

# AHIMA Inpatient Query Toolkit

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## Introduction [Table of Contents](#)

As a result of the variation in documentation practices by providers, querying has become a common communication tool and educational method to advocate for proper documentation practices. Querying the provider is a standard procedure, and a common theme in a clinical documentation integrity (CDI) and coding professional's practice and the American Hospital Association's *Coding Clinic*® for ICD-10-CM and ICD-10-PCS. A query process benefits the hospital's compliance with billing/coding rules and serves as an educational tool for providers, CDI professionals, and coding professionals. Proper responses to queries result in improved accuracy and completeness in documentation, coding, reimbursement, as well as severity of illness (SOI) and risk of mortality (ROM) classifications.

The medical staff should be educated as to the need for the provider query process, which generates constructive communication and promotes regulatory agency compliance. The American Hospital Association (AHA), American Health Information Management Association (AHIMA), National Center for Health Statistics (NCHS), and the Centers for Medicare and Medicaid Services (CMS) are the four Cooperating Parties responsible for the ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting.

### **When to Query**

1. High-quality documentation is vital for accurate quality reporting and appropriate representation of the diagnoses that were treated. The following are important rationale for considering a physician query:

- Clinical indicators of a diagnosis but no documentation of the condition
- Clinical evidence for a higher degree of specificity or severity
- Uncertainty of a cause-and-effect relationship between two conditions or organisms
- Specifying an underlying cause when admitted with symptoms
- Only the treatment is documented (without a documented diagnosis)
- Present on admission (POA) indicator status
- Clinical validation of a diagnosis
- Clinical significance of abnormal test results
- Clarifying diagnostic and therapeutic procedures, treatments and tests ordered, including results
- There is insufficient information to assign the appropriate root operation (based on the objective of the procedure), body part, approach, device, or other PCS qualifier
- Laterality can't be determined from the documentation

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

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

3. Provider documentation entries in the health record should:
  - Address the 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 coexist at the time of the encounter, that develop subsequently, or that affect the treatment received and the patient's length of stay

### **The Query Process**

1. Queries may be either verbal or written and may be generated at any of the following times:
  - Concurrently (while the patient is still an inpatient)
  - Prebill (prior to the claim submission)
  - Retrospectively (post billing)
2. Written, electronically submitted, and e-mail queries are to be made utilizing a compliant query process and should follow all HIPAA security regulations.
3. Verbal and telephonic queries are to follow the same format as written queries.
4. All queries are to be:
  - Clear, concise, and non-leading (if a title is included on a query it should not be leading, and the query should include both supporting as well as conflicting documentation)
  - Simple and direct - A query includes a synopsis of the encounter up to the time the query is being written that will support the intent of the query
  - Itemize the clinical indicators or clues (example: documentation found in nursing documentation, but not mentioned in the primary provider's documentation, lab findings, radiological findings) from the health record
5. The query should contain all of the patient's identifying information such as name, date of admission or service, discharge date (if applicable), unit, etc. The query should also include a clear, concise itemization of the clinical findings, with supporting documentation, that results in a specific question for the provider.
6. Queries are to be initiated by professionals trained and educated in the compliant query process, such as but not limited to, coding and CDI professionals.
7. All queries are to be logged for follow-up, to track responses and to trend for any documentation issues. Any issues identified may provide documentation integrity educational opportunities for providers as well as detecting the overuse of queries by CDI or coding professionals.
8. The highly specific nature of procedure coding systems (ICD-10-PCS, CPT, HCPCS) may also require a query to obtain more detailed information. A compliant query can be directed to professionals who perform a procedure as long as their documentation can be used for coding

purposes. It is at times appropriate to query the surgeon or other providers, but the health record documentation is still ultimately the responsibility of the attending physician.

NOTE: The query template examples in this toolkit are meant to be a guide in developing queries. It is important to point out that each query should be developed in accordance with the policies and procedures of the organization and should follow the guidance of the following AHIMA Practice Briefs: “Guidelines for Achieving a Compliant Query Practice,” “Guidelines for Achieving a Compliant ICD-10-PCS Query,” and “Clinical Validation: The Next Level of CDI.” The clinical indicators included within this toolkit are not all inclusive. All pertinent clinical indicators identified in the health record should be included within the query.

### Example Templates [Table of Contents](#)

Dear [insert provider name],

[Insert the unspecified documentation] was documented within the [insert the location and date of the unspecified documentation].

Clinical Indicators: [Add the pertinent clinical indicators identified from the current health record]

Based on the clinical indicators and your professional judgment, [insert an appropriate question to pose in the query]. Please complete by selecting one of the options below.

- [Enter the diagnostic options. These options should support the query as being non-leading in terms of diagnosis option provided.]
- [Enter the diagnostic options. These options should support the query as being non-leading in terms of diagnosis option provided.]
- Findings of no clinical significance [OPTIONAL: 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 \_\_\_\_\_[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 diagnosis queries. This option is for providers to utilize when there is a need for further specificity but they do not have enough clinical evidence to determine the level of specificity.]
- No further clarification needed [OPTIONAL: may or may not be included in a query. This option 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.]

### Generic Template [Table of Contents](#)

Dear \_\_\_\_\_

\_\_\_\_\_ was documented within the \_\_\_\_\_.

Clinical Indicators: \_\_\_\_\_

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

- \_\_\_\_\_
- \_\_\_\_\_
- Findings of no clinical significance (optional)
- Other explanation of clinical findings
- Unable to determine
- No further clarification needed (optional)

### Miscellaneous [Table of Contents](#)

**Case Scenario:** Mr. Jones is an 84-year-old being admitted with burning urination and found to have the following vitals in the ER (HR 115, RR 25, Temp 101.5). His lab draw in the ER shows WBC of 17.1, Cr of 1.1 with unknown baseline, K of 3.5, and Na of 129. His UA shows evidence of a UTI. He is given IV fluid bolus and started on antibiotics and his follow-up labs showed Cr of 1.0 and Na of 132. He is admitted with Sepsis due to UTI, hyponatremia, and AKI.

### Clinical Validation

Dear Dr. Smith,

AKI was documented within the ED note dated xx/xx with a Cr of 1.1 (unknown baseline). He was given fluid bolus in ED with a follow-up lab showing Cr of 1.0.

Clinical Indicators: Cr of 1.1 on admission requiring a fluid bolus, and a UTI

Based on your professional medical judgment and review of the clinical indicators, can you review the clinical indicators and confirm this diagnosis? Please complete by selecting one of the options below.

- AKI is ruled out
- AKI is ruled in (if so, please document the evidence used to support this diagnosis) \_\_\_\_\_
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

### Chapter 1: Certain Infectious and Parasitic Diseases

**Case Scenario:** Mr. Smith is a 45-year-old male with a history of IV drug abuse and HIV status being admitted with productive cough and fever at home. Chest X-ray in ED shows infiltrate in left lower lobe. His vitals on admission to ED (temp 103.5, HR 125, RR 25, and BP of 90/60) and labs on admission are (WBC 17.1, Lactate 5.0, Cr 3.0, K 5.6, Na 125). Pt with a history of

admission 2 weeks previous with a noted CD4 count of <200 and history of thrush and previous creatinine of 1.1. He is admitted to the floor with Pneumonia (recurrent), Hyperkalemia, Hyponatremia, AKI, and HIV status. He is treated with IV bolus of normal saline and IV fluids started at 150cc/hr and antibiotics.

#### [HIV/AIDS Table of Contents](#)

Dear Dr. Jones,

HIV was documented within the ED documentation dated xx/xx with a positive HIV lab finding.

Clinical Indicators: Previous stay with noted CD4 count of <200, Previous stay with thrush, history of IV drug abuse, current diagnosis of pneumonia (recurrent).

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

- HIV infection related to a current associated diagnosis (if so, please specify associated condition) \_\_\_\_\_
- Asymptomatic HIV infection
- AIDS
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

#### [Severe Sepsis \(Sepsis with single possible Organ failure/dysfunction\) Table of Contents](#)

Dear Dr. Jones,

Recurrent pneumonia was documented within the ED note dated xx/xx, HIV is also noted within this note.

Clinical Indicators: leukocytosis, tachycardia, elevated temp to 103.5, lactate of 5.0, tachypnea, acute kidney injury, recurrent pneumonia, normal saline, antibiotics.

Based on the clinical indicators and your professional judgment, please clarify/specify with an applicable diagnosis such as:

- Severe Sepsis with associated organ failure or dysfunction (if so, please specify the organ failure) \_\_\_\_\_
- Sepsis without associated organ failure or dysfunction
- Acute kidney injury due to other, please specify \_\_\_\_\_
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

#### Reference

American Hospital Association. "Severe sepsis and acute organ dysfunction/failure." *AHA Coding Clinic for ICD-10-CM/PCS*® (Fourth Quarter 2017), pages 98-99.

## Chapter 2: Neoplasm

**Case Scenario:** Mr. Jones is an 84-year-old male admitted for severe back pain and not being able to catch his breath acutely. In the ED he underwent chest X-ray and had labs drawn including D-dimer. His X-ray showed a mass in the middle right lobe and an elevated D-dimer. He was admitted to the floor and underwent a biopsy of the lung mass. The pathology of the biopsy came back with non-small cell lung cancer of the right middle lobe mass. His pain was controlled with pain medication and he was discharged home to follow-up with Oncology appt. Discharge summary documents lung mass.

### 2:1 Pathology clarification [Table of Contents](#)

Dear Dr. Smith,

Pathology results on xx/xx note the lung mass biopsy shows non-small cell lung cancer. He was noted on discharge summary to have a lung mass.

Clinical Indicators: shortness of breath, severe back pain, elevated D-dimer, and lung biopsy pathology showing non-small cell lung cancer

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

- Agree with the pathology finding of non-small cell lung cancer of the middle right lobe
- Disagree with the pathology findings of non-small cell lung cancer of the middle right lobe
- Other explanation of pathology findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

## Reference

American Hospital Association. *AHA Coding Clinic for ICD-9-CM®* (Third Quarter 2008), pages 11-12.

## Chapter 3: Diseases of the Blood and Blood-forming Organs and Certain Disorders Involving the Immune Mechanism [Table of Contents](#)

**Case Scenario:** Ms. Samson is a 65-year-old female admitted for a posterior spinal fusion of T5-L4 for thoracic and lumbar spinal stenosis. Pre-op labs all stable with HGB of 13.1, HCT 40.0, Platelets of 200. Intra-op she had a blood loss of 900cc and was given 2L IVF and 1-unit PRBC's. Two days post-op her labs showed a decrease in Hgb of 8.0 and was administered 2 units of PRBCs with an increase of Hgb to 12.0. She is noted on d/c with spinal stenosis and low hemoglobin.

### 3:1 Anemia type [Table of Contents](#)

Dear Dr. Jones,

Low hemoglobin was documented within the health record H&P on xx/xx with post spinal fusion surgery.



Clinical Indicators: Spinal fusion surgery with 900cc blood loss and drop in Hgb from 13.1 (pre-op) to 8.0 (post-op), administered 2 units PRBCs post-op

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 blood loss anemia
- Anemia of chronic disease (if so, please specify the chronic disease) \_\_\_\_\_
- Other type of anemia
- Findings of no clinical significance
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine

#### Chapter 4: Endocrine, Nutritional, and Metabolic Diseases [Table of Contents](#)

**Case Scenario:** Ms. Smith is a 22-year-old female admitted with newly diagnosed colorectal cancer. She is feeling extremely weak and can't get up the stairs at home and has been vomiting several times a day for the past three days and is afraid she is dehydrated. She called her oncologist who advised her to come to the ED. In the ED, she notes that she is seeing her oncologist and nutritionist as she has been recently diagnosed with malnutrition with a 45-pound weight loss in the last six months. Her labs show hyponatremia and hyperkalemia. Her BMI remains low at 15 and it was decided to put in an NG tube in the ED and start an IV for parenteral nutrition and IV fluids. She appears extremely cachectic and needs to be transported via wheelchair due to her inability to walk with weakness. A dietician consult was ordered, and the RD noted severe protein malnutrition with Aspen criteria of: severe muscle and fat loss with extreme weight loss. The provider notes she is being admitted with malnutrition and cachexia.

#### 4:1 Malnutrition severity [Table of Contents](#)

Dear Dr. Jones,

Malnutrition was noted within the health record progress note on xx/xx.

Clinical Indicators: BMI 15, weakness, RD noted severe malnutrition with Aspen criteria, Colorectal cancer, 45-pound weight loss, parenteral nutrition, normal saline, cachexia

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

- Severe protein calorie malnutrition
- Findings of no clinical significance
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

## References

American Society of Parenteral and Enteral Nutrition (ASPEN). Clinical Guidelines.

[http://www.nutritioncare.org/Guidelines\\_and\\_Clinical\\_Resources/Clinical\\_Guidelines](http://www.nutritioncare.org/Guidelines_and_Clinical_Resources/Clinical_Guidelines).

Morley, J. "Protein-Energy Undernutrition." Merck Manual Professional Version.

<https://www.merckmanuals.com/professional/nutritional-disorders/undernutrition/protein-energy-undernutrition-peu>.

## Chapter 5: Mental, Behavioral, and Neurodevelopmental Disorders [Table of Contents](#)

**Case Scenario:** Mr. Smith is a 53-year-old male admitted with aggressive behavior at home. His wife called 911 after Mr. Smith drank an entire bottle of vodka and became incoherent. Upon arrival to ED Mr. Smith required restraints, and blood work showed an alcohol level of 300. He is being admitted for aggressive behavior and placed on CIWA scale, psych consult ordered, and banana bag started. His wife reports that he drinks alcohol daily and has never sought treatment. She reports that his behavior can be aggressive, but he has never been incoherent before.

### 5:1 Alcohol specificity [Table of Contents](#)

Dear Dr. Jones,

Aggressive behavior was documented within the ED note on xx/xx with aggressive behavior after consuming alcohol.

Clinical Indicators: behavioral changes, intoxication, blood alcohol level of 300, alcohol use, CIWA protocol, banana bag, psych consult ordered

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 (if so, please specify if there is an associated mood disorder, intoxication, or withdrawal) \_\_\_\_\_
- Alcohol dependence (if so, please specify if there is an associated mood disorder, intoxication, or withdrawal) \_\_\_\_\_
- Alcohol use (if so, please specify if there is an associated mood disorder, intoxication, or withdrawal) \_\_\_\_\_
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

## Chapter 6: Diseases of the Nervous System [Table of Contents](#)

**Case Scenario:** Mr. Jones is a 25-year-old male being admitted from home after consuming an unknown amount of Ativan at home with altered mental status and drowsiness. He is incoherent and not responding appropriately to any questions. He has a past history of drug abuse and two past overdose admissions. Poison control has been contacted, IVFs have been initiated, and he

has been placed in soft restraints. Blood work is being drawn. He is being admitted with altered mental status due to Ativan consumption.

#### 6:1 Altered mental status [Table of Contents](#)

Dear Dr. Smith,

Altered mental status was documented within the H&P on xx/xx due to Ativan consumption.

Clinical Indicators: altered mental status, drowsiness, requiring soft restraints, drug abuse, IV fluids given

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

- Toxic encephalopathy (please specify substance due to) \_\_\_\_\_
- Encephalopathy etiology unknown
- Delirium (if so, please specify the acuity and underlying cause) \_\_\_\_\_
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

#### Chapter 7: Diseases of the Eye and Adnexa [Table of Contents](#)

**Case Scenario:** Mr. Jones is a 65-year-old male admitted with diabetic retinopathy and arrived at the ED with extreme eye pain. He is also experiencing headache and blurred vision. The pain has been so intense it prompted this ED visit today. He will need surgical drainage and has been admitted. He is noted to have glaucoma and needing emergency treatment.

#### 7:1 Glaucoma specificity [Table of Contents](#)

Dear Dr. Smith,

Glaucoma was documented within the ED note on xx/xx with known diabetic retinopathy and is experiencing new symptoms requiring his visit to the ED.

Clinical Indicators: blurred vision, eye pain, headache, diabetes, surgery is indicated

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

- Open-angle glaucoma (if so, please specify the stage, mild, moderate, severe)\_\_\_\_\_
- Angle-closure glaucoma (if so, please specify the stage, mild, moderate, severe)\_\_\_\_\_
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

## Chapter 8: Diseases of the Ear and Mastoid Process [Table of Contents](#)

**Case Scenario:** James is a 10-year-old boy presenting with what parents suspect might be an ear infection. He keeps pulling at his ear and is grimacing as if he is in pain. He has no known fever and vitals are stable. He has known trisomy 21 and is non-verbal. After examination he is found to have otitis media with fluid in the ear. He is started on antihistamine and ENT consulted for possible outpatient tube placement.

### 8:1 Otitis media specificity [Table of Contents](#)

Dear Dr. Smith,

Otitis Media was documented within the ED note dated xx/xx and found with fluid in the ear.

Clinical Indicators: ear pain, fluid in the ear, consult for possible ear tubes outpatient, he is placed on antihistamine

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

- Serous otitis media (if so, please specify if acute or chronic) \_\_\_\_\_
- Suppurative otitis media (if so, please specify if acute or chronic) \_\_\_\_\_
- Mucoid otitis media (if so, please specify if acute or chronic) \_\_\_\_\_
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

## Chapter 9: Diseases of the Circulatory System [Table of Contents](#)

**Case Scenario:** Ms. Smith is a 65-year-old female being admitted for shortness of breath with visible accessory muscle use. She has a history of hypertension and obesity. She is started on O2 at 2L via nasal cannula. Chest X-ray performed showing bilateral pleural effusions. She states she had a recent echo performed by her cardiologist. Echo on record from two weeks ago shows EF of 45%. She is given IV Lasix in ED and admitted to the floor. While on the floor, breathing improves and she is being observed with a cardiology consult ordered. She has no home cardiac medications at this time. She is being admitted with a likely CHF exacerbation, newly found.

### 9:1 Heart failure specificity [Table of Contents](#)

Dear Dr. Jones,

CHF was documented within the health record note dated xx/xx with likely exacerbation newly found.

Clinical Indicators: shortness of breath, abnormal ejection fraction, accessory muscle use, hypertension, obesity, treated with Lasix

Diagnostic Findings: Previous echo findings of EF 45%, Chest X-ray on admission with bilateral pleural effusions

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 systolic (congestive) heart failure
- Acute diastolic (congestive) heart failure
- Acute on chronic systolic (congestive) heart failure
- Acute on chronic diastolic (congestive) heart failure
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

#### References

Thygesen, K. et al. "Third Universal Definition of Myocardial Infarction." *Circulation*. 126, no. 16 (2012). <http://circ.ahajournals.org/content/126/16/2020>.

Warnica, J. "Overview of Acute Coronary Syndromes (ACS)." Merck Manual Professional Version. <https://www.merckmanuals.com/professional/cardiovascular-disorders/coronary-artery-disease/overview-of-acute-coronary-syndromes-acs>.

#### Chapter 10: Diseases of the Respiratory System [Table of Contents](#)

**Case Scenario:** Ms. Jones is a 65-year-old female being admitted with shortness of breath. She has a history of COPD with home O2 of 2L all day. She is in clear distress and history is per daughter. She states her mother has had to gradually increase her O2 all day and we are now at 7L and she is head bobbing with accessory muscle use. We gain consent for possible intubation and start her on BIPAP. We administer Solu-Medrol and Duonebs and admit her to the ICU. She is being admitted for respiratory distress due to COPD exacerbation.

#### 10:1 Respiratory failure indicators [Table of Contents](#)

Dear Dr. Smith,

Respiratory distress was documented within the health record note dated xx/xx due to a COPD exacerbation.

Clinical Indicators: shortness of breath, labored breathing, accessory muscle use with head bobbing, COPD, Home O2 with increase in needs up to BIPAP, Solu-Medrol, Duonebs, admitted to the ICU

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 respiratory failure (if so, please specify if it is associated with hypoxia or hypercapnia) \_\_\_\_\_
- Acute on Chronic respiratory failure (if so, please specify if it is associated with hypoxia or hypercapnia) \_\_\_\_\_
- Other explanation of clinical findings \_\_\_\_\_

- Unable to determine
- No further clarification needed

## Chapter 11: Diseases of the Digestive System [Table of Contents](#)

**Case Scenario:** Ms. Jones is an 85-year-old female being admitted with melena. According to her, she noticed blood when wiping this morning and it has progressively increased throughout the day. She has a history of GI bleeds with diverticulitis and history of ulcerative colitis. Initial labs show Hgb of 9.0 with vitals showing tachycardia of 125. She is started on Protonix and given IVF and GI consult ordered. On physical exam she does have evidence of internal and external hemorrhoids. She underwent a scope after bleeding stabilized and no evidence of bleeding source found but pockets of diverticulosis visualized. She was found with GI bleed and acute blood loss anemia now stable for discharge.

### 11:1 Gastrointestinal bleeding [Table of Contents](#)

Dear Dr. Smith,

GI bleed was documented within the health record note dated xx/xx with extensive GI history.

Clinical Indicators: blood in stool, tachycardia, hx of diverticulitis, hx of ulcerative colitis, GI consult, evidence of internal and external hemorrhoids

Based on the clinical indicators and your professional judgment, can this diagnosis be further specified? Please specify the etiology/source of the GI bleed by selecting one of the options below.

- Diverticulosis with or without diverticulitis
- Hemorrhoids
- Other condition (please specify) \_\_\_\_\_
- Unable to determine
- No further clarification needed

## Chapter 12: Disease of the Skin and Subcutaneous Tissue [Table of Contents](#)

**Case Scenario:** Ms. Smith is brought from home (bed bound) with inability to care for herself. She likely needs placement in a skilled nursing facility and requires consult for nutrition. She is severely cachectic with severe malnutrition and is noted with a sore on her sacrum. On day 3 of admission, nursing notes a stage 2 pressure ulcer on sacrum being treated with Mepilex and turning every two hours. Dr. Jones notes patient will be placed in skilled nursing facility with inability to care for self with severe malnutrition and bed bound.

### 12:1 Skin ulcer specificity [Table of Contents](#)

Dear Dr. Jones,

Stage 2 pressure ulcer was documented within the nursing skin flow-sheet on xx/xx located on the sacrum.

Clinical Indicators: Severe malnutrition, bedridden, sore on sacrum on admission, protective pads, repositioning

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

- Pressure ulcer/injury (if so, please specify the stage and location and if present on admission) \_\_\_\_\_
- Non-pressure ulcer (if so, please specify) \_\_\_\_\_
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

### Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue [Table of Contents](#)

**Case Scenario:** Ms. Smith is a 65-year-old female admitted following a left femur fracture at the head of the femur. She tripped over a cord at home and felt immediate pain in her leg when trying to stand. She is being admitted for an ortho consult. She has a history of osteoporosis and takes daily calcium supplements. Ortho is admitting for probable surgical intervention.

#### 13: Pathological Fracture versus Traumatic Fracture [Table of Contents](#)

Dear Dr. Jones,

Femur fracture was documented within the health record note on xx/xx following a fall.

Clinical Indicators: fall at home from standing/tripped over a cord, history of osteoporosis on supplements

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

- Pathological Fracture of the Femur (please specify if cause known) \_\_\_\_\_
- Traumatic Fracture of the Femur (no underlying pathological cause)
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

### Chapter 14: Diseases of the Genitourinary System [Table of Contents](#)

**Case Scenario:** Mr. Jonson is a 65-year-old male admitted with swelling and decrease in urine output (no urine since yesterday AM). Labs drawn and show Cr of 5.0 with a baseline of 2.0 (noted in chart). Nephrology being consulted for possible emergent dialysis. He has a temp of 103 and HR is 125, blood cultures being drawn. Foley placed with dark urine return and U/A collected. Pt with a clear UTI on U/A, blood cultures remain negative at this time. He is admitted with sepsis due to a UTI with AKI on CKD. His nephrologist notes historically his GFR is at 45

and will likely not be accurate with acute infection and AKI. Antibiotics started and emergent dialysis performed. Re-draw on chem lab shows a dramatic improvement in creatinine of 2.5.

#### 14:1 CKD staging [Table of Contents](#)

Dear Dr. Jones,

AKI on CKD was documented within the health record note dated xx/xx and is admitted with sepsis due to a UTI.

Clinical Indicators: decrease in urine output, abnormal GFR of 45, sepsis due to a UTI, dialysis performed

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

- Chronic kidney disease (CKD) Stage 2
- Chronic kidney disease (CKD) Stage 3
- Other stage of chronic kidney disease \_\_\_\_\_
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

#### Chapter 15: Pregnancy, Childbirth, and the Puerperium [Table of Contents](#)

**Case Scenario:** Mrs. Jonson is a 39-year-old female in high risk pregnancy due to advanced maternal age, morbid obesity, hypertension, and gestational diabetes. She is being admitted for pre-term contractions at 30 weeks with a severe headache. Her blood pressure is 150/90 and her home medication is Labetalol 200mg 2x a day (missed her dose this morning). IVF fluids have been started and she is given her dose of Labetalol with improvement in her BP to 125/80. She is given steroid shot and placed on bedrest.

#### 15:1 Hypertension in pregnancy [Table of Contents](#)

Dear Dr. Jones,

Hypertension was documented within the health record note on xx/xx with possible pre-term labor.

Clinical Indicators: severe headaches, advanced maternal age, obesity, gestational diabetes, bed rest, antihypertensives

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

- Gestational hypertension
- Pre-existing hypertension (if present, please specify underlying cause: heart disease, renal disease, etc.) \_\_\_\_\_
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine



- No further clarification needed

## Chapter 16: Certain Conditions Originating in the Perinatal Period [Table of Contents](#)

**Case Scenario:** Baby Smith born via c-section at 29 weeks gestation weighing 1250 grams. He is in extreme distress at birth with apnea and hypoxia without respiratory effort requiring resuscitation and intubated. He was brought to NICU on ventilation and chest X-ray performed. Surfactant administered and baby stabilized. NG placed and baby placed in warmer for low temps. He is being started on antibiotics due to temp variation and mother not having GBS results. He is noted with respiratory distress and being monitored for premature issues (anemia, hyperbilirubinemia, sepsis, ROP).

### 16:1 Neonatal respiratory distress specificity [Table of Contents](#)

Dear Dr. Johnson,

Respiratory distress was documented within the health record note on xx/xx requiring intubation and surfactant.

Clinical Indicators: hypoxia, apnea, no respiratory effort at birth, ventilator, surfactant

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

- Respiratory distress syndrome (cardiorespiratory) type 1
- Respiratory failure of newborn
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

## Chapter 17: Congenital Malformations, Deformations, and Chromosomal

### Abnormalities [Table of Contents](#)

**Case Scenario:** Jack Smith is a six-month-old boy with persistent reflux and occasional vomitus (sometimes projectile according to mother). She brought him in this morning because he appears dehydrated and she is fearful he isn't drinking or eating enough as he is lethargic and not hungry. She states even when he does take in a little it appears to come up with his reflux shortly after and she doubts he is getting anything at all. He undergoes scope to assess upper GI and the scope shows definite stricture in the esophagus. He is admitted for a temporary feeding tube placement and is noted by primary doctor to be diagnosed with GERD, dehydration, and need for feeding tube.

### 17:1 Congenital malformation of the esophagus [Table of Contents](#)

Dear Dr. Jackson,

GERD was documented within the health record note dated xx/xx with feeding tube placement.

Clinical Indicators: GI scope shows esophageal stricture, feeding tube to be placed, GERD with vomiting, dehydrated

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

- Congenital stenosis and stricture of esophagus
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

## Chapter 18: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified [Table of Contents](#)

**Case Scenario:** Mr. Paul is a 35-year-old male admitted with nausea and vomiting for the past two days. He is noted with Na of 129 and K of 4.0 with a creatinine of 1.2, and his WBC is 11.0 and Hgb is 15.0. He has a headache and feels very dehydrated which is what prompted his ED visit today. His vitals on admission to ED are: temp 99.9, HR 110, RR 18. He is noted with likely viral gastroenteritis and is given IVF for dehydration.

### 18:1 Supporting diagnosis [Table of Contents](#)

Dear Dr. Smith,

Dehydration was documented within the ED note dated xx/xx, he was given IVF and has a Na level of 129.

Clinical Indicators: Nausea and vomiting, headache, normal saline given, dehydration

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

- Hyponatremia
- Finding of no clinical significance
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

## Chapter 19: Injury, Poisoning, and Certain Other Consequences of External Causes [Table of Contents](#)

**Case Scenario:** Ms. Smith is a 65-year-old female admitted with altered mental status and femur fracture after falling at home. According to patients' husband, she took her normal dosage of Xanax which does not usually make her drowsy but after tonight's dosage she became so lethargic that she fell down the stairs and broke her leg and was incoherent (not making any sense and not able to communicate appropriately). After looking at the pill bottle, it appears she may have taken more than her usual amount; she should have six pills remaining but only four

pills are there. The husband thinks this is his fault as he usually prepares her weekly pills a week in advance and might have taken extra from this container, inadvertently mixing it up with a different medication that she also usually takes in the evening. He states the pills are similar in size. She is admitted with femur fracture and likely toxic encephalopathy from Xanax.

#### 19:1 Adverse Effects versus poisoning [Table of Contents](#)

Dear Dr. Johnson,

Likely toxic encephalopathy from Xanax was documented within the health record note dated xx/xx.

Clinical Indicators: altered mental status on admission, drowsy and lethargic, fall at home with subsequent broken femur, and evidence of missing pills

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

- Adverse effect medication (taken appropriately with proper dosage), please state the medication \_\_\_\_\_
- Poisoning with medication (wrong dosage or wrong medication), please state the medication and intention (intentional/not intentional) \_\_\_\_\_
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

#### Chapter 20: External Causes of Morbidity [Table of Contents](#)

**Case Scenario:** Mr. Jones is a 15-year-old male admitted with several life-threatening injuries: skull fracture, femur fracture, kidney laceration, and punctured lung. He was hit by an automobile while crossing the street. There was a “do not walk” signal flashing and verbal command of “do not cross”. It is unclear why he walked into oncoming traffic at this time, some bystanders have stated it appeared he was texting on his phone. He is currently intubated for airway protection. We are consulting ortho, nephrology, and psych for possible intentional self-harm. He is being admitted to the ICU with induced sedation. Three days into the stay, psych consult is reporting that according to family he does not have any suicidal ideations that they know of but did have a recent break-up with girlfriend which was a difficult stressor for him. He also has phone records indicating that he was texting at the time of the accident.

#### 20:1 Self-harm versus accident [Table of Contents](#)

Dear Dr. Johnson,

Walking into oncoming traffic was documented within the health record note dated xx/xx with subsequent life-threatening injuries.

Clinical Indicators: skull fracture, femur fracture, kidney laceration, punctured lung, ventilated and induced coma

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

- Intentional self-harm
- Accidental harm
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

## Chapter 21: Factors influencing Health Status and Contact with Health Services [Table of Contents](#)

**Case Scenario:** Ms. Jackson is being seen for pre-term contractions. She hasn't had pre-natal care, so she is unsure of how far along she is in the pregnancy. She thinks her last menstrual cycle was about eight months ago. After assessing her and performing ultrasound, baby is breech presentation and looks to weigh about six pounds. Her water has broken and we will proceed with c-section. After delivery, baby appears fully formed without any distress but with a thick layer of Vernix and is taken to NICU for observation.

### 21:1 Weeks of gestation [Table of Contents](#)

Dear Dr. Jones,

Possible pre-term labor was documented within the health record note dated xx/xx but unknown term due to lack of pre-natal care.

Clinical Indicators: water broke, baby is breech, c-section, infant fully formed without any distress, thick layer of Vernix

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

- 30-39 weeks (if so, please specify the last completed week) \_\_\_\_\_
- 40-42 weeks (if so, please specify the last completed week) \_\_\_\_\_
- Other explanation of clinical findings \_\_\_\_\_
- Unable to determine
- No further clarification needed

## Resources [Table of Contents](#)

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