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Queries in outpatient CDI: Developing a compliant, effective process

POSITION PAPER

Summary: A decade ago, the HIM and CDI industry had to define acceptable practices for itself related to concurrent record review and CDI query. The jointly published AHIMA/ACDIS Guidelines for Achieving an Effective Query Practice (first published in 2013, then updated in 2016) set the standard for query practice within the inpatient setting. It is now seen as the foremost authority on compliant query practice. This position paper has been built upon that foundation.

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CDI professionals review a number of outpatient encounters, including observation services, emergency department (ED) visits, diagnostic testing/interventions, and physician office encounters. Outpatient CDI reviews impact medical necessity of care, professional billing, charge capture, quality data, and risk adjustment.

However, these reviews are not the same as the ones typically conducted in the inpatient setting, where time is less of a factor and volumes are lower. The brevity of most outpatient encounters, the high volume of cases to review, and a need to ease the burden for busy providers all challenge CDI specialists in outpatient venues. What remains the same, however, is the importance of establishing a compliant and effective query process.

The focus of this paper is to provide guidance for establishing such a process in the outpatient setting. It offers a compliant practice for review and clarification of diagnoses as related to the ICD-10-CM code set. This paper does not speak specifically to the coding practices related to CPT®/HCPCS, E/M professional billing, or ICD-10-PCS codes, but its guidance can be applied to query and provider communications in these code sets as well.

This paper does not define or outline processes of CDI practice in the various areas of outpatient care; to learn about where CDI can function in the outpatient setting and the initial steps of structuring a CDI department, please view the ACDIS white paper *Outpatient Clinical Documentation Improvement: An Introduction* (https://acdis.org/resources/outpatient-clinical-documentation-improvement-cdi-introduction).

Outpatient encounters move at a much faster pace than the inpatient arena, meaning communication with providers must be timely and efficient. Concurrent record review is challenging in the outpatient setting due to the compressed nature of encounters and use of the problem list. Retrospective reviews allow for a review of a large number of records, but this can burden the provider with multiple queries to answer. As a result, reviews are often performed prospectively, or prior to an encounter, to allow for providers to be queried before the patient has been seen (letting providers answer the query during the actual patient encounter). But no matter the timing of the review—concurrent, retrospective, or prospective—or the nature of the query, CDI professionals must adopt compliant practices.

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A decade ago, the HIM and CDI industry had to define acceptable practices for itself related to concurrent record review and CDI query. The jointly published AHIMA/ACDIS *Guidelines for Achieving an Effective Query Practice* (first published in 2013, then updated in 2016) set the standard for query practice within the inpatient setting. It is now seen as the foremost authority on compliant query practice. This position paper has been built upon that foundation.

The AHIMA/ACDIS practice brief describes a query as "a communication tool used to clarify documentation within the health record for accurate code assignment. The desired outcome for a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment." It adds, "A proper query process ensures that appropriate documentation appears in the health record. Personnel performing the query function should focus on a compliant query practice and content reflective of appropriate clinical indicators to support a query."

We have now reached a new challenge. How do we adapt this guidance to ensure outpatient CDI practices are compliant? How do we assist providers without leading them to inappropriate conclusions? How do we deal with out-of-date problem lists? Can CDI specialists review previous encounters to help facilitate commonly employed prospective review processes? This paper seeks to answer these questions.

Existing query guidance and application

Guidelines for Achieving a Compliant Query Practice was intended to provide CDI specialists and coding professionals guidance on how to issue compliant provider queries in the inpatient setting in order to maintain the integrity of coded healthcare data. Similarly, all professionals regardless of licensure, credentials, or background are expected to follow the query guidelines promulgated in this position paper.

CDI professionals should query a provider when the medical record documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Describes or is associated with clinical indicators but does not have a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Provides a diagnosis without underlying clinical validation
- Is unclear regarding present on admission (POA) indicator assignment

Queries must not contain any information about their impact on reimbursement. According to *Guidelines for Achieving a Compliant Query Practice,* "a leading query is one that is not supported by the clinical elements in the health record and/or directs a provider to a specific diagnosis or procedure." The practice brief stresses the importance of not leading the provider. Whether inpatient or outpatient, all queries (no matter the format) should contain clinical indicators to support why the query was

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initiated. The query can be formatted differently depending upon the organization's query process and provider preference. For example, some organizations prefer to list the clinical indicators first, followed by the specific question; other organizations will provide the question first, then the indicators. The practice brief states, "The justification (i.e., inclusion of relevant clinical indicators) for the query is more important than the query format." Examples of differing query formats are provided in the appendix below.

According to *Guidelines for Achieving a Compliant Query Practice,* "clinical indicators should be derived from the specific medical record under review and the unique episode of care. Clinical indicators supporting the query may include elements from the entire medical record, such as diagnostic findings and provider impressions." However, in the outpatient setting, not all clinical indicators are available for review during a particular visit or encounter. For example, some laboratory tests are performed outside of the face-to-face encounter, possibly prior to the visit. As a result, the outpatient CDI team may need to reference these labs within the query to support why further clarification was initiated.

"The guidance for the "yes/no" query format remains the same in the outpatient setting. A "yes/ no" query should not be used in circumstances where only clinical indicators of a condition are present and the condition/ diagnosis has not been documented in the medical record.

ACDIS recommends implementing a strong policy and procedure for the outpatient CDI team that addresses the parameters of an appropriate visit or encounter. This will be further described in the section "Physician queries and the use of prior information" below.

Open-ended, multiple-choice, and "yes/no" query formats are acceptable in the outpatient setting. Multiple-choice query formats should always include "clinically significant and reasonable options as supported by clinical indicators in the health record." Additional options such as "clinically undetermined" and "other" should be included in multiple-choice query formats so that providers can add free text if the options provided are not applicable.

The guidance for the "yes/no" query format remains the same in the outpatient setting. A "yes/no" query should not be used in circumstances where only clinical indicators of a condition are present and the condition/diagnosis has not been documented in the medical record. New diagnoses cannot be achieved with a "yes/no" query; for this purpose, an open-ended or multiple-choice query format should be used.

The guidance within this practice brief relating to POA status using the "yes/no" format will not apply to most outpatient settings, which often do not require the reporting of POA status. An exception is the ED, as some ED visits lead to inpatient admissions, making ED documentation vital for the assignment of POA indicators. Therefore, it may be appropriate for some POA "yes/no" queries to be initiated in the ED setting under the following circumstances:

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- Substantiating or further specifying a diagnosis that is already present in the health record (i.e., findings in pathology, radiology, and other diagnostic reports) with interpretation by a physician
- Establishing a cause-and-effect relationship between documented conditions such as manifestation/etiology, complications, and conditions/diagnostic findings (i.e., hypertension and congestive heart failure, diabetes mellitus, and chronic kidney disease)
- Resolving conflicting documentation from multiple practitioners

Furthermore, it remains best practice to capture all verbal and/or written queries (both question and answer) in the outpatient setting. Doing so will allow CDI professionals to account for documentation that might appear out of context. If a provider responds to a query within a medical record and there are no clinical indicators supporting the response, ask the provider to document his or her clinical rationale for the diagnosis within the health record or on the query form (either are acceptable, if the query form is retained as a permanent part of the record). This step will help to minimize any secondary review risks or questions because the record will speak for itself. With this in mind, the use of "sticky notes" or other temporary tools to clarify documentation is not recommended.

Similar to the inpatient CDI process, every organization should develop a policy that addresses the tracking and documentation of verbal and/or written queries, the escalation process for unanswered queries, and the retention of provider queries (i.e., retained as a permanent part of the medical record versus non-permanent). As acknowledged in *Guidelines for Achieving a Compliant Query Practice,* "healthcare professionals that work alongside practitioners to ensure accuracy in health record documentation should follow established facility policies and procedures that are congruent with recognized professional guidelines." ACDIS recommends following the same guidance as described in the practice brief:

> *The policy should indicate if the query is part of the patient's permanent health record or stored as a separate business record. If the query form is not part of the health record, the policy should specify where it will be filed and the length of time it will be retained. It may be necessary to retain the query indefinitely if it contains information not documented in the health record. Auditors may request copies of any queries in order to validate query wording, even if they are not considered part of the legal health record.*

Relevant coding/CDI guidance from *Coding Clinic* and *Official Guidelines for Coding and Reporting*

To develop a valid query, a CDI specialist must be able to differentiate between complete and incomplete documentation. The most authoritative guidance on this topic is contained in the *Official Guidelines for Coding and Reporting,* Section IV, Diagnostic Coding and Reporting Guidelines for Outpatient Services. These guidelines are approved for use by hospitals/providers in hospital-based outpatient services and

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provider-based office visits, and contain some of the rules that govern the translation of documentation into codes.

CDI specialists operating in the outpatient setting must familiarize themselves with not only this particular section, but the entirety of the *Guidelines*. The introduction of Section IV states, "Guidelines in Section I, Conventions, general coding guidelines and chapter-specific guidelines, should also be applied for outpatient services and office visits."

Specific guidelines on the documentation that drives query development can be found in Section IV.C, "Accurate reporting of ICD-10-CM diagnosis codes," which states: "… the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter …"

Chronic disease management and reporting is the focus of many outpatient encounters and reviews. CDI specialists should therefore incorporate outpatient guideline IV.I, "Chronic diseases," which states, "Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)."

One critical difference between inpatient and outpatient documentation and coding guidelines is the following guidance on what constitutes a reportable diagnosis. In the outpatient setting, the terms "probable, suspected, rule out," etc. do not apply:

> *The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis does not apply to hospital-based outpatient services and provider-based office visits. Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.*[1]

The outpatient counterpart to the UHDDS is the Uniform Ambulatory Care Data Set (UACDS). First developed in the early 1970s, the UACDS underwent several revisions and was eventually incorporated in August 1996, along with the UHDDS, into the National Committee on Vital and Health Statistics (NCVHS) core health data elements document. In fact, *Coding Clinic,* First Quarter 1989, pp. 5–7, "Coding accuracy, data uses and HCFA initiative," states the following: "The ambulatory care data set, which is still in the developmental stages, will be used as the basis for reporting outpatient care when it becomes available."

The UACDS guidelines contained within the NCVHS core elements describe ambulatory conditions as those "which [describe] all conditions requiring evaluation and/or treatment or management at the time of the encounter as designated by the health care practitioner," and further describe "other conditions" as "the

[1] While inconclusive "possible/probable/suspected/rule out" diagnoses cannot be reported with ICD-10-CM codes in the outpatient setting, physicians should be encouraged to document them, as they can be used in their own medical decision-making and professional (i.e., E/M) leveling. This distinction represents an opportunity for CDI to provide education to providers. See "Evaluation and Management Services" from CMS, August 2017, pp. 13, 14, 31, 32, 80, and 81, for guidance on "possible" and "probable" diagnoses.

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additional code(s) that describes any coexisting conditions (chronic conditions or all documented conditions that coexist at the time of the encounter/visit, and require or affect patient management. Condition(s) should be recorded to the highest documented level of specificity."

In addition to the above, the *CPT Manual* published by the AMA contains guidelines on coding, reporting, and documentation. The documentation guidelines in the *CPT Manual* are mainly contained in the E/M section, which houses information on the documentation of the following components:

- The three key components: Medical decision-making, history, and examination
- The supporting components: Nature of the presenting problem, counseling, coordination of care, and time

The limited information in the E/M section of the *CPT Manual* can be found in full within AMA and CMS' jointly published 1995 Documentation Guidelines for Evaluation and Management Services and subsequent 1997 Documentation Guidelines for Evaluation and Management Services (referred to as the DG within those documents and herein).

With very little information on medical decision-making in the official guidelines, and with most agreeing (and the E/M guidelines suggesting) that medical decision-making is the most important component used in patient care, the DGs provide needed guidance. Section II, *General Principles of Medical Record Documentation,* partially states (in both the 1995 and 1997 DGs):

"The documentation of each patient encounter should include:

- Assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.
- For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as 'possible', 'probable', or 'rule out' diagnoses.
- Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies and medications."

Section III, *Documentation of E/M Services, Part C, Documentation of the Complexity of Medical Decision Making,* contains specific guidance on documentation of the encounter. It speaks to the "complexity of establishing a diagnosis and/or selecting a management option as measured by the number of possible diagnoses and/or the number of management options that must be considered, the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed, and the risk of significant complications, morbidity, and/or mortality, as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options," all of which are based on documentation of the provider's expert judgment and opinion.

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Risk of noncompliance and nonclinical validation

The need for a compliant query practice is evident. Physician documentation must support medical necessity of diagnostic testing, monitoring, evaluation, and treatment of submitted diagnoses. For example, if during a wellness visit a patient makes note of an unexpected clinical concern or complaint that requires additional workup to address and manage, additional charges can be billed for a problem-focused visit (i.e., a higher-level evaluation and management code, used by physicians in professional billing)—but only if the documentation is adequate to support both services.

As additional services are performed on an outpatient basis, CDI must remain vigilant in regard to the need for compliant and clinically validated diagnoses.

Compliant query practice supports the various objectives of outpatient CDI. Although they vary between organizations, outpatient CDI initiatives often include monitoring documentation of diagnoses—particularly chronic conditions—for outpatient visits. These diagnoses impact a broad array of risk-adjusted payment systems, including the CMS Hierarchical Condition Categories (HCC) model, under which Medicare Advantage (MA) organizations reimburse commercial insurance companies on a capitated basis adjusted for health risks and anticipated complexity of care as a proxy for expenses associated with that care.

Within most risk-adjusted payment systems, certain chronic conditions must be documented every calendar year in order to be submitted for appropriate reimbursement. Providers need to be educated on these documentation requirements according to authoritative ICD-10-CM coding guidelines. As additional services are performed on an outpatient basis, CDI must remain vigilant in regard to the need for compliant and clinically validated diagnoses.

The challenge is determining whether these diagnoses are clinically validated in the record and demonstrated as medically necessary. The Office of Inspector General (OIG) *2017 Work Plan* included the work item “Risk Adjustment Data—Sufficiency of Documentation Supporting Diagnoses.” In it, the OIG stated that it would audit medical record documentation submitted by MA organizations “to ensure that it supports the diagnoses that MA organizations submitted to CMS for use in CMS’s risk score calculations and determine whether these diagnoses submitted complied with Federal requirements.”

Section IV of the FY 2018 ICD-10-CM *Official Guidelines for Coding and Reporting,* item J, states that “Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).” The key part of this phrase is “as many times as the patient receives treatment and care for the condition(s).” The following documentation examples indicate that the patient is still receiving management for a chronic condition, so the condition may therefore be coded and reported:

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- Diabetes mellitus Type 2, stable. Patient instructed to monitor glucose and will re-evaluate in three months.
- Diabetes mellitus Type 2, A1C 6.3, fasting glucose 145, continue on Metformin. Instructed the patient to monitor glucose and provided nutritional assessment.

A good query process will result in compliant supporting documentation for all reported diagnoses. [2]

> **In order to compliantly code secondary diagnoses in both inpatient and outpatient settings, there must exist a reasonable indication that the condition was evaluated and assessed based on standards of clinical practice.**

In order to compliantly code secondary diagnoses in both inpatient and outpatient settings, there must exist a reasonable indication that the condition was evaluated and assessed based on standards of clinical practice. Clinical validation (such as covered in the recent ACDIS white paper *Clinical Validation and the Role of the CDI Professional)* has focused on clinical indicators, diagnostic testing, and/or treatment to support the diagnosis and meet the requirements of the *Official ICD-10-CM Guidelines for Coding and Reporting* as they apply to inpatient encounters and services. While the *Guidelines* also include outpatient coding guidelines, there is no clear direction regarding what constitutes clinical validity in the outpatient arena.

As a starting point, ACDIS recommends following evidence-based clinical practice (EBCP) guidelines. These provide information regarding diagnoses and treatment for specific conditions. Since auditors often review claims for supportive documentation of a diagnosis, consider EBCP as a reference to determine if the clinical indicators, management, evaluation, and treatment for a diagnosis are present. As noted, diagnoses must be supported by clinical indicators in the health record, but this evidence is often supported by, and derived from, the body of the record. If that is the case, the physician does not need to re-document this evidence in the assessment/plan.

Managing the problem list

The problem list was first defined and created by Lawrence Weed in the 1960s, long before the implementation of electronic health records (EHR). Problem lists became widely used and were later required as part of the meaningful use incentive program.[3] Recently, they have become an aid in the development and issuance of queries in the outpatient setting. The problem list can carry a wealth of information vital to the patient's care; however, it can also cause misinterpretation and errors if not maintained appropriately. By querying for additions and deletions to the problem list, CDI specialists can help the list add significant value to the quality and continuity of patient care.

The meaningful use program required the problem list to include all past and existing diagnoses, pathophysiological states, abnormal physical signs and laboratory findings,

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[2] Note that a physician does not need to restate these supporting clinical indicators if they are already documented within the health record. In the outpatient setting, the A1C, glucose, and meds can typically be captured from the remainder of the record.
[3] Weed, Lawrence L. (1968). Medical records that guide and teach. *New England Journal of Medicine, 278*(11), 593–600.

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disabilities, and unusual conditions.[4] AHIMA defines the problem list as “a compilation of clinically relevant physical and diagnostic concerns, procedures, and psychosocial and cultural issues that may affect the health status and care of patients.[5]

A well-maintained problem list is vital in the continuity of patient care; however, due to differing views of what the list should and should not include, most healthcare institutions have left its contents up to the healthcare provider. Per AHIMA, the problem list should provide a “working” list of conditions and diagnoses that can be updated during any episode of care.[6]

Some organizations use their CDI staff to help manage the problem list through provider education or queries. The most opportune time for the CDI specialist to query the provider for any additions or deletions is during the annual visit. Chronic conditions typically remain on the problem list; however, to be included on the outpatient claim, they must meet the requirements listed in Section IV of the *Official Guidelines for Coding and Reporting.* Without identified treatment or evaluation, diagnoses aren’t reportable.

Although some CDI specialists in the outpatient setting review the patient’s medical record prior to the patient’s visit, many find opportunities for query after the visit. Following the outpatient visit, and prior to claims submission, the CDI specialist should review all substantiated and documented conditions to confirm that they meet the requirements for a reportable diagnosis. If there is no evidence indicating a condition on the problem list was evaluated or treated, query the provider. The following is an example:

> *Dear Provider,*
>
> *Asthma was added to this patient’s problem list following her visit today. Would you please document how this diagnosis was addressed or managed? Thank you.*
>
> *Susan, CDI Specialist*

Another example might include documentation on the problem list of “breast cancer/status post radiation.” This presents numerous issues for the potential outpatient coder: The documentation is unclear as to whether the condition is still present or a “history of,” and it lacks specificity. The following is an appropriate query:

> *Dear Provider,*
>
> *Documentation of “breast cancer/status post radiation” was noted following the patient’s annual visit. Would you please add to the notes the laterality of breast, the specific quadrant, and if the cancer has been completely eradicated or is still under active treatment? Thank you.*
>
> *Susan, CDI Specialist*

[4] Department of Health and Human Services, Centers for Medicare and Medicaid Services (2010, July 28). Medicare and Medicaid programs; electronic health record incentive program, final rule.
[5] AHIMA (2008). Best practices for problem lists in an EHR. *Journal of AHIMA, 79*(1), 73–77.
[6] AHIMA Work Group. (2011, September). Problem list guidance in the EHR. *Journal of AHIMA,* 82(9), 52–58.

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Although it is easy for a provider to add to the problem list, many conditions unnecessarily remain on the list long after they are resolved. Clutter is a common complaint when it comes to the problem list. CDI specialists can query the physician to remove conditions that are no longer being treated. When to remove a condition varies widely among providers, although acute conditions such as UTIs, bronchitis, and influenza would ordinarily be removed after they resolve. One study concluded that a problem could safely be deleted after one year without a reoccurrence requiring treatment,[7] although organizations are encouraged to develop their own policy and procedure for maintaining the problem list and requirements on when physicians should remove diagnoses. However, conditions that continue to require provider assessment, observation, screening, and/or continued monitoring—for example, amputation or malignancies—will remain on the problem list far longer, if not indefinitely.

Consider the following scenario of a 66-year-old female with frequent bouts of pyelonephritis. After two consecutive infections, the physician added the diagnosis to the problem list. However, the CDI specialist noted 11 months later that the patient hadn't been on antibiotics for the past 10 months, and there had been no documentation of pyelonephritis for the past nine months. The following is an appropriate query:

> *Dear Provider,*
>
> *Pyelonephritis remains on the patient's problem list. Per documentation she hasn't had documented infections in the past nine months and hasn't received antibiotics or other evidence of assessment and monitoring in over 10 months. If appropriate, please update the problem list to show the current status of the pyelonephritis (i.e., active, resolved). Thank you.*
>
> *Susan, CDI Specialist*

Physician queries and the use of prior information

As noted above, when reviewing outpatient records, CDI specialists may encounter diagnoses within the problem list or history whose continued relevance is in doubt. CDI specialists are faced with the dilemma of reviewing previous encounters to learn more about these diagnoses. With the proliferation of EHRs, CDI specialists can now search previous encounters for conditions that may have been lost in the paper shuffle of years past. But is this practice acceptable? *Coding Clinic for ICD-9-CM,* Third Quarter 2013, offers the following guidance:

> **Question:** *Is there a guideline or rule that indicates that you should only use the medical record documentation for that specific visit/admission for diagnosis coding purposes? Does each visit or admission stand alone? Would the coder go back to previous encounter records to assist in the coding of a current visit or admission?*

[7] Holmes, C., Brown, M., Hilaire, D. S., & Wright, A. (2012, November 11). Healthcare provider attitudes towards the problem list in an electronic health record: A mixed-methods qualitative study. *BMC Medical Informatics and Decision Making, 12,* 127.

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> **Answer:** *Documentation for the current encounter should clearly reflect those diagnoses that are current and relevant for that encounter. Conditions documented on previous encounters may not be clinically relevant on the current encounter. The physician is responsible for diagnosing and documenting all relevant conditions. A patient's historical problem list is not necessarily the same for every encounter/visit. It is the physician's responsibility to determine the diagnoses applicable to the current encounter and document in the patient's record. When reporting recurring conditions and the recurring condition is still valid for the outpatient encounter or inpatient admission, the recurring condition should be documented in the medical record with each encounter/admission. However, if the condition is not documented in the current health record, it would be inappropriate to go back to previous encounters to retrieve a diagnosis without physician confirmation.*

Coding Clinic does not specify whether a CDI specialist can or cannot look at previous encounters, but notes that if a condition is carried over from a previous encounter, it would need to be queried to the provider in order to obtain confirmation and validity.

"Just as physicians review the previous visit, CDI specialists may review previous visits in order to advocate for patients and ensure continuity of care.

Just as physicians review the previous visit, CDI specialists may review previous visits in order to advocate for patients and ensure continuity of care. If a patient has a history of diabetic neuropathy, retinopathy, and seizures, CDI specialists must ensure that future caregivers have this same specific information versus seeing a nonspecific "DM2" written in the patient's chart.

The standard for query in all settings is whether the condition is still being treated or is affecting the patient's condition. Chronic conditions are those conditions most often reviewed for HCC reporting, and they often are still affecting the patient—hence the word "chronic." CDI specialists must therefore review previous encounters in order to determine clinical relevance based on current signs and symptoms, medications, and recent treatments.[8] Lacking authoritative coding guidance, ACDIS recommends that each facility develop its own policy on how far back it will review prior records and follow that policy in a consistent manner.

When reviewing previous encounters to obtain a complete history and accurate portrayal of patients, CDI specialists must query the provider appropriately. It is leading to introduce a diagnosis to the provider in a query without previous clinical indication. The following is an example of a compliant prospective query in which the CDI specialist reviewed the record prior to the patient's arrival:

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[8] For additional guidance on the use of prior records, see the ACDIS white paper "Physician queries and the use of prior information: Reevaluating the role of the CDI specialist." Available at *https://acdis.org/resources/physician-queries-and-use-prior-information-reevaluating-role-cdi-specialist*

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Dear Physician,

Your patient, Mr. Jones, has a past medical history of CAD, CHF, and COPD, as noted on his previous office visit. Current medications include albuterol, nitroglycerin PRN, and Lasix. Please review this encounter and these conditions for relevancy and document within Mr. Jones' upcoming appointment if these are still relevant, and please provide clinical support of how they are affecting his care and/or if these conditions are being managed.

Conclusion

"CDI specialists and coding professionals have historically worked with providers to assist in ensuring medical record documentation is complete and accurately describes the encounter and the patient's story.

Medical record documentation serves a number of purposes. Most importantly, it is a communication tool between providers and caregivers, providing a clear record of the patient's specific medical needs, plan of care, and progress. CDI specialists and coding professionals have historically worked with providers to assist in ensuring medical record documentation is complete and accurately describes the encounter and the patient's story. In 2007, the United States Federal Register encouraged organizations to assist providers with documentation needs, stating, *"We highly encourage physicians and hospitals to work together to use the most specific codes that describe their patients' conditions. Such an effort will not only result in more accurate payment by Medicare but will provide better information on the incidence of this disease in the Medicare patient population."*[9] The primary purpose of the physician query process is to assist providers in accurately and specifically capturing the patient's present health status to include all reportable conditions, complexity of medical decision-making, and the treatment applied.

As this paper has discussed, there are a number of reasons CDI specialists review records and apply queries. Obtaining thorough and complete documentation related to a patient encounter in the outpatient setting supports medical necessity of care, physician professional billing, capture of the patient's level of risk adjustment, and communication of the plan of care. Queries must be applied in a thoughtful and compliant manner, allowing for complete documentation to occur. Organizations must work together using guidance provided within this paper and the direction of their compliance department to develop policies related to template development, format, application, and storage of both written and verbal queries. Policies should also direct when and how query practice will be audited and monitored for compliance, as well as how often these policies will be reviewed and revised.

Physician communication and education is a principal focus of CDI practice. It is used to ensure accurate and complete medical records and to work with providers on achieving needed documentation clarity. The efforts of CDI specialists must be organized and compliant as the profession expands its influence and reach. As the ACDIS *Code of Ethics* states, "Clinical documentation improvement specialists shall support the reporting of all healthcare data elements required for external reporting purposes (e.g., reimbursement and other administrative uses, population health,

[9] Federal Register, Vol. 72, No. 162, August 22, 2007. Rules and Regulations, pp. 47180–47181.

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quality and patient safety, measurement, and research) completely and accurately, in accordance with regulatory and documentation standards and requirements and applicable official coding conventions, rules, and guidelines." As CDI specialists, we must remain educated and participate in the development of query policies and practices that support documentation improvement; comply with industry guidance; and meet regulatory, legal, and ethical standards of coding and reporting.

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Appendix

Suggested template for all queries:

1. Patient identifiers.
2. Date of query.
3. Query: Clarification that is needed in the visit note.
4. Relevant clinical indicators: What is contained in the record (or problem list) in relation to the diagnosis needing clarification. Should state which notes in the medical record are being referenced, including the date of the note.
5. CDI reviewer: Include the name and contact number of the CDI specialist.

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Query examples

Leading query example

Note: The following is an example of a leading (i.e., noncompliant) query:

Your patient, Mr. Jones, has a past medical history of CAD, CHF, and COPD. Please document these conditions during the encounter today. Thank you.

Compliant query examples

Example 1:

In this example, the CDI specialist is reviewing a case for a primary care clinic. The query opportunity is to capture alcohol dependency in remission.

Clinic note:

- Chief complaint: “Released from hospital two weeks ago, for CHF exacerbation.”
- History: Mr. Smith is a 72-year-old male, with a history of chronic systolic heart failure, severe COPD with asthma, cirrhosis of the liver, and alcohol use, presents for a follow-up appointment since hospital discharge.
- Patient was released with a discharge diagnosis of systolic heart failure exacerbation, started on oxygen 2L, increased Lasix to 40 mg BID and continued home Coreg. Patient has been compliant with new Lasix increase, but still has some shortness of breath when walking while on 2L NC. Continues smoking 1 ppd.
- Physical exam:
  - Cardiovascular: BP 150/86 HR 80 RR 26, murmur
  - Lungs: 92% on 2L NC, no distress noted
  - Abdomen: Right abdominal tenderness, slightly distended
  - Extremities: 1+ pitting edema on bilateral lower extremities, skin WNL
- Social history:
  - Current tobacco use
  - Alcohol: quit 2015; used to drink 6–9 beers daily, 10–12 beers on weekend with 4–5 shots of tequila
  - Attends Alcoholics Anonymous (AA) meetings
- Assessment and plan:
  - Severe COPD with asthma: Continue oxygen 2L NC at home, Advair, and albuterol.
  - Systolic heart failure: Continue Lasix 40 mg BID and Coreg, check daily weights. Check BNP today.
  - Cirrhosis of liver: Abdomen still slightly distended, stable. Will draw ammonia level today to see if we need to stop lactulose.
  - Current smoking: Discussed with patient about taking medication to stop smoking; patient stated he didn’t feel the need to quit.

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Query:

Please include in the next visit note and problem list if alcohol use is:

- Abuse
- Dependence
- In remission
- Other (please specify)
- Unable to determine

Reference note: Per family medicine visit 11/20/16, patient has history of alcohol use; quit in 2015; used to drink 6–9 beers daily, 10–12 beers on weekend with 4–5 shots of tequila.

Management: Attends AA meetings.

Example 2:

In this example, the CDI specialist is reviewing a case for a primary care clinic. The opportunity is to clarify if the DVT is acute or chronic and to have it added to the problem list as well as outpatient visit notes.

Clinic note:

> Patient presents with leg swelling. She was seen at urgent care earlier this month with acute left knee pain and swelling. Recent x-ray done at urgent care on 7/3/17 revealed moderate medial and mild lateral and patellofemoral compartment degenerative changes, progressed since 2006. At that time, she was prescribed Mobic, instructed on RICE therapy, and given a knee brace for comfort and support.
>
> Patient states that she has had progressive left lower extremity pain and swelling over the past two weeks. She states that initially it started in her knee but has progressed to her leg and proximal thigh. She has pain in her medial thigh. She has pain with movement that is only slightly improved with rest. She has no past history of DVT; however, she is morbidly obese, sedentary, and spends most of her day in bed.
>
> Plan: Swelling of left lower extremity
>
> Acute LLE edema, pain on palpitation of medial thigh suggestive of DVT. No past history of DVT; however, morbid obesity, sedentary, and recent LLE injury place her at high risk for blood clots. Stat Doppler of LLE to rule out DVT.
>
> 7/22/17 Attending attestation: Patient presents with known DVT; PE includes LLE swelling and good perfusion. Treat with Xarelto.

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Query:

Please update the problem list and outpatient visit notes to include the status of the DVT:

- Acute
- Subacute[10]
- Chronic
- Resolved
- Other (please specify)
- Unable to determine

> *Tha*nk you.
> 7/21/17 clinic note states: Known DVT, with progressive LLE pain and swelling over the past two weeks
> Monitoring: Doppler of LLE performed
> Treatment: Xarelto

Example 3:

In this example, the CDI specialist is reviewing the medical record of a patient in observation status. The opportunity is to capture failed antibiotic therapy, which will allow the patient to meet inpatient medical necessity criteria and be admitted to inpatient status.

> *82-ye*ar-old female presents to the clinic with concerns of worsening erythema, swelling, induration, and tenderness to palpation concerning for possible DVT of LLE versus worsening cellulitis of previous I&D site, despite administration of PO antibiotics. After presenting to clinic with signs of recurrent cellulitis, induration, and pain on 6/12/17, she was placed in observation and started on IV vancomycin. DVT of LLE was ruled out with venous Doppler. CT left lower extremity did not reveal drainable abscess*.*
>
> Per case manager, evidence-based clinical guidelines indicate that patient meets observation care criteria for cellulitis.

Query:

Please clarify if you believe that the cellulitis is due to:

- Failed antibiotic therapy
- A new infection
- Other (please specify)
- Unable to determine

> Noted in H&P that patient underwent I&D of site and IV antibiotics last month, discharged on PO antibiotics. She now returns with recurrent cellulitis of the same site, being treated with IV vancomycin.

[10] *AHA Coding Clinic*, Fourth Quarter 2011, p. 21

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Example #4:

In this example, the CDI specialist is reviewing the medical record for an ED patient who is being returned to the SNF. The opportunity is to concurrently clarify conflicting documentation related to the patient's possible wound during her ED encounter.

> An 82-year-old female patient presents to the ED from a local SNF with complaints of discomfort in lower back. The physician documents under ROS, "skin – W & D, no rashes or lesions." Nursing documentation at 2200 indicates that there is a stage 3 sacral pressure ulcer requiring wet-to-dry dressing changes.

Query:

> Noted in your first note that the patient has skin that is warm and dry with no rashes or lesions; however, nursing documentation at 2200 describes a "stage 3 sacral pressure ulcer" requiring wet-to-dry dressing changes. Please clarify the diagnosis under treatment in your ED assessment note.

Example #5:

In this example, the CDI specialist is reviewing the medical record of a patient who is scheduled for a colonoscopy at outpatient clinic. The opportunity is to clarify whether this is a screening colonoscopy or a diagnostic colonoscopy.

> This 42-year-old female was referred by her PCP to the clinic for a colonoscopy. The referral does not mention whether this is a screening or diagnostic colonoscopy. Review of the record reveals no GI symptoms that would indicate the need for a diagnostic study; however, the patient has a family history (father) with colon cancer.

Query:

> When this patient is seen, please clarify whether this is a screening colonoscopy or diagnostic colonoscopy, if known. Noted that this patient is referred for a colonoscopy. She has no documented GI symptoms and has a family history of colon cancer.
>
> **Note:** *In this situation, there are only two reasonable options, so "other" as an option does not apply.*

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Example #6:

In this example, the CDI specialist is reviewing a case in an outpatient preop assessment clinic. The query opportunity is to determine what diagnosis the dexamethasone is being used to treat.

> This 44-year-old male with glioblastoma multiforme with cerebral edema is diagnosed by MRI. The last visit indicates, “I reviewed the most recent MRI which showed that there has been interval development of multi cystic ring enhancing lesion with surrounding edema in the right temporal lobe. Thankfully, patient is not very symptomatic since starting steroids.”
>
> For the upcoming preop assessment visit, dexamethasone is listed in the med list without a diagnosis.

Query:

> The patient has documented glioblastoma multiforme. The clinic notes document a lesion with surrounding edema and the patient is “not very symptomatic since starting steroids.” The preop assessment notes continued use of dexamethasone. Please document which diagnosis the dexamethasone is treating, if known.

What is an ACDIS Position Paper?

An ACDIS Position Paper sets a recommended standard for the CDI industry to follow. It advocates on behalf of a certain position or offers concrete solutions for a particular problem. All current members of the ACDIS Advisory Board must review/approve a Position Paper and are encouraged to materially contribute to its creation.

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