Clinical Documentation Reference Guide

A comprehensive resource for clinical documentation experts

SECOND EDITION
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Introduction

Designed for all clinical documentation improvement (CDI) team members, this book will help you and your team better understand the role documentation plays in care management, coding, and billing. Proper documentation ensures quality patient care and optimal reimbursement through more accurate coding and compliance. Accurate documentation is also your one best defense in the event of litigation. The Clinical Documentation Reference Guide walks you through the minefield of common documentation pitfalls and teaches you the skills necessary to create, overhaul, or enhance your organization’s documentation improvement program to protect your reimbursement and operate ethically.

This extensive guide is filled with page after page of insights to guide you in developing or expanding the qualities necessary to meet and manage clinical documentation. This start-to-finish CDI primer covers medical necessity, joint/shared visits, incident-to billing, preventative care visits, the global surgical package, complications and comorbidities, and CDI for EMRs.

Prevent documentation deficiencies and keep your claims on track for optimal reimbursement with this expert guidance:

- Understand the legal aspects of documentation.
- Anticipate and avoid documentation trouble spots.
- Keep compliance issues at bay.
- Learn proactive measures to eliminate documentation problems.
- Work the coding mantra — specificity, specificity, specificity.
- Avoid common documentation errors identified by CERT and RACs.
- Know the facts about EMR templates — and the pitfalls of auto-populate features.
- Master documentation in the EMR with guidelines and tips.
- Conquer CDI for time-based coding for E/M.

Learn the all-important steps to ensure your records capture the work your providers perform during each encounter. Benefit from methods to effectively communicate CDI concerns and protocols to your providers. Leverage the practical and effective guidance in the Clinical Documentation Reference Guide to triumph over your toughest documentation challenges.
a documented CC which, if not documented as a separate statement, may be pulled from the HPI.

**Tip:** If the CC has not been documented, the visit is not billable.

The HPI is a description of the patient’s current problem or illness. Table 3.1 charts out the eight different elements of HPI:

<table>
<thead>
<tr>
<th>Element</th>
<th>Examples of Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Eye pain, shoulder pain</td>
</tr>
<tr>
<td>Quality</td>
<td>Yellow-thick sputum</td>
</tr>
<tr>
<td>Severity</td>
<td>Pain scale 5 out of 10</td>
</tr>
<tr>
<td>Duration</td>
<td>For the past three weeks</td>
</tr>
<tr>
<td>Timing</td>
<td>This morning, yesterday</td>
</tr>
<tr>
<td>Context</td>
<td>Fell while riding bike</td>
</tr>
<tr>
<td>Modifying factors</td>
<td>Patient took pain meds</td>
</tr>
<tr>
<td>Associated signs and symptoms</td>
<td>Also, complains of itchy-watery eyes</td>
</tr>
</tbody>
</table>

Table 3.1: HPI Elements and Examples

The 1997 guidelines allow the provider the option of documenting four or more elements from the HPI, or the status of three chronic conditions for an extended HPI. CMS also allows an extended HPI for the status of three chronic conditions in the 1995 guidelines as well.

The ROS is a review of the 14 body systems. Table 3.2 shows a list of the body systems with examples:

<table>
<thead>
<tr>
<th>Body Systems</th>
<th>Examples of Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td>Weight loss, weakness, fever</td>
</tr>
<tr>
<td>Eyes</td>
<td>Itching, blurred vision</td>
</tr>
<tr>
<td>Ears, nose, and throat</td>
<td>Congestion, sore throat</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Chest pain, flutter, fibrillation</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Shortness of breath, cough</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Diarrhea, vomiting</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>Dark urine, burning on urination</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Muscle pain and weakness, joint swelling</td>
</tr>
<tr>
<td>Integumentary</td>
<td>Rash, acne</td>
</tr>
<tr>
<td>Neurological</td>
<td>Syncope, tingling</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Stress, anxiety, depression</td>
</tr>
<tr>
<td>Endocrine</td>
<td>Increase in thirst, decreased appetite</td>
</tr>
<tr>
<td>Hematologic/Lymphatic</td>
<td>Bruising, swollen glands</td>
</tr>
<tr>
<td>Allergy/Immune</td>
<td>Medication allergies, itching, anaphylaxis</td>
</tr>
</tbody>
</table>

Table 3.2: Review of Body Systems and Examples

During the ROS, the provider asks the patient if they are experiencing any signs or symptoms in any of the body systems. Ancillary staff, physician assistants, nurse practitioners, and physicians can document the ROS.
An operative report is a note produced by a healthcare professional for procedures they provide. The report must be written or dictated immediately after the procedure was performed and must contain a detailed summary of the findings throughout the surgery, the procedure performed, any specimens removed, the pre- and postoperative diagnoses, and the names of the primary performing surgeon and any assistants.

An operative report is typically divided into four main sections that include the header, indications for surgery, the detail or body of the procedure, and the findings.

The header of an operative note is designed to identify:
- Patient name
- Date of surgery
- Preoperative diagnosis
- Postoperative diagnosis
- The procedure performed
- Primary surgeon
- Assistant surgeon(s)
- Anesthesia administered
- Anesthesiologist

The indication typically gives a brief history outlining the reasons for medical necessity for the procedure. Specific details of the surgery are described in the body of the note. The details in this area will determine the CPT® code(s) used to convey the surgical services performed. This description usually begins with the documentation of healthcare staff taking a “time out” to verify they have the correct patient, and identification of the expected procedure to take place. After this verification has been made, the operative note will provide details of the entire surgery, beginning with prepping the patient and the approach, and continuing to explain any findings, removal of specimens for analysis, and/or intra-operative complications.

The operative report will be finalized with the findings upon completion of the surgery. Estimated blood loss will be documented here, as well as the status of the patient upon completion of the surgery.

Reading and analyzing an operative report requires time and great attention to detail. Challenges arise when the report indicates a specific procedure as being performed in the header, but the details in the body of the note do not support that procedure, or indicate additional procedures not reported in the title. For this reason, it is very important to read the entire note slowly and carefully. Attempt to gain an understanding of the entire surgical case before taking more time to read the report thoroughly to analyze for proper code assignment.

Remember that physicians write an operative note in a manner that would be easily understood and interpreted by their colleagues. If there are elements missing
form should be adjustable for each patient and should not create an exact duplicate record across several patients who all came in with the same key complaints.

All patients are unique in their treatment needs, and their records should be, too. A single template cannot adequately capture the care of all patients, and practices will need to adjust these forms on a regular basis based on practice and patient requirements.

**Caution:** Most payers and auditors are not in favor of templates and may often report their use in an audit report and scores.

**Tip:** CDI team members should note certain nuances or suggested changes to the template and discuss these revisions with the CDS or practice manager. Updates can be added as and when needed, based on the specific considerations of the patients of that practice.

**EMR Templates: A Boon or a Bane?**

**Downside:** As speedy and convenient as they are to operate, templates create their own set of problems. Attorneys are increasingly reporting that EMR systems are keeping them in business, and it’s the templates, across the board, that are the biggest culprit.

Physicians must fully document within the EMR using their own words, rather than letting the computer fill it out or auto-populate the record for them. Keep in mind, when providers dictated their notes, they had to carefully consider each patient encounter to provide enough detail for the transcriptionist. Now, the computer does the work for them. Even though the result looks similar, computers cannot match the scope of the clinician’s thought process 100 percent.

**Hidden trap:** Since the implementation of EMR systems, there has been an increase in concerns about documentation across providers and payers. The computerization of information in the medical record means a whole new set of errors that are foreign to handwritten paper documentation and dictated notes.

These unique types of errors have warranted greater exposure and increased scrutiny of claims, with the added risk to physicians of being accused of professional malpractice. And EMR systems are, of course, on the radar of CMS and the OIG.

**Caution:** Watch out for the self-populating fields, or “exploding” documentation feature, which add in all of the patient’s prior clinical history at the click of a checkbox. These fields may seem like a time-saving function, but incorrectly completing them can do great harm to a provider and, ultimately, the patients.

**Mistake:** Depending on which EMR the physician uses, they may inadvertently document a full assessment and ROS that they have yet to perform (or may not perform at all). If the physician does not take the time to review the documentation, the coder will code the services, which will then be billed to the payer, leading to incorrect reimbursement and a possible fraud investigation. Compounding this problem is the fact that documentation for subsequent encounters will also be impacted by the incorrect documentation.

**Copy and Paste**

Physicians and staff should use extreme caution when using the copy and paste function if available within software templates. Copying information from one
A physician query is a method of communication used by coders and clinical documentation professionals to request clarification of patient diagnoses or procedures from the physician. The physician query is used to clarify documentation by resolving conflicting, ambiguous, illegible, or incomplete information about significant conditions, procedures, or reasons for tests in the medical record of the patient. Queries may also be required to determine the correct code for a primary diagnosis or procedure, or to clarify if a causal relationship exists between two diagnoses. In addition to obtaining clarification, the query may serve as an educational tool to improve physician documentation and the coders’ understanding of clinical scenarios.

Queries can be done while the patient is still admitted to the hospital or prior to leaving the physician’s office. This allows the physician an opportunity to clarify a diagnosis or procedure prior to the patient’s departure. These are called concurrent reviews and queries. A query conducted after the patient has left is called a retrospective query. In the outpatient setting, review of the patient’s medical record prior to admission can provide opportunities to query at the encounter. This is often called prospective documentation review. The facilities’ processes should include some manner of recording the queries, such as an electronic database, or inclusion of the query in the medical record.

The query should include:
- Patient name
- Admission date and/or date of service
- Health record number
- Account number
- Date query initiated
- Name and contact information of the individual initiating the query
- Statement of the issue in the form of a question along with clinical indicators specified from the chart

The query should not be constructed in a manner that can be interpreted as leading the physician. Queries can be verbal, open, multiple choice, or yes/no, and should provide documentation from the medical record to obtain a more concise diagnosis from the physician. When multiple choice or yes/no queries are utilized, it is important to provide choices for a physician including options like “other” or “unspecified.” Unlike querying in the inpatient setting, outpatient queries should not include terms like “probable,” “suspected,” “ruled out,” etc. These options do not apply as per outpatient coding guidelines only confirmed diagnoses can be coded.

A valuable skill and necessary tool for a documentation specialist is learning how and when it is appropriate to query a physician. Querying assists with accurate diagnostic, procedural, and risk adjustment coding. During concurrent coding, querying for clarification can help to determine if a patient has additional procedures or complications that may affect discharge management. Particularly in the outpatient setting, conducting a prospective review and initiating relevant queries.
children, adolescents and pregnant women may have additional or modified information recorded in each history and examination area.

As an example, newborn records may include under history of the present illness (HPI) the details of mother's pregnancy and the infant's status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family. In addition, the content of a pediatric examination will vary with the age and development of the child. Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

A. DOCUMENTATION OF HISTORY

The levels of E/M services are based on four levels of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

- Chief complaint (CC)
- History of present illness (HPI)
- Review of systems (ROS) and
- Past, family, and/or social history (PFSH).

The extent of the history of present illness, review of systems, and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history all three elements in the table must be met. (A chief complaint is indicated at all levels.)

<table>
<thead>
<tr>
<th>History of Present Illness (HPI)</th>
<th>Review of Systems (ROS)</th>
<th>Past, Family, and/or Social History (PFSH)</th>
<th>Type of History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief</td>
<td>N/A</td>
<td>N/A</td>
<td>Problem Focused</td>
</tr>
<tr>
<td>Brief Problem</td>
<td>Problem Pertinent</td>
<td>N/A</td>
<td>Focused Expanded Problem</td>
</tr>
<tr>
<td>Extended</td>
<td>Extended</td>
<td>Pertinent</td>
<td>Detailed</td>
</tr>
<tr>
<td>Extended</td>
<td>Complete</td>
<td>Complete</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>
5. **Centers for Medicare & Medicaid Services, MLN Booklet Evaluation and Management Services Guide.**


**UPDATES**

- Updated for 2021 Medicare Physician Fee Schedule final rule dates and links

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### Single Organ System Examination

<table>
<thead>
<tr>
<th>TYPE OF EXAMINATION</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Include performance and documentation of one to five elements identified by a bullet, whether in a box with a shaded or unshaded border.</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>Include performance and documentation of at least six elements identified by a bullet, whether in a box with a shaded or unshaded border.</td>
</tr>
<tr>
<td>Detailed</td>
<td>Examinations other than the eye and psychiatric examinations should include performance and documentation of at least twelve elements identified by a bullet, whether in a box with a shaded or unshaded border. Eye and psychiatric examinations include the performance and documentation of at least nine elements identified by a bullet, whether in a box with a shaded or unshaded border.</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Include performance of all elements identified by a bullet, whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in a box with an unshaded border is expected.</td>
</tr>
</tbody>
</table>

Both types of examinations may be performed by any physician, regardless of specialty.

Here are some important points to keep in mind when documenting general multi-system and single organ system examinations (in both the 1995 and the 1997 documentation guidelines):

- Document specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s). A notation of “abnormal” without elaboration is not sufficient.
- Describe abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s).
- It is sufficient to provide a brief statement or notation indicating “negative” or “normal” to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

---

Table 3: Single Organ System Examination
to augment the practice’s own compliance efforts.

The opportunities for collaborative compliance efforts could include participating in training and education programs or using another entity’s policies and procedures as a template from which the physician practice creates its own version. The OIG encourages this type of collaborative effort, where the content is appropriate to the setting involved (i.e., the training is relevant to physician practices as well as the sponsoring provider), because it provides a means to promote the desired objective without imposing excessive burdens on the practice or requiring physicians to undertake duplicative action. However, to prevent possible anti-kickback or self-referral issues, the OIG recommends that physicians consider limiting their participation in a sponsoring provider’s compliance program to the areas of training and education or policies and procedures.

The key to avoiding possible conflicts is to ensure that the entity providing compliance services to a physician practice (its referral source) is not perceived as nor is it operating the practice compliance program at no charge. For example, if the sponsoring entity conducted claims review for the physician practice as part of a compliance program or provided compliance oversight without charging the practice fair market value for those services, the anti-kickback and Stark self-referral laws would be implicated. The payment of fair market value by referral sources for compliance services will generally address these concerns.

B. Steps for Implementing a Voluntary Compliance Program

As previously discussed, implementing a voluntary compliance program can be a multi-tiered process. Initial development of the compliance program can be focused on practice risk areas that have been problematic for the practice such as coding and billing. Within this area, the practice should examine its claims denial history or claims that have resulted in repeated overpayments, and identify and correct the most frequent sources of those denials or overpayments. A review of claim denials will help the practice scrutinize a significant risk area and improve its cash flow by submitting correct claims that will be paid the first time they are submitted. As this example illustrates, a compliance program for a physician practice often makes sound business sense.

The following is a suggested order of the steps a practice could take to begin the development of a compliance program. The steps outlined below articulate all seven components of a compliance program and there are numerous suggestions for implementation within each component. Physician practices should keep in mind, as stated earlier, that it is up to the practice to determine the manner in which and the extent to which the practice chooses to implement these voluntary measures.

Step One: Auditing and Monitoring

An ongoing evaluation process is important to a successful compliance program. This ongoing evaluation includes not only whether the physician practice’s standards and procedures are in fact current and accurate, but also whether the compliance program is working, i.e., whether individuals are properly carrying out their responsibilities and claims are submitted appropriately. Therefore, an audit is an excellent way for a physician practice to ascertain what, if any, problem areas exist and focus on the risk areas that are associated with those problems. There are two types of reviews that can be performed as part of this evaluation: (1) A standards and procedures review; and (2) a claims submission audit.

1. Standards and Procedures

It is recommended that an individual(s) in the physician practice be charged with the responsibility of periodically reviewing the practice’s standards and procedures to determine if they are current and complete. If the standards and procedures are found to be ineffective or outdated, they should be updated to reflect changes in Government regulations or compendiums generally relied upon by physicians and insurers (i.e., changes in Current Procedural Terminology (CPT) and ICD–9–CM codes).

2. Claims Submission Audit

In addition to the standards and procedures themselves, it is advisable that bills and medical records be reviewed for compliance with applicable coding, billing and documentation requirements. The individuals from the physician practice involved in these self-audits would ideally include the person in charge of billing (if the practice has such a person) and a medically trained person (e.g., registered nurse or preferably a physician (physicians can rotate in this position)). Each physician practice needs to decide for itself whether to review claims retrospectively or concurrently with the claims submission. In the Third-Party Medical Billing Compliance Program Guidance, the OIG recommended that a baseline, or “snapshot,” be used to enable a practice to judge over time its progress in reducing or eliminating potential areas of vulnerability. This practice, known as “benchmarking,” allows a practice to chart its compliance efforts by showing a reduction or increase in the number of claims paid and denied.

The practice’s self-audits can be used to determine whether:

- Bills are accurately coded and accurately reflect the services provided (as documented in the medical records);
- Documentation is being completed correctly;
- Services or items provided are reasonable and necessary; and
- Any incentives for unnecessary services exist.

A baseline audit examines the claim development and submission process, from patient intake through claim submission and payment, and identifies elements within this process that may contribute to non-compliance or that may need to be the focus for improving execution. This audit will establish a consistent methodology for selecting and examining records, and this methodology will then serve as a basis for future audits.

There are many ways to conduct a baseline audit. The OIG recommends that claims/services that were submitted and paid during the initial three months after implementation of the education and training program be examined, so as to give the physician practice a benchmark against which to measure future compliance effectiveness.

Following the baseline audit, a general recommendation is that periodic audits be conducted at least once each year to ensure that the compliance program is being followed. Optimally, a randomly selected number of medical records could be reviewed to ensure that the coding was performed accurately. Although there is no set formula to how many medical records should be reviewed, a basic guide is five or more medical records per Federal payor (i.e., Medicare, Medicaid), or five to ten medical records per physician. The OIG realizes that physician practices receive reimbursement from a number of different payors, and we would encourage a physician practice’s auditing/monitoring process to consist of a review of claims from all Federal payors from which the practice receives reimbursement. Of course, the larger the sample size, the larger the comfort level...
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