

Missing, Conflicting & Incomplete Documentation: When to Query

A compliant query clarifies the record. It does not manufacture support for a code.

WHY THIS MATTERS

Anesthesia coding frequently depends on details that are easy to omit: exact procedure, anatomical target, anesthesia time, provider participation, postoperative-pain intent, catheter technique, ultrasound documentation, or the patient's clinical status. When a material fact is missing, unclear, or conflicting, the coder should not guess. A compliant clarification process protects both coding accuracy and record integrity.

THE CODING TIP

Query for clarity - not for reimbursement. The purpose of a query is to obtain clinically accurate documentation when the existing record cannot support a definitive coding decision. The question should be neutral, supported by the record, and should not steer the practitioner toward a particular code or billable answer.

THE 5-QUESTION QUERY TEST

01	IS THE FACT MATERIAL?	Would the missing or conflicting information change the code, modifier, units, care model, medical necessity, or whether a service is separately reportable?
02	CAN THE EXISTING RECORD ANSWER IT?	Review the relevant anesthesia, procedure, operative, nursing, and ancillary documentation before querying.
03	IS THE DOCUMENTATION UNCLEAR, INCOMPLETE, OR CONFLICTING?	A query should resolve a genuine documentation issue—not replace routine coder research.
04	CAN THE QUESTION BE ASKED NEUTRALLY?	Present relevant clinical facts and reasonable options without signaling a preferred reimbursement outcome.
05	WILL THE RESPONSE BECOME PART OF THE COMPLIANT RECORD?	Follow organizational policy for authentication, timing, retention, and incorporation of the clarification.

THREE DIFFERENT DOCUMENTATION PROBLEMS

PROBLEM	WHAT IT LOOKS LIKE	CODER RESPONSE
Missing	A required coding fact is absent.	Determine whether clarification is appropriate under policy.
Incomplete / vague	Some information exists, but not enough to select the code confidently.	Clarify the specific unresolved fact.
Conflicting	Two parts of the record materially disagree.	Do not choose the version that produces the expected result; resolve the conflict.

ANESTHESIA-SPECIFIC REASONS A QUERY MAY BE APPROPRIATE

- Anesthesia start or stop time is missing or materially conflicting.
- The final procedure differs from the scheduled procedure and the anesthesia documentation is unclear.
- A regional block name is documented but the nerve, plexus, branch, or fascial plane cannot be determined.
- Single-injection versus continuous-catheter technique is unclear.
- Postoperative-pain intent or the relationship of the block to the primary anesthetic is unclear when it affects reporting.
- Provider participation or the reported medical-direction/supervision care model cannot be established.

- The documented physical-status modifier materially conflicts with the clinical assessment.
- TEE, invasive line, ultrasound guidance, or another separately reported service lacks a code-defining detail.
- Laterality or the number of distinct procedures cannot be determined.
- An operative note, anesthesia record, and procedure note contain material contradictions.

WHEN A QUERY IS NOT THE RIGHT TOOL

- The coder simply needs to research the correct CPT/ASA code from documentation that is already complete.
- The answer can be established from another valid part of the existing record under applicable policy.
- The question is being asked only because a different answer would increase reimbursement.
- The desired response would require the practitioner to document something that did not occur.
- The query is being used to routinely repair weak templates rather than correcting the underlying documentation process.
- The coder is asking the provider to choose a billing code rather than clarify the clinical facts.

NEUTRAL VS LEADING

Neutral concept: “The block note documents an injection in the posterior knee region. Please clarify the anatomical neural target or tissue plane, if clinically determinable from the procedure performed.”

Leading concept to avoid: “Please document that this was a sciatic nerve block so CPT 64445 can be billed.”

The first asks for the clinical fact. The second supplies both the desired diagnosis/procedure characterization and the reimbursement consequence.

THE QUERY SHOULD NOT TEACH THE ANSWER

Educational feedback and provider queries serve different purposes. If a recurring documentation problem exists, address it through education, templates, tip sheets, or workflow improvement. Keep the individual query focused on accurately clarifying that patient's record.

CODER'S TIP

Ask for the missing FACT, not the missing CODE. “What nerve was targeted?” is a documentation question. “Can we bill 64445?” is a coding question. Keeping those roles separate makes the clarification more defensible.

QUICK EXAMPLE

Scenario: The block header says “adductor canal,” but the body of the note describes anatomy that could support more than one interpretation and never identifies the intended neural target.

Coding point: Do not select a code from the header alone. If the existing record cannot resolve the target, use the organization's compliant clarification process to ask for the clinical anatomy rather than suggesting a CPT code.

QUERY DOCUMENTATION SHOULD BE TRACEABLE

- Identify the patient/encounter according to organizational policy.
- Reference the relevant clinical facts already present in the record.
- State the specific area requiring clarification.
- Offer clinically reasonable choices when permitted, including an option such as other/clinically unable to determine when appropriate.
- Avoid reimbursement language or a preferred answer.
- Retain and authenticate the query/response according to organizational and payer requirements.

AUDITOR'S RED FLAGS

- Queries are sent only when they could increase reimbursement.
- Providers receive code numbers or expected modifiers in the question.
- Late queries repeatedly create support for medical direction, postoperative pain, or separately billable services.
- Query responses contradict contemporaneous documentation without explanation.
- Identical answer choices are used regardless of the clinical facts.
- Clarifications are not retained or cannot be traced to the practitioner who responded.
- Coders routinely infer missing facts instead of following the clarification policy.

AUTHORITATIVE RESOURCES

- AHIMA/ACDIS Guidelines for Achieving a Compliant Query Practice - use current guidance for compliant query principles.
- CMS Medicare documentation and program-integrity guidance applicable to medical-record amendments and corrections.
- Current payer policy/contract - verify any payer-specific documentation and clarification requirements.
- Organizational compliant-query, amendment, authentication, and coding policies.

BOTTOM LINE

When the record leaves a coding fact unanswered: clarify it - don't create it.

Chart Talk ~ Anesthesia Coding Conversations | Lead. Educate. Comply. Excel.

Educational use only. Verify current CMS, AHIMA/ACDIS, payer-specific, facility, and organizational query/documentation requirements for the applicable date of service. This resource is not a substitute for official coding, compliance, legal, clinical, or payer guidance.