AHIMA OUTPATIENT QUERY
TOOLKIT

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ACKNOWLEDGMENTS

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CHAPTER 1: INTRODUCTION

Querying the provider is a standard procedure and a common theme in a clinical documentation improvement (CDI) and coding professional's practice. A compliant query process benefits the hospital's and provider's compliance with billing/coding rules and serves as an educational tool for providers, CDI, and coding professionals. The accuracy of data and reimbursement is ensured when the highest level of specificity is documented and coded, and this accuracy is often achieved through the query process. Additionally, having providers understand the importance of query communications in promoting the highest level of accuracy and improving compliance with regulations and reported data is vital to a successful CDI program.

The AHIMA practice briefs "Guidelines to Achieving a Compliant Query Practice" and "Clinical Validation: The Next Level of CDI" should be followed when developing queries.

With the shift from fee-for-service to value-based models, payors are beginning to use and rely on reported data to evaluate a provider's ability to offer quality care while effectively managing the costs of care. The trend in cost/quality balancing has resulted in pushing more services from the hospital inpatient setting to an outpatient environment. Historically, in the inpatient setting, the process of querying has been performed either through paper or through the electronic health record (EHR). The query process has become a common practice to address ambiguity in documentation practices by providers. However, as healthcare continues to evolve with a stronger focus on containing the costs of quality care across the continuum of care, CDI and the art of querying are now expanding beyond the inpatient setting to include hospital outpatient clinics, physician clinics, emergency departments, ambulatory surgery centers, hospital observation, and other outpatient care settings. Therefore, providers across the healthcare spectrum need to be educated about the importance of documentation improvement.

Quality outpatient documentation requires complete, accurate, and specific diagnoses; identification of the relevant components of the patient's history; correct determination of the extent of the physical examination; selection of the level of medical decision-making; and procedural service details. CDI professionals come from a variety of backgrounds and experience: HIM, nursing, physician, etc. To achieve complete and accurate clinical documentation, CDI professionals will have to expand their provider education to include required documentation elements for an outpatient encounter (visit). For example, the physician query process in the outpatient setting will not only support the diagnosis for medical necessity and the treatment or services rendered but also the required documentation elements for the accurate reporting of the Current Procedure Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and modifier codes, which are the foundation of the Medicare Ambulatory Payment Classification (APC) reimbursement system in the outpatient setting.[1]

Recovery Audit (RA) program auditors are not only checking the accuracy of the clinical coding but also validating the diagnoses for clinical reasonableness and medical necessity. Accurate documentation is vital. There will be times when documentation improvement and specificity are needed to support the encounter. A coordinated effort should be established between the provider and the CDI professional for timely interaction, which will be key to obtaining improved documentation in outpatient care. Therefore, an EHR may provide advantages for primary care physicians treating their patients in the emergency department (ED), as the ED documentation may be accessed from the office setting in real time. Regardless of the tools, working through the processes and steps to develop a smooth line of communication will take effort and dedication.

Time is limited for CDI professionals in the outpatient setting. Outpatient encounters are shorter and can occur in a significant number of focus areas. For example, hospital outpatient encounters will move to "discharge" at a much quicker pace than in the inpatient setting and may not allow an opportunity for CDI to review and/or re-review the documentation in a timely manner.

Dependent on the organization's policy and procedure, CDI queries may be performed:

- Concurrently: CDI review during an encounter
- Retrospectively: CDI review after an encounter

CDI teams may wish to perform a CDI review prospectively (prior to an encounter) to monitor for potential documentation gaps that may require a concurrent and/or retrospective query. (It would not be appropriate to send a query prior to the provider entering the documentation.) A prospective review may allow a CDI professional to identify opportunities for further clarifications and/or opportunities to remind the provider of the importance of documenting both acute (active) and chronic conditions that are continuously managed by either home medications and/or monitoring (e.g., hypertension, hyperthyroidism, etc.).

Performing retrospective reviews may allow a larger number of encounters to be reviewed, but they can heighten provider query fatigue due to an increased number of queries. Retrospective queries can disturb a provider's workflow with additional documentation after a patient's encounter.

Finally, CDI programs that choose to perform concurrent record reviews will need to prioritize specific encounters to review, which will assist in managing the volume of patient encounters and prioritizations of the reviews.

CHAPTER 2: OFFICIAL CODING GUIDELINES IN THE OUTPATIENT SETTING

The ICD-10-CM official coding guidelines are used for coding and reporting of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) in both the inpatient and outpatient settings. The coding guidelines are organized into four sections for easy reference. Below is the breakdown of the sections and, as shown below, Section I is used for all settings, and Section IV contains specific guidelines for the outpatient setting.

- Section I includes "conventions, general guidelines and chapter specific guidelines applicable to all health care settings unless otherwise indicated"[2]
- Section II includes guidelines for selection of principal diagnosis in the inpatient setting
- Section III includes guidelines for reporting additional diagnoses in the inpatient setting
- Section IV is for outpatient coding and reporting

The general coding guidelines instruct that "the appropriate code or codes from A00.0 through T88.9, Z00-Z99 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit." Frequently, in the outpatient setting, a specific diagnosis is not identified at the time of the encounter, but coding professionals are still required to submit the most specific diagnosis, condition, problem (e.g., sign or symptom) that is documented in the health record to be chiefly responsible for the patient's encounter/visit. Additional codes that describe any co-existing conditions (e.g., secondary diagnoses for chronic diseases) documented in the health record will also be reported.

As stated above, Section IV of the coding guidelines is specific to outpatient settings. According to the official coding guidelines, "the terms encounter and visit are often used interchangeably in describing outpatient service contacts." The guidelines also state, "though the conventions and general guidelines apply to all settings, coding guidelines for outpatient and provider reporting of diagnoses will vary in a number of instances from those for inpatient diagnoses."[3] They recognize that:

- The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis applies only to inpatients in acute, short-term, and long-term care, as well as psychiatric hospitals.
- In the outpatient setting, the first-listed diagnosis is the term used in the place of principal diagnosis.
- Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.
- In the outpatient setting, diagnostic tests with a confirmed diagnosis or diagnoses documented in the final report that have been interpreted by a physician at the time of coding can be coded.

Diagnoses are often not established at the time of the initial provider encounter/visit. It may take two or more encounters before the diagnosis is confirmed, and therefore all coding prior to the confirmed diagnosis may involve signs and symptoms codes. ICD-10-CM codes that describe symptoms and signs are acceptable for reporting purposes when a diagnosis has not been confirmed and/or established by the provider.

Section IV provides specific guidance on how to report patients receiving only diagnostic services, therapeutic services, preoperative evaluations, outpatient surgeries, and observation. Here are some helpful documentation hints for such outpatient services:

- When a patient presents for outpatient surgery (same-day surgery), it is important that the reason for the surgery is clearly documented (reason for the encounter), even if the surgery is not performed due to a contraindication. In addition, if the patient develops complications after surgery, the complication needs to be documented so that it can be reported as a secondary diagnosis.

- When a patient is admitted for observation for a medical condition, providers need to clearly document all medical conditions and treatment/plan of care to support the observation stay and meet medical necessity.

As a CDI professional, it is important to recognize that the major difference in outpatient versus inpatient coding is the reporting of abnormal findings and uncertain diagnoses. In the outpatient setting, diagnoses documented as "probable," "suspected," "questionable," "rule out," "working diagnosis," or other similar terms indicating uncertainty cannot be coded. Instead, the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or another reason for the visit, will be reported.

Additionally, CDI professionals must understand that it is very important for a coding professional to code all documented conditions that coexist at the time of the encounter/visit and/or affect the management of care for the patient. Conditions that were previously treated and no longer exist will not be reported; therefore, it is important for CDI professionals to ensure that any ongoing treatment of chronic diseases is accurately documented for each encounter/visit. The reporting of these conditions may impact the patient's overall risk score and severity of illness.

CHAPTER 3: KEY COMPONENTS FOR CPT E/M CODE SELECTION IN THE OUTPATIENT SETTING

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CDI professionals need to know and understand that there are three key components for selecting a particular CPT evaluation and management (E/M) code in most outpatient settings, including the emergency department and physician clinics. (Facility E/M criteria may be different.) These include:

- History
- Physical exam
- Medical decision-making

There are four additional components: counseling, coordination of care, nature of the presenting problem, and time. However, time is not used as a component for the emergency department, since a variety of patients may be treated simultaneously by one provider, and actual face-to-face professional service time is difficult to measure.[4]

History

The history is designed to act as a narrative that provides information about the clinical problems or symptoms being addressed during the encounter. History of present illness (HPI) should be obtained and documented by:

- Location
- Quality
- Duration
- Modifying factors
- Timing
- Associated signs and symptoms
- Severity
- Context

Review of Systems (ROS)

As a screening tool at the E/M visit, a physician asks a list of questions, arranged by organ system, designed to identify diseases or conditions. Often the screening is limited based on the patient's risk factors (age, gender, previous illness). Documentation included in the history of present illness (HPI) should include assessments of some of the following systems:

- Constitutional
- Musculoskeletal
- Eyes
- Integumentary (skin)
- Ear, nose, throat
- Neurological
- Cardiovascular
- Psychiatric
- Respiratory
- Endocrine
- Gastrointestinal
- Hematologic/Lymphatic
- Genitourinary
- Allergy/Immunology

Past Medical History, Family History, and Social History (PFSH)

The past medical history will include a review of past illnesses, operations, or injuries, which may include documentation of the following:

1. Prior illnesses or injuries
2. Prior operations
3. Prior hospitalizations
4. Current medications
5. Allergies
6. Age-appropriate immunization status
7. Age-appropriate feeding/dietary status

The family history documentation will include a review of medical events in the patient's family, which may include information about the following:

1. The health status or cause of death of parents, siblings, and children
2. Specific diseases related to problems identified in the chief complaint, HPI, or ROS
3. Diseases of family members that may be hereditary or place the patient at risk

The social history would be an age-appropriate review of the patient's past and current activities, which may include significant information about:

1. Marital status and/or living arrangements
2. Current employment
3. Occupational history
4. Use of drugs, alcohol, or tobacco
5. Level of education
6. Sexual history
7. Other relevant socioeconomic factors

PHYSICAL EXAMINATION

The physical examination will usually fall into one of four categories:

1. **Problem-Focused:** Under the 1997 guidelines, documentation should include one to five assessments from one or more organ systems or a general constitutional listed below.

The 1997 E/M guidelines recognize the following constitutional (general review) and 14 organ system reviews for examinations:

Constitutional (general review)

1. Eyes
2. Ears, nose, mouth, and throat
3. Neck
4. Respiratory
5. Cardiovascular
6. Chest (breasts)
7. Gastrointestinal (abdomen)
8. Genitourinary (male)
9. Genitourinary (female)
10. Lymphatic
11. Musculoskeletal
12. Skin
13. Neurologic
14. Psychiatric

2. **Expanded Problem-Focused:** Under the 1997 guidelines, documentation should include at least six assessments from any one organ system and basic constitutional.

3. **Detailed:** Under the 1997 guidelines, documentation should include at least two assessments from six organ systems, or 12 assessments from two or more organ systems and general constitutional.

4. **Comprehensive:** Under the 1997 guidelines, documentation should include at least two assessments from nine of the 14 organ systems and general constitutional.

Medical Decision-Making (MDM)

MDM reflects the intensity of the cognitive labor performed by the physician. The documentation should reflect the medical decision-making by the nature and number of clinical problems, the amount and complexity of the data reviewed by the physician, and the risk of morbidity and mortality to the patient.

Within the standards of clinical practice, the physician should acknowledge the review of clinical data such as the laboratory results, radiology reports, and/or ancillary tests (EKG, Echo, etc.,); discuss such results with the performing physician; independently review images, tracings, and/or specimens; and review any old records obtained. This is all part of the MDM and demonstrates the work of the physician in providing patient care.

Thus, having the MDM documented is critical in selecting the correct E/M level of care. If the level of MDM is missing from the record, a physician query can be initiated by the coding or CDI professional, depending on the practice.

CHAPTER 4: SOME EXAMPLES OF OUTPATIENT SETTINGS

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4.1 HOSPITAL OBSERVATION

Observation status is a designation used by hospitals that is considered an outpatient service billed to Medicare Part B and paid under OPPS methodology. CMS defines observation status as "a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital."[5]

In 2013, Medicare developed the "two-midnight rule" due to the rise in observation stays. The two-midnight rule states that "for patients expected to require hospital services for at least two midnights, inpatient admission will be presumed appropriate for payment. Likewise, for patients expected not to require hospital services for at least two midnights, outpatient observation is presumed appropriate."[6] Documentation must support why a two-midnight stay is expected.

Documentation created during this time frame is critical in order to support the need for subsequent admission of a patient previously in observation status. Providers are often nonspecific in their documentation, causing unspecified codes to be assigned during the coding process. The provider will need to be queried for clarification to differentiate between symptoms versus diagnoses. For example, "chest pain, elevated troponins, treat" is not specific enough for an appropriate code to be assigned. Chest pain should never be the reason for an inpatient admission, as it is a symptom of other underlying conditions such as angina, pneumonia, or congestive heart failure.

4.2 EMERGENCY DEPARTMENT

Emergency department documentation by attending and primary care physicians (PCPs) is critical for the continuum of care. The ED health record serves multiple purposes. Primarily, the documentation aims to accurately paint the picture of the patient care for that encounter and to illuminate a course either for inpatient admission or patient discharge instructions. The PCP may at times come to the ED to see their own patient, and thus the diagnosis, E/M, and procedure documentation are essential for office billing and claim processing.

A preliminary diagnosis in the ED will most likely be related to the patient's "chief complaint." The chief compliant is an important piece of documentation, obtained either directly from the patient or an accompanying family member or friend. In the ED record, it should be a very concise statement that describes the problem, symptom(s), and/or reason the patient came into the emergency department to be seen and treated.

The impression of the attending/primary physician regarding this chief complaint, condition, or symptoms will lead to the first-listed diagnosis. The first-listed diagnosis is the condition treated or investigated during the relevant episode of care. It is documented by the physician as the "diagnosis" or "assessment" in the progress note (of the physician documentation section of the patient record).[7]

According to the ICD-10-CM official coding guidelines, if no definitive diagnosis can be ascertained by the physician, then the main symptom, abnormal findings, or problem is used as the diagnosis. Because ED cases are considered outpatient patient care, suspected diagnoses, rule-out conditions, or qualified diagnoses (where ancillary tests or lab results are needed to establish a definitive diagnosis) are not considered as the official ICD-10-CM diagnoses. In addition, the diagnostic impression will assist in supporting medical necessity for the encounter.

Although the diagnosis is a critical component for proper documentation in the ED record, payment for outpatient care for Medicare patients is based on the APC system through CPT procedure and service codes. Based on CPT guidelines, the first-listed service for ED cases is coded from CPT Level I Codes in the E/M Section.

> *To ensure that healthcare data are captured accurately and consistently and that health claims are processed properly for Medicare, Medicaid, and other health programs, a standardized coding system for medical services and procedures is essential. CPT, developed by the American Medical Association (AMA), is used for just these purposes.*[8]

Evaluation and Management (E/M) Codes in the Emergency Department

When patients have multiple comorbidities, the list of signs and symptoms may be lengthy. The documentation elements detailed require the CDI professionals to have knowledge of the E/M coding to some degree. Complete and thorough documentation is of the utmost importance for the selection of the correct E/M service levels.

Specifically, ED documentation demonstrates three key components: the extent of the history, physical exam, and medical decision-making. The various levels of E/M services impact reimbursement as well as the course of care for review by other providers and healthcare professionals who will subsequently be caring for the patient. Once the patient is seen by the ED physician, the patient's own primary care physician, or consulting physician, all signs and symptoms should be documented.

For most cases, face-to-face E/M professional services are distinguished by whether the patient is a new or established patient of the physician or the provider's practice.[9] However, E/M services provided in the ED do not differentiate, as all patients are treated as "new patients." Therefore, all three of the key components must exist in selecting the appropriate level of care. Additionally, as mentioned previously, time does not play a factor in the ED, since it may be difficult to establish the amount of time spent on individual patients in a busy ED when multiple patients are being served simultaneously.

ED Surgical Procedure: Physicians

ED PROCEDURES

Although the ED physician(s) and advance practice providers will most often perform surgical procedures in the ED, there may be times when the patient's primary care physician or a consultant will be asked to come into the ED and provide surgical services (procedures).

ED procedures can include a broad range of services from setting a fracture, laceration repair, or incision and drainage, to stopping a hemorrhage, cerumen removal, or intubating the critically ill. Due to the urgent needs of the patient, often the ED physician will take on the immediate responsibility of the direct patient care with the initial evaluation, rather than the primary care physician.

The outpatient procedure documentation will be the foundation for the procedural CPT and HCPCS codes that will be assigned and reported. These CPT codes will drive the outpatient reimbursement for services provided and provide insight into a variety of quality initiatives and monitoring. The diagnosis codes are the primary link to medical necessity for these procedural services.

It is beneficial to run a data report (from the hospital data base if possible) to pull the top 25 surgical procedures (via CPT codes, excluding E/M) that are performed in the ED with the physician identifier and determine what percentage of these procedures were performed by patients' primary care physicians. This can provide some insight into the severity and level of procedures often performed, so that an initial documentation review can be focused. Depending on the outcome, the CDI and/or coding professional will want to analyze the findings from a documentation perspective and identify improvement opportunities.

CHAPTER 5: WHEN TO QUERY IN THE OUTPATIENT SETTING

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Queries will be initiated as a result of identified documentation gaps. Queries may be required in situations such as:

- Documentation that is conflicting, contrasting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Clinical indicators of a diagnosis, but no documentation of the condition
- Only the treatment is documented without a diagnosis documented (e.g., Lisinopril documented as a refill medication, but no documentation of hypertension)
- Clinical evidence for a higher degree of specificity or severity
- Uncertainty of a cause-and-effect relationship (e.g., urinary tract infection with a urinary catheter)
- When it appears, a documented diagnosis is not clinically validated
- Present on admission indicator status (e.g., in the ED/observation setting, in the event the patient gets admitted as an inpatient)
- An order for test or procedure without further documentation in the record or plan of treatment

Additionally, it may be appropriate to generate a provider query when documentation in the patient's health record fails to meet one of the following seven criteria identified below:

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

Provider documentation entries in the health record should:

Address clinical significance of abnormal test results

- Support the intensity of patient evaluation and treatment, and describe the thought process and complexity of medical decision-making
- Include all diagnostic and therapeutic procedures, treatments, and tests ordered and performed in addition to the results
- Include any changes in the patient's condition, including psychological and physical symptoms
- Include all conditions that coexisted at the time of the visit and were monitored, evaluated, assessed, or treated

The Query Process

Queries may be performed in a written format, electronically, or verbally by the CDI professional. Outpatient queries may be generated in a variety of ways:

- Concurrent (while the patient is being seen by the provider)
- Retrospective (post-visit)

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Written and e-mail queries will be generated by following and utilizing compliant query templates.

Provider query templates in this toolkit may only be edited as follows:

• Deletion of any part of the query template that is not pertinent to the query

• Addition of any pertinent clinical findings as documented in the health record

Verbal queries will follow the same format as written queries.

All queries should:

• Be clear, concise, and non-leading

• Be simple and direct

Itemize the clinical indicators or clues (e.g., documentation of high blood pressure found in nursing intake documentation, but not mentioned in the primary provider's documentation, lab findings, radiological findings, etc.) from the health record

The query should contain all of the patient's identifying information such as name, date of visit, discharge date (if applicable for observations), etc., as well as clear, concise itemization of the clinical findings with supporting documentation resulting in a specific query question for the provider.

The query should include the contact information of the individual generating the query to the provider (e.g., name, title, email, telephone number, etc.).

Queries may be initiated by either CDI or coding professionals.

All queries (verbal and written) will be logged for follow-up to track responses and to trend for any documentation issues that may indicate additional documentation improvement educational opportunities for providers or overuse of queries by CDI or coding professionals.

CHAPTER 6: INSTRUCTIONAL STEPS TO USE THE QUERY TEMPLATES

These query templates are meant to be a guide in developing queries and may be used as a guide to create query templates within your own query tool. Remember to add any disclaimer and identification (e.g., logo) required by your organization any relevant patient demographics. It is important to note that each query should be developed, whether it is electronic or in another format (e.g., paper or verbal), according to the policies and procedures of your organization and AHIMA's practice briefs. Enlist your compliance leadership to help assess your queries, whether paper or electronic, to determine that they are compliant and non-leading. You may follow this link to download a Microsoft® Word version of this document.

Note: The clinical indicators included in the query examples within this toolkit are not all-inclusive; all pertinent clinical indicators identified in the health record should be included within the query. *(Please refer to example 1, example 2, and example 3 on the next page to visualize the steps within the query template.)*

1. Thoroughly review the health record (encounter) and identify a query opportunity following the guidance and criteria outlined in AHIMA's "Guidelines for Physician Office Query Practice" and "Guidelines for Achieving a Compliant Query Practice."

2. Click on the query template that best fits your query need.

3. **Example 1: Use of Drop-Down Template:** Fill in each section of the query to add the specificity needed for each patient. Free text can be added to any section; each query should include all the clinical indicators used to support the query. Click on the free text or drop-down box to insert the query specific information.

   a. Insert the provider name into the free text box.

   b. Insert the unspecified documentation, such as CHF and/or conflicting documentation, that requires clarification within the free text box.

   c. Add the date(s) and location(s) of the unspecified documentation within the free text box.

   d. Add the pertinent clinical indicators identified from the current health record/visit. There are a series of drop-down boxes with frequently seen indicators for each template. Only one choice per drop-down is available. There is also a free text box for additional indicators/treatment. If any of the drop-downs are not needed, right click and remove.

   e. The next drop-down box is a list of questions that can be chosen; choose the one that best describes the question you wish to ask the provider.

   f. Enter the reasonable diagnostic options. There are two reasonable diagnostic options provided in the template. If needed, additional reasonable diagnostic options may be added before the "Other explanation of clinical findings" option.

   g. For option "Other explanation of clinical findings," the provider may enter another reasonable diagnostic option that was not listed as an option within the free text box.

4. **Example 2: Free Text Template:** Fill in each section of the query to add the specificity needed for each patient. You can add free text to any section; each query should include all the clinical indicators used to support the query. Click on the free text box to insert the query-specific information.

    a. Insert the provider name into the free text box.

    b. Insert the unspecified documentation such as CHF and/or conflicting documentation that requires clarification within the free text box.

    c. Add the date(s) and location(s) of the unspecified documentation within the free text box.

    d. Add the pertinent clinical indicators identified from the current health record/visit. There are free text boxes for clinical indicators and additional indicators/treatment. If any of the free text boxes are not needed, right click and remove.

    e. Type the question you wish to ask the provider in this free text box.

    f. Enter the reasonable diagnostic options. There are two reasonable diagnostic options provided in the template. If needed, additional reasonable diagnostic options may be added before the "Other explanation of clinical findings" option.

    g. For option "Other explanation of clinical findings," the provider may enter another reasonable diagnostic option that was not listed as an option within the free text box.

5. **Example 3: Open-Ended Templates for the Following Scenarios:**

    • Clarify documentation of diagnosis in problem list, or

    • Whether a condition was monitored during the encounter, or

    • Lack of associated diagnostic statement, or

    • Confirmation of pathology report findings

Fill in each section of the query to add the specificity needed for each patient. You can add free text to any section; each query should include all the clinical indicators used to support the query. Click on the free text box to insert the query specific information.

    a. Insert the provider name into the free text box.

    b. Insert the specific documentation that requires clarification and/or documented treatment with no associated diagnosis.

    c. Add the date(s) and location(s) of the unspecified documentation.

    d. Add the pertinent clinical indicators identified from the current health record/visit. There are free text boxes for clinical indicators and additional indicators/treatment. If any of the free text boxes are not needed, right click and remove.

    e. The next drop-down box is a list of questions that can be chosen; choose the one that best describes the question you wish to ask the provider, or you may choose to use free text.

EXAMPLE 1: USE OF DROP DOWN QUERY TEMPLATE

This template will allow a CDI professional to select prepopulated clinical indicators and a question, along with the ability to free text documentation, location of documentation, other indicators/risk factors, and reasonable options.

a. Insert provider name

b. Insert the unspecified documentation and/or conflicting documentation that requires clarification

c. Add the date and location of the unspecified documentation

Dear Click here to enter text:

Click here to enter text: was documented within the Click here to enter text:

Clinical Indicator(s): Clinical Indicators:

Clinical Indicators:

Risk Factors:

Additional Risk Factors:

Treatment:

Treatment:

Additional Treatment(s):

d. Add the pertinent clinical indicators identified from the current medical record in this section. Only one choice per drop-down is available. There is a free text box for additional indicators. If any of the drop-downs are not needed, right click and remove. Drop-down selections can be edited; these are only examples.

Based on the clinical indicators and your professional judgment Please complete by selecting one of the options below.

Questions:

e. Choose the correct question to post in the query.

- Click here to enter text:
- Click here to enter text:

f. Free text reasonable diagnostic options. These options should support the query as being non-leading in terms of diagnosis option provided.

- Findings of no clinical significance (optional): *This option may or may not be included in a query. This option was developed to be used when clarifying the clinical significance of abnormal findings.*

- Other explanation of clinical findings Click here to enter text: (required) *This is a required option for multiple choice queries. This provides an option for providers to document a greater level of specificity that was not provided as an option on the query.*

- Unable to determine (required): *This is a required option for multiple-choice queries. This option is for providers to utilize when there is a need for further specificity but there is not enough clinical evidence to determine the level of specificity.*

- No further clarification needed (optional): *This option may or may not be included in a query. It was developed to assist organizations who want to track a disagreement rate. When a provider chooses "no further clarification is needed," this means they do not agree with the need for a query.*

EXAMPLE 2: USE OF FREE TEXT QUERY TEMPLATE

This template will allow a CDI professional to enter clinical indicators, reasonable options, and clarification questions as free text.

a. Insert provider name

b. Insert the unspecified documentation and/or conflicting documentation that requires clarification

Dear Click here to enter text:

Click here to enter text: was documented within the   Click here to enter text:

c. Add the date and location of the unspecified documentation

Clinical Indicators: Clinical Indicators: Clinical Indicators: Additional Indicators: Risk Factors:

Additional Risk Factors: Treatment: Additional Treatment:

d. Add the pertinent clinical indicators identified from the current medical record in this section. You can enter free text for these specific indicators. If specific sections (e.g., appearance, signs and symptoms, etc.) are not needed, right click and remove.

Based on the clinical indicators and your professional judgment Add compliant question here
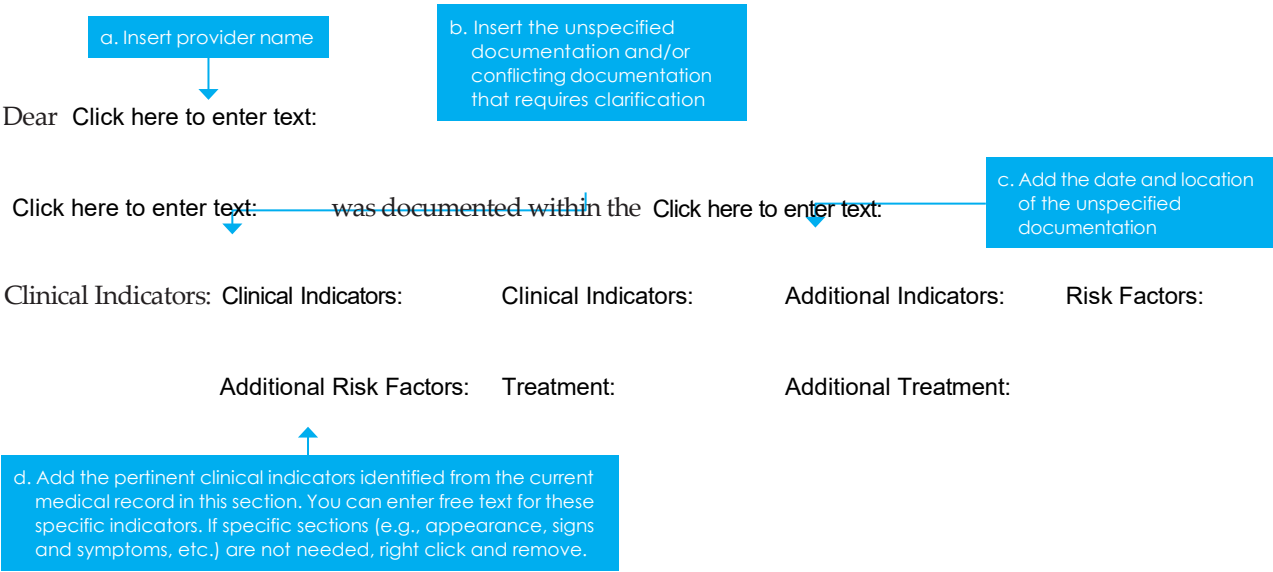Please complete by selecting one of the options below.

e. Type the question you wish to ask the provider in this free text box.

- Click here to enter text:
- Click here to enter text:
- Findings of no clinical significance
- Other explanation of clinical findings Click here to enter text:
- Unable to determine

f. Free text reasonable diagnostic options

g. The provider may enter a reasonable diagnostic option that was not listed as an option in this text box.
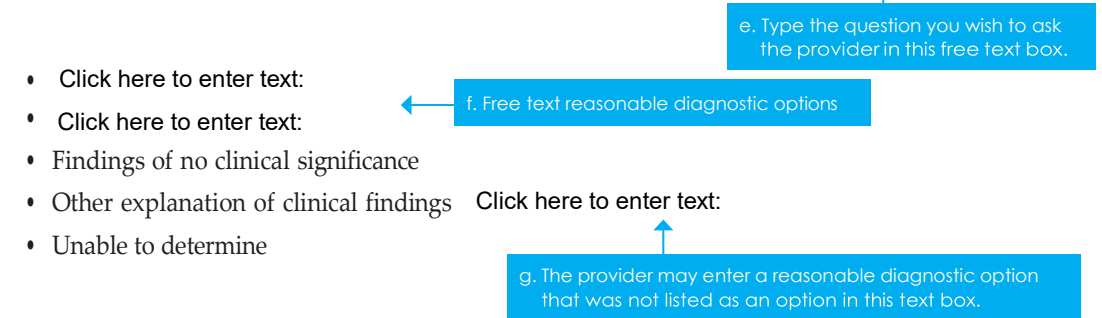
EXAMPLE 3: USE OF OPEN-ENDED QUERY TEMPLATE FOR THE FOLLOWING SCENARIOS:

- Clarify documentation of diagnosis in problem list, or
- Whether a condition was monitored during the encounter, or
- Lack of associated diagnostic statement, or
- Confirmation of pathology report findings

a. Insert provider name

b. Insert the specific documentation that requires clarification and/or documented treatment with no associated diagnosis.

Dear Click here to enter text:

c. Add the date and location of the unspecified documentation

Click here to enter text: was documented within the   Click here to enter text:

Clinical Indicators: Clinical Indicators: Clinical Indicators: Additional Indicators: Risk Factors:

Additional Risk Factors: Treatment: Additional Treatment:

d. Add the pertinent clinical indicators identified from the current medical record in this section. You can enter free text for these specific indicators. If specific sections (e.g., appearance, signs and symptoms, etc.) are not needed, right click and remove.

If appropriate, please Questions: OR Click here to enter text:

e. Choose the correct question to post in the query or you can free text the question.

CHAPTER 7: GENERIC TEMPLATE

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7.1 : DROP-DOWN QUERY TEMPLATE

Dear (add provider(s) name)

Identify the opportunity   was documented within the   Reference document location(s)

Clinical Indicator(s): | Clinical Indicators: | Clinical Indicators: | Additional Indicators: |

Risk Factors:

Additional Risk Factors: Treatment: Treatment: Additional Treatment
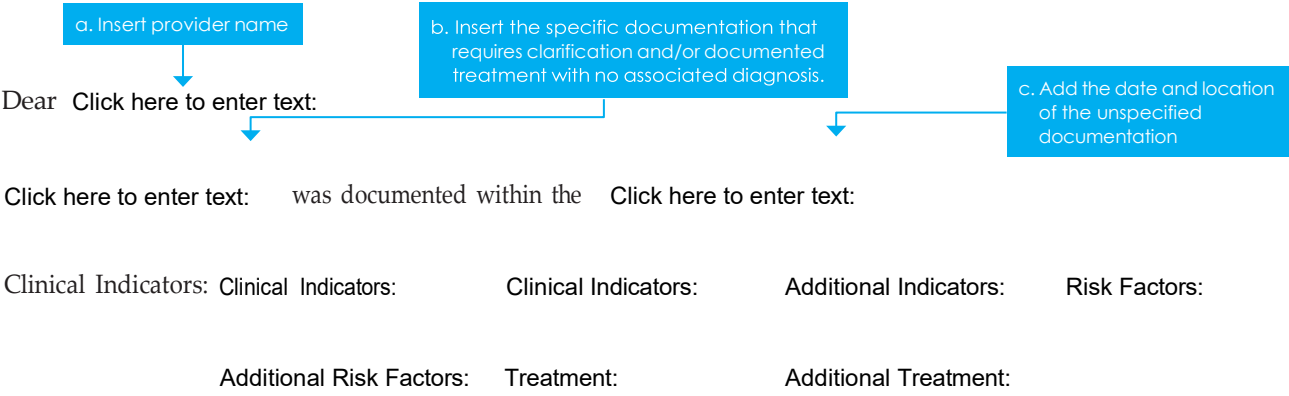
Based on the clinical indicators and your professional judgment   Questions:
Please complete by selecting one of the options below.

- Reasonable diagnostic option 1
- Reasonable diagnostic option 2
- Findings of no clinical significance
- Other explanation of clinical findings Click here to enter text:
- Unable to determine

7.2 : FREE TEXT QUERY TEMPLATE

Dear (add provider(s) name)

Identify the opportunity   was documented within the   Reference document location(s)

Clinical Indicators: Clinical Indicators: Clinical Indicators: Additional Indicators: Risk Factors:

Additional Risk Factors: Treatment   Treatment   Additional Treatment

Based on the clinical indicators and your professional judgment   Click here to enter text:
Please complete by selecting one of the options below.

- Reasonable diagnostic option 1
- Reasonable diagnostic option 2
- Other explanation of clinical findings   Click here to enter text:
- Unable to determine

7.3 : OPEN-ENDED QUERY TEMPLATE

Dear Click here to enter text:

Click here to enter text: was documented within the   Click here to enter text:

Clinical Indicators: Clinical Indicators: Clinical Indicators: Additional Indicators: Risk Factors:

Additional Risk Factors: Treatment   Additional Treatment

If appropriate, please   Questions: OR Click here to enter text:

Case Scenarios

Case scenarios will be provided in the following Chapters (8–12) of this toolkit. These scenarios provide examples of documentation opportunities that may be seen in various outpatient settings. Following each of the scenarios will be a query example using one of the templates provided in Chapter 7. These scenarios are provided to guide the users of this toolkit in determining documentation opportunities that may require a query for clarification.

CHAPTER 8: AMBULATORY SURGERY CENTERS (ASCS)

8.1 : SCREENING VERSUS DIAGNOSTIC COLONOSCOPY QUERY EXAMPLE

Scenario:

55-year-old male presents for a colonoscopy upon his PCP's recommendation. The PCP's pre-operative history and physical indicated that there were no GI symptoms and that the patient's father and grandfather both had a history of colon cancer. This was also documented by the anesthesiologist prior to the procedure.

Query from Scenario Above:

Dear Click here to enter text:

The patient was referred by his PCP for a colonoscopy. A family history of colon cancer was documented within the anesthesiologist note and previous pre-operative assessment by his PCP. The patient's referral did not indicate whether this is a screening or diagnostic colonoscopy.

Clinical Indicators: Per pre-op note, there are no reported GI symptoms.

 Per family history, both his father and grandfather had colon cancer.   Colonoscopy was performed.

Based on the clinical indicators and your professional judgment, can you please clarify the type of colonoscopy? Please complete by selecting one of the options below.

- Diagnostic colonoscopy
- Screening colonoscopy
- Unable to determine
- Other explanation of clinical findings   Click here to enter text:

8.2 : DOCUMENTATION OF MEDICATION WITH NO ASSOCIATED CHRONIC CONDITION

Scenario:

67-year-old female presented for a lung biopsy. According to the pre-operative assessment performed by her PCP a week ago, the patient has a history of congestive heart failure and home medication includes Lasix 40mg. History of CHF and use of Lasix 40 mg was also documented by the anesthesiologist in their assessment. According to the PCP's pre-operative history and physical, the patient's last echocardiography was performed on mm/dd/year with an ejection fraction of 20 percent.

Query from Scenario Above:

Dear Click here to enter text:

Lasix and history of congestive heart failure was documented in the pre-operative assessment performed by the PCP a week before the scheduled procedure. In addition, the anesthesiologist documented Lasix 40 mg under the home medication list.

Clinical Indicators: Echo showed an ejection fraction (EF) of 20 percent.   History of congestive heart failure.

Lasix 40 mg   Echo in chart performed on mm/dd/year.

Based on the clinical indicators and your professional judgment Questions:
Please complete by selecting one of the options below.

- Chronic systolic congestive heart failure
- Chronic systolic and diastolic congestive heart failure

- Other explanation of clinical findings   Click here to enter text:
- Unable to determine

8.3 : CLARIFICATION OF PATHOLOGY FINDINGS

Scenario:

55-year-old female with a family history of colon cancer presented for a colonoscopy on mm/dd/year. Based on the operative report, two polyps were excised and biopsied. Specimen was sent to pathology. Final pathology report confirms adenocarcinoma of the colon.

Query from Scenario Above:

Dear Click here to enter text:

Clinical Indicators: Per colonoscopy report "two polyps" were excised and biopsied. Adenocarcinoma was documented in the final pathology report. Family History of Colon Cancer.   Colonoscopy on mm/dd/year.

If appropriate, please specify if you agree or disagree with this pathology finding and document in your note.

8.4 : CLARIFICATION OF FRACTURE SITE

Scenario:

45-year-old male was involved in a recent accident involving a hammer falling on his foot while he was working on building a structure for his backyard. The patient was admitted for a repair of his fractured metatarsals in his left foot. Pre-operatively a left foot x-ray showed a fracture of his first and second metatarsals. Preliminary operative report currently documents repair of fractured foot.

Query from Scenario Above:

Dear Click here to enter text:

Clinical Indicators: Patient underwent a repair of his fractured foot status post having a hammer fall on his left foot.

Pre-operatively a left foot x-ray showed a fracture of the first and second metatarsals.

If appropriate, please specify if you:

agree or disagree with the x-ray findings and provide the site specificity in your final operative report.

CHAPTER 9: HOSPITAL OBSERVATION

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9.1 : CAUSE AND EFFECT

Scenario:

70-year-old male presents to the ED and was admitted to observation status with a chief complaint of erythema, swelling in the right upper extremity with possible worsening abscess/cellulitis. Patient was seen in urgent care and treated with oral cephalexin two weeks ago and recently finished the oral medication. Since the patient was exhibiting signs of recurrent abscess/cellulitis, he was placed in observation and started on IV clindamycin. A CT was performed on the right upper extremity and it did reveal a drainable abscess. Provider assessment concluded right upper extremity abscess/cellulitis.

Query from Scenario Above:

Dear Click here to enter text:

"Right upper extremity abscess/cellulitis" was documented in the provider assessment in the ED/observation note.

Clinical Indicators: Provider assessment documented "right upper extremity abscess/cellulitis".

CT performed showed a drainable abscess.   Recent treatment of RUE abscess/cellulitis.

Was treated with oral cephalexin two weeks ago and just finished oral medication.

Based on the clinical indicators and your professional judgment Can this diagnosis be further specified?
Please complete by selecting one of the options below.

- Right upper extremity abscess/cellulitis due to new infection.
- Right upper extremity abscess/cellulitis due to failed antibiotic treatment.
- Other explanation of clinical findings Click here to enter text:
- Unable to determine

9.2 : CLARIFICATION OF A DIAGNOSIS LISTED AS HISTORY BUT MAINTAINED ON HOME MEDICATION

Scenario:

80-year-old male with a history of HTN, COPD was admitted with shortness of breath and chest pain. Per the patient's history and physical in the emergency department, past medical history of "heart failure" was documented. The patient is on the following home medications: Lasix, Lisinopril, and Advair. The patient had both an EKG and an echocardiography performed in the emergency department. The EKG showed normal sinus rhythm and echocardiography showed an ejection fraction of 60 percent. Patient was admitted to observation for a pulmonary evaluation. The patient was treated with oxygen, IV steroids, PO Lasix, and Lisinopril. At time of discharge, COPD exacerbation was documented as the final diagnosis.

Query from Scenario Above:

Dear Click here to enter text:

Past medical history of "Heart failure" was documented in the emergency department history and physical.

Clinical Indicators: Echocardiography showed an ejection fraction of 60%. History of CHF with HTN and COPD.

Patient is on Lasix, Lisinopril, and Advair at home   Echocardiography.

Based on the clinical indicators and your professional judgment Can an associated diagnosis be documented?
Please complete by selecting one of the options below.

- Acute on chronic diastolic congestive heart failure
- Chronic diastolic congestive heart failure
- Other explanation of clinical findings   Click here to enter text:
- Unable to determine

9.3 : SPECIFICITY FOR A DOCUMENTED CONDITION

Scenario:

59-year-old male presented to the ED with severe shortness of breath. He in on hypertension medications, 40 mg Lasix daily for CHF, and has a history of COPD on Spiriva. The patient claimed he has been without his Spiriva for three days. The patient was placed on supplemental room air, IV steroids and was admitted to observation for a pulmonary evaluation.

Work up revealed abnormal ABGs and BNP elevated at 2181. IV steroids were discontinued, and patient was started on IV Lasix. Due to cardiac history, an echocardiogram was ordered. Echo results revealed "normal LV size with low-normal systolic function. Visually estimated ejection fraction is 50-55 percent." Patient recovered quickly within 24 hours and was discharged at hour 40 with discharge note documenting "acute CHF and COPD. Continue at home meds."

Query from Scenario Above:

Dear Click here to enter text:

"Acute CHF" was documented within the discharge note.

Clinical Indicators: Presented with severe shortness of breath;

Echo showed "normal LV size with low-normal systolic function. EF 50-55%. BNP=2181.

Patient has a history of COPD and CHF.   Patient is on Lasix and Spiriva as OP.   Lasix was switched to IV.

Based on the clinical indicators and your professional judgment Can this diagnosis be further specified? Please complete by selecting one of the options below

- Acute on chronic diastolic congestive heart failure
- Acute diastolic congestive heart failure
- Other explanation of clinical findings   Click here to enter text:
- Unable to determine

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9.4 CLARIFICATION FOR A POTENTIAL SECONDARY DIAGNOSIS

Scenario:

66-year-old female was sent to the ED by her primary care physician for abdominal pain, diarrhea, and weakness for the past three days. She has a Hx of colon cancer and has been in remission for three years. Work-up found patient to be dehydrated with an elevated BUN= 48 and normal Creatinine of 1.3. WBC was elevated at 11 and she had a mild fever of 99.4^0 F. She was admitted to the observation unit for IV fluids and monitoring. Physician ordered NS bolus and switch to 60 cc/hr, Tylenol p.o., nutrition consult, and Boost t.i.d. in between meals.

ED provider wrote that she "appears very cachectic… recent weight loss due to poor intake. Poor nutritional status." The provider refers to previous admission findings of "15 percent weight loss in the last year, energy intake <75 percent of needs, and muscle/fat wasting." Patient states she eats more than 75 percent of meals consumed on average if she likes the food. Albumin and total protein levels were not ordered.

Query from Scenario Above:

Dear   Click here to enter text:

"Poor nutritional status" was documented within the provider assessment in the ED/observation note for this 66-year-old female that was admitted for rehydration.

Clinical Indicators: ED provider writes "appears very cachectic… recent weight loss due to poor intake.

Poor nutritional status with a 15 percent weight loss in the last year, energy intake <75 percent of needs, and muscle/fat wasting."

Nutritional consult has been ordered and patient is on Boost three times a day.

Based on the clinical indicators and your professional judgment   Can an associated diagnosis be documented?
Please complete by selecting one of the options below.

- Mild protein calorie malnutrition
- Moderate protein calorie malnutrition
- Findings of no clinical significance
- Other explanation of clinical findings Click here to enter text:
- Unable to determine

AHIMA

9.5 VAGUE DOCUMENTATION: CLARIFICATION FOR A POTENTIAL SECONDARY DIAGNOSIS

Scenario:

72-year-old female with history of COPD and use of home oxygen presented with chest pain and shortness of breath. Per ED physical exam results, "Effort normal and breath sounds normal. No respiratory distress. She has no wheezes. She has no rales." She was initially placed in observation on standard order set for COPD. That same evening while patient was in the observation unit, review of systems revealed pulse ox between 65–70 percent at 3 liters via nasal cannula. Patient was placed on an NRB mask and it was increased to 100 percent. ABG results: pH-7.33, pCO2-61.2, and pO2 of 62 with an FIO2 of 36.0 percent.

Patient was transferred from observation to inpatient status for "severe COPD." Orders included "respiratory therapy to follow patient."

Query from Scenario Above:

Dear Click here to enter text:

"Severe COPD" was documented within the provider assessment in the ED/observation note.

Clinical Indicators: Patient presented with chest pain and shortness of breath.

 Pulse ox between 65-70% at 3 liters via NC. ABG results: pH-7.33, pCO2-61.2(HH), and pO2 of 62 (L) with a FIO2 of 36.0%.

 Patient was placed on an NRB mask and it was increased to 100 percent.

Based on the clinical indicators and your professional judgment Can this diagnosis be further specified and/or can an assoc Please complete by selecting one of the options below.

- Acute respiratory failure with hypercapnia
- Acute on chronic respiratory failure with hypercapnia
- Acute respiratory failure with hypoxia
- Acute on chronic respiratory failure with hypoxia
- Chronic respiratory failure with hypercapnia
- Chronic respiratory failure with hypoxia
- COPD exacerbation
- Other explanation of clinical findings Click here to enter text:
- Unable to determine

CHAPTER 10: EMERGENCY DEPARTMENTS

10.1 : ALTERED MENTAL STATUS

Scenario:

82-year-old female presented in the emergency department with altered mental status. "Altered mental status" documented in the health record. Patient has a history of confusion over the past two days according to the family. The past medical history indicates a TIA two years ago. CT scan was performed which showed some neurological changes, and a neurology consult was ordered.

Query from Scenario Above:

Dear Click here to enter text:

"Altered mental status" was documented within the provider assessment in the ED.

Clinical Indicators: Reported confusion and altered mental status over the past two days.

 Patient has a history of TIA two years ago.   CT scan indicates some neurologic changes and a neurology consult was ordered.

If appropriate, please Document an associated diagnostic statement in your encounter note.

10.2 : FRACTURED DIAGNOSIS AND TREATMENT

Scenario:

52-year-old male with a history of diagnosis of prostate cancer and a history of back pain for five days. Yesterday the patient was performing ADLs and had an increase in back pain, worsening today and came to the ED for evaluation and treatment. A radiology report of the spine indicates there is a "L4 fracture." Physical therapy and a surgical consult were ordered.

Query from Scenario Above:

Dear Click here to enter text:

"L4 fracture" was documented within the radiology report.

Clinical Indicators: Reported back pain without an injury for five days. Increased back pain after performing ADLs yesterday.

 Patient has a history of TIA two years ago.

 Radiology report indicates a L4 fracture in the lumbar spine. Physical therapy was ordered along with a surgical consult.

If appropriate, please Document an associated diagnostic statement along with the treatment plan for this associated diagnos

10.3 : FRACTURED DIAGNOSIS

Scenario:

48-year-old male with iron deficiency anemia and HTN presented to the emergency department status post falling off a ladder today while working in his backyard. To his recollection, he fell about three steps off the ladder. The patient had pain and tenderness in his right arm. There was pain also with movement and he came to be evaluated. There is a right "fracture" diagnosis documented in the ED record. X-ray of the right arm indicates a lower-end fracture of the radius. Patient was placed in a short arm cast and an orthopedic consult was ordered.

Query from Scenario Above:

Dear Click here to enter text:

"Right fracture" was documented within the emergency record.

Clinical Indicators: Pain and tenderness on his right arm status post falling off a ladder at home.

Patient has a history of iron deficiency anemia and HTN.

Patient's arm was placed in a short arm cast and an orthopedic consult was ordered.

X-ray of the right arm indicates a lower end fracture of the radius.

Based on the clinical indicators and your professional judgment Can this diagnosis be further specified?
Please complete by selecting one of the options below

- Closed fracture of the lower end of the right radius
- Open fracture of the lower end of the right radius
- Other explanation of clinical findings Click here to enter text:
- Unable to determine

10.4 : LACERATION TREATMENT

Scenario:

18-year-old healthy male was helping install a window when the window slipped, hit, and broke on the right calf of his leg. He has a 3–4 cm laceration that required repair. The patient's physical exam indicated a 4 cm laceration on the right calf with glass. Repair was performed with both vicryl and catgut sutures after cleaning the wound. Procedure note also indicated that some subcutaneous tissues had to be excised due to the injury from the glass window.

Query from Scenario Above:

Dear Click here to enter text:

4 cm laceration on the right calf was repaired with both vicryl and catgut sutures and "subcutaneous tissues had to be excised due to the injury from the glass window" was documented within the emergency record.

Clinical Indicators: Patient sustained a 4 cm laceration to his right calf status post having a window breaking on his calf.

Patient's right calf was repaired with both vicryl and catgut sutures. Subcutaneous tissues were excised due to the injury from the glass window.

Based on the clinical indicators and your professional judgment Can this diagnosis be further specified?
Please complete by selecting one of the options below.

- Excisional debridement of the right calf subcutaneous tissues
- Non-excisional debridement of the right calf subcutaneous tissues

- Other explanation of clinical findings   Click here to enter text:
- Unable to determine

CHAPTER 11: PHYSICIAN CLINICS

11.1 : CKD STAGE

Scenario:

66-year-old female with a PMH of hypertension, type 1 diabetes mellitus, and chronic kidney disease (CKD) presented to the primary care clinic for a follow-up visit. The patient was seen last month for high blood pressure and during that office visit, the provider documented type 2 diabetes mellitus with CKD and hypertension. The office visit from the visit in February noted an order for labs which included a recent lab result of GFR=31.

Query from Scenario Above:

Dear Click here to enter text:

This patient was seen in your clinic on xx/xx. Labs were ordered prior to this visit and the patient's GFR= 31 was documented within the recent lab results.

If appropriate, please document in your note the significance of this lab result, along with the appropriate diagnostic statement, and Document how this diagnosis was addressed or managed during this encounter.

11.2 : STATUS OF ALCOHOL USE

Scenario:

This is a 69-year-old female, with a history of congestive heart failure, hypertension, asthma, esophageal varices, and alcohol use presents for a follow-up visit on March 29 status post hospital admission for hematemesis due to esophageal varices last week on March 18. The patient's discharge diagnosis on March 22 was hematemesis due to esophageal varices. The patient was treated with Octreotide in the hospital and was discharged with Inderal to prevent further bleeding. The patient is also here to discuss band ligation for her esophageal varices. Per your social history assessment, it stated that the patient has a history of drinking alcohol and used to drink a bottle of vodka every two days and that she had tried to stop drinking alcohol and has attended Alcoholics Anonymous meetings.

Query from Scenario Above:

Dear Click here to enter text:

"The patient has a history of drinking alcohol and used to drink a bottle of vodka every two days and that she had tried to stop drinking alcohol and has attended Alcoholics Anonymous meetings" was documented within your social history assessment within the current encounter notes dated March 29.

Clinical Indicators: Recent admission for Hematemesis due to Esophageal Varices.

 Patient has a history of drinking a bottle of vodka every two days and has attended Alcoholics Anonymous meetings.

Based on the clinical indicators and your professional judgment Can an associated diagnosis be documented? Please complete by selecting one of the options below.

- Alcohol Abuse
- Alcohol dependence
- Alcoholism in remission
- Other explanation of clinical findings   Click here to enter text:
- Unable to determine

11.3 : STATUS DEEP VEIN THROMBOSIS

Scenario:

75-year-old male presents for a follow-up visit after being discharged on January 18 with right leg pain, erythema, and swelling caused by a right DVT. He was seen at a local ED on January 15 with right calf pain and swelling of the lower leg last week after his flight back from San Francisco to New York. The patient's history in the ED note, which was faxed over to his PCP office, did not document a history of deep vein thrombosis (DVT). The ultrasound from January 15 showed a right deep vein thrombosis in the popliteal vein. The patient was treated with Xarelto and is now here for a follow-up office visit.

Query from Scenario Above:

Dear Click here to enter text:

"Right deep vein thrombosis in the popliteal vein" was documented in the ultrasound note dated January 15.

Clinical Indicators: Patient has right leg pain, erythema, and is swollen.

 Patient had a recent flight from San Francisco to New York.   Patient was treated with Xarelto.

Based on the clinical indicators and your professional judgment Can this diagnosis be further specified?
Please complete by selecting one of the options below.

- • Acute deep vein thrombosis
- • Subacute deep vein thrombosis
- • Chronic deep vein thrombosis
- • Other explanation of clinical findings Click here to enter text:
- • Unable to determine

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CHAPTER 12: HOSPITAL-BASED CLINICS (E.G. DIALYSIS, ONCOLOGY, WEIGHT LOSS, ETC.)

12.1 : DIABETES

Scenario:

A 59-year-old male with type 2 diabetes, first diagnosed three years ago, presents to the diabetes clinic. Other medical problems include hypothyroidism and obesity. Patient has a history of significant alcohol use but quit drinking alcohol two years ago. He presents now for routine follow-up and is noted to have a blood pressure of 158/100 mm Hg. He is asymptomatic. Laboratory testing reveals trace protein on urinalysis, blood urea nitrogen of 13 mg/dl, serum creatinine of 1.2 mg/dl, random serum glucose of 159 mg/dl, normal electrolytes, and normal thyroid-stimulating hormone levels. A 24-hour urine collection to assess albuminuria is ordered. Provider assessment and physical exam concludes that there is no retinopathy or thyromegaly nor clinical evidence of congestive heart failure or peripheral vascular disease.

Query from Scenario Above:

Dear Click here to enter text:

"Type 2 diabetes was diagnosed three years ago" was documented in the patient's health record.

Clinical Indicators: Patient noted to have a blood pressure of 158/100mm Hg.   Patient has a history of significant alcohol use but quit drinking alcohol two years ago. Other medical problems include hypothyroidism and obesity.

Laboratory testing reveals trace protein on urinalysis, blood urea nitrogen of 13 mg/dl, serum creatinine of 1.2 mg/dl, random serum glucose of 159 mg/dl, normal electrolytes, and normal thyroid-stimulating hormone levels. A 24-hour urine collection to assess albuminuria is ordered.

Based on the clinical indicators and your professional judgment can you please provide further specificity regarding the "diabetes" diagnosis and the management that was provided?

12.2 : QUERY 1, TYPE OF DIALYSIS

Scenario:

30-year-old female with juvenile onset of diabetes and newly diagnosed Stage V chronic kidney disease presents to the dialysis clinic for the first time for dialysis. Patient's hematocrit and hemoglobin were tested and noted to be extremely low, at 26 percent and 10 g/dL respectively. Clinic staff relayed these results to the patient's attending physician for further instruction.

Query from Scenario Above:

Dear Click here to enter text:

Patient w/juvenile onset of diabetes and newly diagnosed Stage V chronic kidney disease presents "to the dialysis clinic for the first time for dialysis" was documented within the encounter note. Patient has juvenile onset of diabetes and newly diagnosed Stage V chronic kidney disease. Dialysis and Labs

Based on the clinical indicators and your professional judgment please provide further specificity on type of dialysis that was rendered. Please complete by selecting one of the options below.

- Hemodialysis
- Peritoneal dialysis
- Other explanation of clinical findings Click here to enter text:
- Unable to determine

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12.2 : QUERY 2, CLARIFICATION FOR A POTENTIAL SECONDARY DIAGNOSIS

Query from Scenario Above:

Dear Click here to enter text:

Patient w/juvenile onset of diabetes and newly diagnosed Stage IV chronic kidney disease presents "to the dialysis clinic for the first time for dialysis" was documented within the encounter note. There is no documentation of type of dialysis being performed.

Clinical Indicators: Patient's hematocrit and hemoglobin were tested and noted to be extremely low, at 26 percent and 10 g/dL respectively.   Patient has juvenile onset of diabetes and end-stage renal disease.   Dialysis and Labs.

Based on the clinical indicators and your professional judgment can an associated diagnosis be documented? Please complete by selecting one of the options below.

- Anemia due to chronic kidney disease
- Iron-deficiency anemia
- Findings of no clinical significance
- Other explanation of clinical findings   Click here to enter text:
- Unable to determine

12.3 : ONCOLOGY

Scenario:

52-year-old female with a four-month history of intermittent rectal bleeding and confirmed squamous cell carcinoma of the rectum presents to the oncology clinic. The mass is 2.5 × 3.5 cm at a distance of 9 cm from the anal verge. Provider assessment and physical exam concludes that the Nigro protocol will be followed with preoperative use of concurrent radiation in conjunction with 5-FU and mitomycin chemotherapy, followed by surgical excision if necessary. The chemo regimen is to begin immediately, with continuous infusion of 5-FU 1,000 mg/m2 plus mitomycin 10 mg/m2 on day 1.

Query from Scenario Above:

Dear Click here to enter text:

"The chemotherapy regimen is to begin immediately with continuous infusion of 5-FU 1,000mg/m2 plus mitomycin 10mg/m2 on day 1" was documented within the provider assessment.

Clinical Indicators: History of four months of intermittent rectal bleeding.   Squamous cell carcinoma of the rectum.
                Chemotherapy

Please document in your note the remaining chemotherapy regimen since only day 1 was documented.

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12.4 : WEIGHT LOSS

Scenario:

49-year-old female with unsuccessful attempts at weight loss presents to the weight loss clinic. Patient's height (5'4") and weight (300 pounds) were taken and BMI was calculated at 51.5. Patient has been trying to lose weight for the past seven years. While she did manage to lose some weight on her own, it was the same few pounds that she kept losing and regaining again and again. Provider assessment and physical exam concludes that patient's self-taught approach to dieting and weight loss were inadequate and that dietitian counseling was in order as a first step. Laboratory testing is also ordered to determine other possible etiologies for the persistent weight gain.

Query from Scenario Above:

Dear Click here to enter text:

Patient presents to the weight loss clinic after unsuccessful attempts at weight loss were documented within the encounter note.

Clinical Indicators: Patient's height (5'4") and weight (300 pounds). BMI= 51.5.   Provider assessment and physical exam concludes that patient's self-taught approach to dieting and weight loss were inadequate and that dietitian counseling was in order as a first step. Laboratory testing is also ordered to determine other possible etiologies for the persistent weight gain. Patient has a PMH of diabetes and hypertension.   Dietitian Counseling and Labs.

Based on the clinical indicators and your professional judgment can you document an associated diagnostic statement in your encounter note. Please complete by selecting one of the options below.

- Morbid obesity with a BMI of 51.5
- Overweight with a BMI of 51.5
- Other explanation of clinical findings Click here to enter text:
- Unable to determine

12.5 : WOUND CARE

Scenario:

65-year-old male with HTN and diabetes, status post bicycle versus MVA accident four months ago, presents to the wound care clinic with a stagnant lower left leg wound. Initial physical exam is unremarkable. The left lower extremity had an open, irregularly shaped, shallow wound that measured 1.9 cm in length, 2.1 cm in width, of questionable depth secondary to the wound bed containing 100 percent slough that was fibrinogen, recent treatment of esophageal varices with Ostreotide and d/c with Inderal. Provider assessment includes a treatment consisting of normal saline cleansing, SilvaSorbgel, vaseline gauze, and application of Promogran Matrix wound dressing. Patient is also started on two weeks of cephalexin 500 mg twice a day, with follow-up scheduled in two weeks.

Query from Scenario Above:

Dear Click here to enter text:

The patient's left lower extremity had an open, irregularly shaped, shallow wound that was documented within the wound care clinic notes.

Clinical Indicators: The patient's left lower extremity had an open, irregularly shaped, shallow wound that measured 1.9 cm in length, 2.1 cm in width, of questionable depth secondary to the wound bed containing 100percent slough that was fibrinous and adherent to the underlying tissue. Patient has a PMH of HTN and diabetes.   Treatment consisting of normal saline cleansing, SilvaSorb gel, vaseline gauze, and application of Promogran Matrix wound dressing.

Based on the clinical indicators and your professional judgment, can this diagnosis be further specified? Please complete by selecting one of the options below.

- Non-healing left leg wound status post bike versus MVA accident
- Diabetic ulcer of the left leg
- Other explanation of clinical findings   Click here to enter text:
- Unable to determine

CONCLUSION

A toolkit for the outpatient setting that either a coding or CDI professional can utilize and benefit from can significantly impact clinical documentation and the associated connections across the continuum of care. It's always useful to look at best practices such as those contained in this toolkit to provide guidance and examples. Moreover, using the AHIMA Practice Briefs related to querying and documentation improvement along with this toolkit can enhance success and improve the quality of clinical documentation.

NOTES

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5. Center for Medicare Advocacy. "Outpatient Observation Status." http://www.medicareadvocacy.org/medicare-info/observation-status/#CMSdefinition.

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APPENDIX

Frequently Used E/M CPT Codes

- **Codes 99201–05:** New Patient Office Visit are used for patients that have not been seen by a physician in the same specialty group within the previous three years.
    - 99201–Problem-focused
    - 99202–Expanded problem-focused
    - 99203–Detailed
    - 99204–Comprehensive, moderate
    - 99205–Comprehensive, high
- **Codes 99211–15:** Established Patient Office Visit are used for patients that have been seen by a physician in the same specialty group within the previous three years.
    - 99212–Problem-focused
    - 99213–Expanded problem-focused
    - 99214–Detailed
    - 99215–Comprehensive
- **Codes 99231–33:** Initial Hospital Care are used for new or established patients that have been admitted to the hospital.
    - 99231–Requires two of the three key components
        - Problem focused interval history
        - Problem focused examination
        - Straightforward or low complexity medical decision-making
    - 99232–Requires two of the three key components
        - Expanded problem focused interval history
        - Expanded problem focused examination
        - Moderate complexity medical decision-making
    - 99233–Requires two of the three key components
        - Detailed interval history
        - Detailed examination
        - High complexity medical decision-making
- **Codes 99241–45:** Office Consultations are used when a patient seeks the opinion of another physician.
    - 99241–Problem-focused
    - 99242–Expanded problem-focused
    - 99243–Detailed
    - 99244–Comprehensive, moderate
    - 99245–Comprehensive, high

Emergency Department CPT Codes

Physicians utilize CPT E/M codes 99281–99285 for emergency department encounters.

- **CPT Code 99281** is used for an emergency department visit for the evaluation and management (E/M) of a patient and requires all three of these key components:
  - A problem focused history;
  - A problem focused examination; and
  - Straightforward medical decision-making

Under this code, counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies that is provided should be consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor.

- **CPT Code 99282** is used for an ED visit for the evaluation and management of a patient and requires all three of these key components:
  - An expanded problem focused history;
  - An expanded problem focused examination; and
  - Medical decision-making of low complexity

Under this code, counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies that is provided should be consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.

- **CPT Code 99283** is used for an ED visit for the evaluation and management of a patient and requires all three of these key components:
  - An expanded problem focused history;
  - An expanded problem focused examination; and
  - Medical decision-making of moderate complexity

Under this code, counseling and/or coordination of care with other qualified healthcare professionals, or agencies that is provided should be consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.

- **CPT Code 99284** is used for an ED visit for the evaluation and management of a patient and requires all three of these key components:
  - A detailed history;
  - A detailed examination; and
  - Medical decision-making of moderate complexity

Under this code, counseling and/or coordination of care with other qualified healthcare professionals, or agencies that is provided should be consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and require urgent evaluation by the physician or other qualified healthcare professionals but do not pose an immediate significant threat to life or physiologic function.

- **CPT Code 99285** is used for an ED visit for the evaluation and management of a patient and requires all three of these key components within the constraints imposed by the urgency of the patient's clinical condition and or mental status:

  - A comprehensive history;
  - A comprehensive examination; and
  - Medical decision-making of high complexity

Under this code, counseling and/or coordination of care with other qualified healthcare professionals or agencies that is provided should be consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

Note: The above codes are subject to change with guideline regulations and should be validated.