The Nine "Cs" of Clinical Documentation Improvement

Work together to ensure CDI is maximized in all practitioner documentation.

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Clinical documentation affects the entire revenue cycle. If a medical note is not properly documented, a domino effect leads to inaccurate coding, which affects billing and financial management of the practice. Poor documentation may also affect quality of patient care because all elements aren't captured accurately or considered based on a practitioner's findings. Because of this, clinical documentation improvement (CDI) plays a key role across the spectrum of healthcare business management.

The fundamental basis for CDI is to improve the clinical note, which contains information about the encounter such as the patient's symptoms (i.e., the reason for the visit) and history of present illness, data measured and recorded, examination observations, an assessment, a definitive diagnosis, and a care management plan. A clinical note may reflect a variety of services and formats, such as a progress note compiled by a doctor or staff nurse during an encounter with a patient in the office or outpatient setting, a summary of laboratory findings and recommendations, a radiological interpretation or report, and an operative note.

A clinical note is a like a snapshot. Physicians may see dozens of patients a day, and if the information isn't recorded in the progress note or operative report, it's probably lost for good. Will a physician really remember how many minutes he spent counseling a patient on smoking cessation or what the specific dimensions of a skin wound repair were if this information is not documented at the time of the encounter? This accentuates one of the assertions of the coders' creed: "If it's not documented, it didn't happen."

To assess the quality of your providers' clinical documentation, you may want to refer to what I call the "Nine Cs of CDI."

1. Clarity

The doctor may be able to read his own handwriting, but if you can't make it out, the documentation is worthless. It shouldn't be your responsibility to decipher something illegible or ambiguous, and risk miscoding based on that interpretation. Providers who are still using pen and ink need to be enlightened to the 21st century, where we have sophisticated electronic health record (EHR) templates. Shockingly, some practitioners with EHRs are still in the habit of preparing their notes manually and relying on a scanner to transmit them; this should be discouraged while using technological resources should be encouraged.

2. Consistency

Medical notes must not contain any words or sentences that could be interpreted as inconsistent with the diagnosis assessed or the procedure performed. Consistency of documentation is important not only for coding accuracy, but also for compliance. It's easy to slip up on this if close attention is not paid to the chronology of the patient's present illness and treatment. In the event of an external audit or a payer request for supporting documentation, the documenter must be able to back up a claim of medical necessity. Inconsistencies in the encounter note diminish the preparer's credibility.

3. Completeness

As we strive to capture the entire clinical picture of the patient, it's important for the physician to document all information pertinent to the patient's diagnosis, such as any current and recently discontinued medications and changes in condition status. For example:

If a patient is diagnosed with septic arthritis or bursitis, the organism causing the sepsis should be documented.

If a patient returns with lower sugar readings a week after diabetes was assessed as out of control, controlled diabetes (reflected by the lower readings) should be documented for the current encounter.

Hypoxia caused by respiratory failure should be documented for accuracy of coding, as well as clarity of the illness severity.

If a lysis of adhesions was performed, what organs or structures were released? If an acquired absence of an organ is relevant to a physician's finding, it should be documented and picked up by you.

It may not be sufficient to simply document "status post surgery" because you may need to know whether a complication was actually post-procedural or caused by the surgery. Be sure to list any potentially related comorbid conditions. Key elements missing from the clinical note disservice the coders and billers, as well as quality of care.

4. Cohesion

There are many different styles of clinical notes, but whether the practitioner uses a SOAP, CHEDDAR*, or narrative format, the underlying document should outline the patient's chief complaint and other related subjective data, as well as objective data, and smoothly segue into the assessment of the patient's condition and the course of action the provider will pursue.

*SOAP stands for subjective, objective, assessment plan and CHEDDAR stands for chief complaint, history of presenting illness, examination, details, drugs and dosages, assessment, return visit information or referral.

5. Coder Friendliness

Physicians sometimes document in terms only they understand. You may need to learn quickly about what is documented; Internet researching often helps, but it's not a cure-all. You and your physicians should educate each other.

For example, if an orthopedic surgeon treats an open fracture, he can simply add the word "open" to his diagnosis, or at least document that a skin wound was caused by the fracture. If the treatment was performed on the proximal humerus, the specific location (surgical neck, greater tuberosity, etc.) will help you to code more precisely, instead of selecting an unspecified code within this anatomic site. Physicians should also try to minimize the amount of unfamiliar abbreviations they enter into clinical notes.

6. Concision

Ideal documentation stays on point with the patient's current problem and the reason for seeking medical care. It's not necessary to enumerate (or copy and paste) the patient's entire medical history or medication regimen, or make statements in the note that have no bearing on treatment of the condition being managed or a related procedure being performed. Despite extreme severity of certain comorbid illnesses that must remain a part of the patient's record of active problems, a specialist does not need to reiterate conditions if they are not relevant to the encounter. Concise documentation speeds up the coding process because you aren't bogged down reading superfluous text.

7. Compartmentalization

Sometimes physicians will document everything they are supposed to, but in no particular order or pattern. This may cause you to overlook information germane to accurate coding.

Most EHR packages provide medical practice staff with the capability to design sophisticated templates from which they can fill in the details of their progress note in a timely, cost-effective manner. In the EHR, the most valuable feature of the compartmentalization process is the ability to standardize the location of any key element within the note. This greatly eases validating a charge or coding the note from scratch, saves time, and creates a much less error-prone workflow.

For instance, if a patient is given an inhalation treatment or a vaccination, the details of this procedure (drug dosage, constituents, etc.) can be entered into a field called "Orders," and you will always know to look there for this piece of data.

8. Cleanliness

A clinical note riddled with grammatical and typographical errors lacks professionalism and can create repercussions down the revenue cycle, including the possibility of a payer audit. Language barriers can sometimes cause transcription of incorrect information, such as "50 mg" instead of "15 mg." With medical terms, you have to be especially careful with spelling and pronunciation because words may look and sound similar (e.g., hypertension vs. hypotension). It's important for all clinical staff, including medical assistants who act as data processors and transcriptionists, to be properly trained in CDI. This may require someone validating their work before it gets submitted.

9. Credibility

Credibility is one of the most important facets of CDI. When coding for professional services, medical staff — including on-site and off-site coders — cannot use "working diagnoses" to code actual findings. Words such as "question of," "probable," or "likely" preceding a clinical diagnostic term negate that term because no actual diagnosis has been established. If the physician has determined the actual diagnosis, he or she should not add words in the documentation that cast doubt on the finding.

During the dictation and transcription process, you must be careful with "cloned" documentation, which is boilerplate text lifted (i.e., copied and pasted) from one patient visit to the next (or even from one patient to another). Such habits are fraught with peril, especially if cloned text hasn't been proofread for parameters that can vary from encounter to encounter or patient to patient.

As deemed necessary, subordinate data entry should be quality-controlled at a checkpoint before a claim is submitted. This checkpoint should primarily be the responsibility of the clinical staff because the workflow may completely bypass you if no major edits are caught between the EHR and the billing pipeline.

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CDI Is More Important than Ever

The clinical note is a legal document. Physicians, coders, billers (and anyone else involved in healthcare) are touched by the clinical note. It's the source from which you abstract information to select optimal codes for reporting to payers. We all must work as a team to ensure we are maximizing the CDI factor in all practitioner documentation. With ICD-10 now a reality, specificity of documentation is more important than ever, and more stringent governmental and payer regulations reflecting CDI are in our future. Coders and clinical staff should convene periodically or as needed to address CDI, reviewing general issues discussed here, as well as those that are specialty-specific.

CDI Checklist for Clinicians

- **Make sure someone other than the documenter can read every element in the note.**
- **Avoid any inconsistencies in a clinical note.**
- **Capture all clinical information that may affect patient care.**
- **Use clear paragraph structure, where sentences adhere together, so as not to break the reader's train of thought.**
- **Strive to document in a coder-friendly manner to the extent possible.**
- **Cut to the chase. Don't document what isn't relevant to the encounter.**
- **Ease the validation process by standardizing location of common key elements.**
- **Perform quality assurance checks to find obvious errors and questionable transcriptions in clinical notes.**
- **Make sure the note is credible in all respects.**

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