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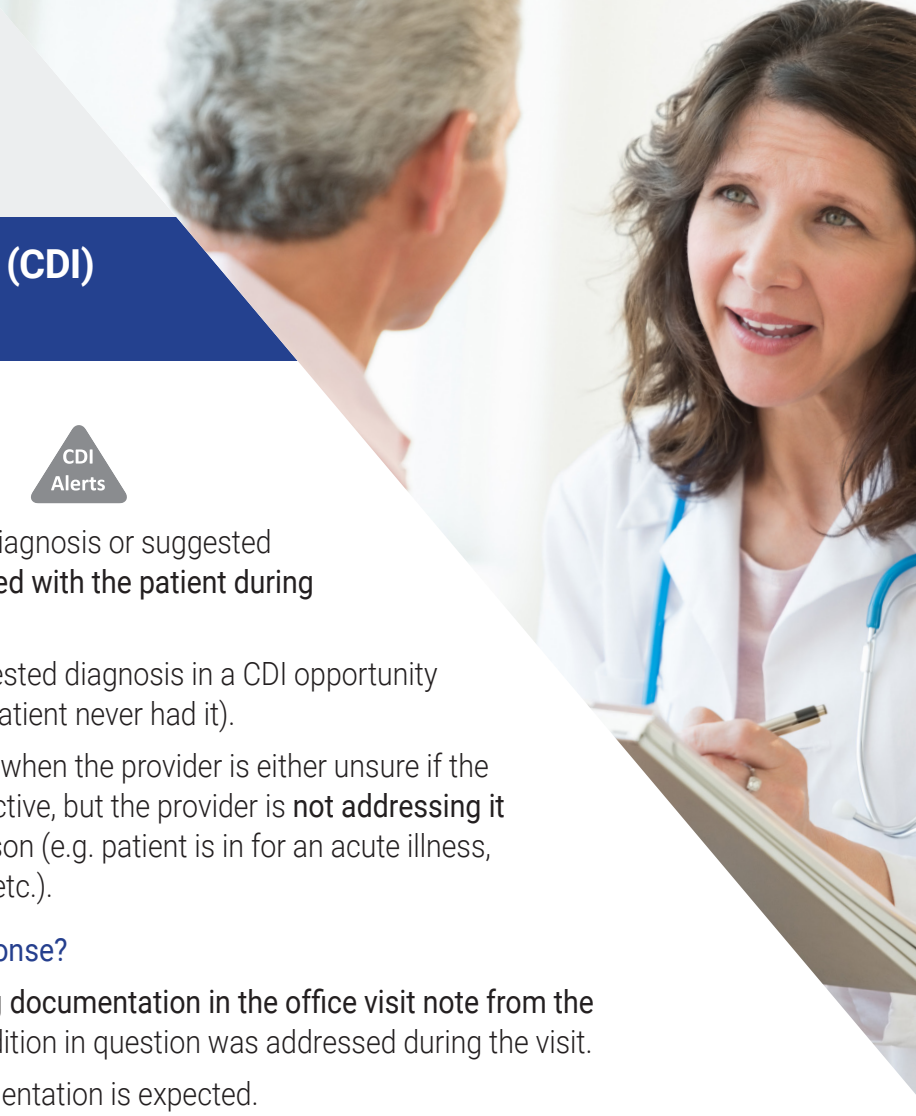

Clinical Documentation Improvement (CDI) Alert Completion Tips

How to Complete the CDI Alert

CDI Alerts

1. Which response should be marked on the alert?

- **"Yes"** should be marked on the CDI Alert if the diagnosis or suggested diagnosis in a CDI opportunity is **being addressed with the patient during the current face-to-face visit.**
- **"No"** should be marked if the diagnosis or suggested diagnosis in a CDI opportunity **does not exist**. (e.g. diagnosis resolved, or the patient never had it).
- **"Not Addressed"** should be marked on the alert when the provider is either unsure if the diagnosis exists **OR** the diagnosis is valid and active, but the provider is **not addressing it during the current face-to-face visit** for any reason (e.g. patient is in for an acute illness, not enough time to get through the entire alert, etc.).

2. What documentation is expected with each response?

- If **"Yes"** is marked, **there needs to be supporting documentation in the office visit note from the current face-to-face visit,** showing that the condition in question was addressed during the visit.
- If **"No"** or **"Not Addressed"** is marked, no documentation is expected.

3. What is considered sufficient documentation?

- A condition is considered **addressed** if it includes the diagnosis **AND** one or more of the following items. To make sure you're following the guidelines for addressing a condition, remember MEAT:
  - > Monitoring by ordering test (e.g. labs, x-rays, CT scan or echocardiograms)
  - > Evaluating as part of the physical exam (e.g. monofilament exam for diabetic neuropathy or checking dorsalis pedis pulses for peripheral vascular disease)
  - > Assessing the stability or progression of a disease (e.g. documenting the condition is stable or improving)
  - > Treating the condition (e.g. providing a new prescription or instructing the patient to continue his or her current medication)
    - Treating also includes **referring patients to specialists**, as related to their diagnosis (e.g. to an ophthalmologist for exudative macular degeneration or to a psychiatrist for recurrent major depression)

Please note: A condition must be **addressed**, not only listed in the office visit note. Merely writing the diagnosis in the assessment or the problem list doesn't satisfy the Center for Medicare & Medicaid Services (CMS) and ICD-10-CM Official Coding Guidelines for Reporting a condition as active.

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4. Additional information

- If **"Yes"** is marked on the alert and **no supporting documentation** is found in the office visit note to show this condition was addressed during this visit, **or** if the **documentation is incomplete or not specific enough** to meet CMS guidelines for reporting a condition, **a query will be issued** to the provider requesting to add the missing or incomplete documentation.
- When a provider receives a query, **they are expected to amend their office visit note or add an addendum with the missing documentation** that provides the complete and accurate representation of the diagnosis in the medical record.
- CMS guidelines allow providers to change their documentation in the medical record **up to 30 days from the date of the face-to-face visit.** Providers will not be asked to make any changes to their documentation outside of the 30-day timeframe.
- The CDI Alert is not part of the permanent medical record. **All documentation relative to the patient's diagnoses, assessment, management and referrals should be done in the office visit note.** Providers are only expected to mark their responses on the alert, sign and date it.