCs that was removed two days after admission. The cultures were positive for E.coli and the progress note reflect a catheter associated urinary tract infection (CAUTI) and this was coded. Quality has requested review of the HAC condition to ensure it should be coded as it does not meet the CDC definition for CAUTI.

Query: The quality department has indicated that your documented diagnosis of CAUTI does not meet the CDC definition which impacts the Hospital Acquired condition statistics for your profile as well as the hospital. Does your patient have a catheter associated urinary tract infection?

Yes _____

No _____

Other _____

Clinically Undetermined _____

Name: _____ Date: _____

Rationale: This query is inappropriate as it explains the impact of the addition or removal of the diagnosis for the physician and hospital profiles. This query questions the physician's clinical judgment which may be more appropriate in an escalation policy and/or physician education regarding the CDC definition of CAUTI.

[box type="info"] For more content on clinical documentation improvement topics, check out the *Journal of AHIMA* blog "[Documentation Detective](#)." This monthly blog discusses the components of quality clinical documentation with a comprehensive approach to cover all areas of the healthcare industry.[/box]

