Annova

The Pocket Guide to

CLINICAL DOCUMENTATION IMPROVEMENT (CDI)

Key CDI principles, common pitfalls, and quick solutions - ***right at your fingertips***

About Annova Solutions

At Annova Solutions, we empower health plans and providers to optimize performance and achieve superior outcomes. Our expertise spans risk adjustment coding across all lines of business, including Medicare (Part C & D), ACA, and Medicaid (CDPS). Whether retrospective, concurrent, or prospective, we ensure coding accuracy, compliance, and financial integrity.

Beyond coding, we enable health plans and providers to enhance the member experience, improve Star Ratings, and achieve operational excellence. By prioritizing efficiency and quality, we equip organizations with the expertise and tools needed to drive financial performance, maintain compliance, and ensure long-term success.

Introduction

Despite the exceptional care that providers deliver, ensuring that their efforts are accurately reflected in documentation remains a challenge. With the evolving landscape of Risk Adjustment, increased scrutiny of care evidence, and the expansion of Value-Based Care, robust encounter documentation is more critical than ever.

This guide provides a concise yet insightful overview of key Clinical Documentation Improvement (CDI) concepts, highlighting common pitfalls and quick wins in documentation. Acknowledging the limited bandwidth of providers, we've designed this guide to be simple and actionable. However, this is not an attempt to oversimplify CDI, replace a comprehensive CDI process, or cover the full depth of CDI as a discipline.

Let the power of documentation be with you!

Warm Regards,

Annova

General Documentation Patterns

Not a ‘History’ lesson!

Pitfall

Using ***"history of"*** when you mean **"long-term" or "long-standing"** can lead to incorrect coding and documentation gaps

Example:

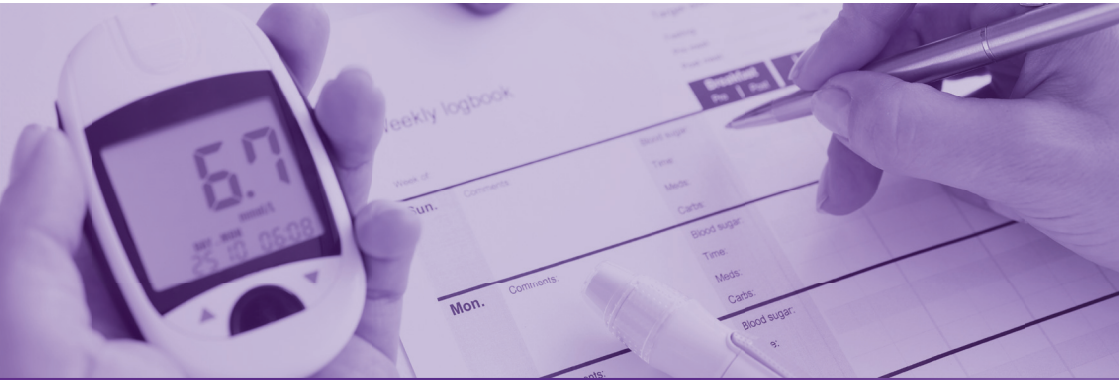
"A long term history of Diabetes"

Quick Wins

Drop the ***‘History’!***

Example:

"Long-standing diabetes" or "Hypertension for 10 years"



Patient vs. Provider Voice

Pitfall

Documenting conditions in a way that sounds like it's coming directly from the patient

This includes phrases like ***"as per patient"*** or ***"patient reports"***

Additionally, avoid only documenting conditions in the Review of Systems (ROS) section, as this is often viewed as a patient-completed questionnaire

Quick Wins

Use provider (Your) voice to document conditions, ensuring clear and accurate information. Carry over the conditions in HPI and Assessment.

The root cause analysis!

PITFALL

Failing to document causal linkages between diseases. Although guidelines may establish these relationships, explicit documentation is still essential

Assuming that the ***'plan of care'*** of etiology will cover the manifestation- can lead to denials and down coding

Example:

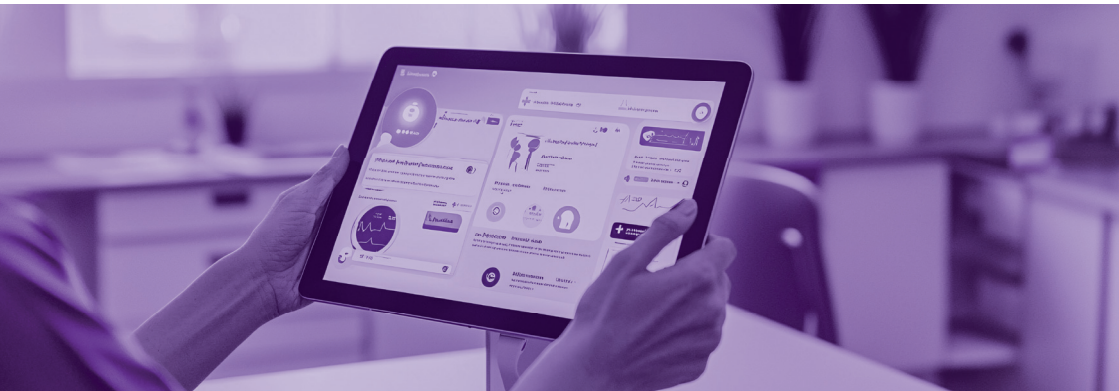
Documenting **"Diabetes"** (with plan of care) in assessment and **"Peripheral neuropathy"** in HPI

Quick Wins

Document the conditions with manifestations together with linking terms like **'secondary to'** or **'Diabetic'** and separate plan of care for both

Example:

Diabetic polyneuropathy on Glipizide and Gabapentin, medication refilled



The curious case of ‘Problem lists’!

Pitfall
Relying on Problem Lists for Diagnostic Information

Problem lists are often considered "past headers" and may be auto populated by EMR systems, making them unreliable for extracting diagnostic information.

Quick Wins

- Refresh and Refine Problem Lists
- Regularly review and update problem lists to ensure accuracy

Best Practices

- Remove resolved conditions
- Drop sub-acute and acute conditions from Problem lists
- Document the "reviewed date"
- Document active conditions in "active headers" like Assessment

Medication list OD

PITFALL

Inaccurate or Incomplete Medication Lists

Failing to regularly reconcile medications can lead to unsupported Diagnoses, or worse, care gaps!

Quick Wins

- Regularly reconcile medications
- Add refill dates and medication list reviewed date
- Avoid documenting conditions in medication lists
- Remove short-term medications no longer active
- Link conditions in active headers with medications in medication list
- Clearly document one-to-one linkages of medications with diseases
- Document off label uses, wherever applicable

Vague Management Verbiage

Pitfall
Vague Documentation of Condition Management

Avoid using vague terms that don't provide clear insight into the management of conditions

Examples of Vague Documentation

"Hypertension is well-controlled"

Why These Examples Are Problematic:

- "Well controlled" and "under control" are often part of ICD descriptions and don't provide enough context for management.
- "Continue current medications, follow up with specialists. Monitoring" lacks specific details about the plan of care.

Quick Wins:
Clear and Specific Documentation

- Avoid vague terms
- Provide specific details about the plan of care
- Document measurable goals and outcomes
- Include timelines for follow-up and reassessment

Examples

"Hypertension is being managed with Amlodipine and lifestyle changes, with a goal of reducing blood pressure to <140/90 mmHg"

Primary and Secondary Conditions

Most conditions are considered primary unless otherwise specified. However, it is always preferable to document the nature of the condition explicitly, such as ‘Primary Hypothyroidism’ and ‘Secondary Hyperparathyroidism’

Conditions That Are Commonly Secondary:

Some conditions are secondary more than 90% of the time due to an underlying condition, such as chronic kidney disease (CKD) and Peripheral Neuropathy. Physicians should acknowledge that while coders understand the usual nature of conditions, they cannot make assumptions and must adhere strictly to ICD coding guidelines.

Action for Providers

Clearly document whether a condition is primary or secondary to avoid down coding or claim denials

Proper Documentation of Etiology

- Conditions like Pulmonary Hypertension and Hyperparathyroidism are usually secondary to longstanding cardiopulmonary and kidney disease. However, they are often documented as standalone conditions by providers
- Use the terms ‘due to’ and ‘secondary to’ in documentation. These are essential, not just preferred
- Avoid using ambiguous terms like ‘with’ and ‘associated with’, which may cause confusion in differentiating between etiology and manifestation

Cause-and-Effect Relationships in Documentation

Providers should distinguish between

- Two conditions complicating each other
- A direct cause-and-effect relationship

For example:

"Hypertension complicated by poorly controlled Diabetes due to accelerated end organ damage" could lead a coder to incorrectly infer that the Hypertension is secondary to Diabetes, (Secondary Hypertension is a serious high-risk condition), rather than just comorbidities

ICD example:

Per ICD Guidelines, pulmonary hypertension is assumed to be secondary and should be coded as I27.20 Pulmonary Hypertension, Unspecified under subcategory I27.2- Other Secondary Pulmonary Hypertension

Documenting this without an explicitly linked underlying condition could lead to denials

Diabetes

A Common & Critical Diagnosis

Diabetes is the most common and frequently documented chronic conditions in patients. Ensuring precise and comprehensive documentation of diabetes is crucial for accurate coding, proper risk adjustment, and optimal patient care

Common Pitfalls and Best Practices

Poor Documentation Practices

Using outdated terminology like IDDM, NIDDM, Juvenile diabetes and adult-onset diabetes

Improper usage of ICD descriptions like ‘unspecified/uncomplicated diabetes, diabetes with unspecified and/or other specified complications, unspecified nephropathy/ retinopathy etc

Relying on ICD guidelines and coders to link manifestations- Peripheral neuropathy in HPI and Diabetes in assessment

Conflicting documentation across the encounter- Well controlled Diabetes in HPI, Prediabetes in Problem list and Diabetes with hyperglycaemia in Assessment

Quick Wins

Document the type of Diabetes as Type 1 or 2

Leave terms like ‘unspecified/ other specified’ for the coders. Be as specific as possible in describing the conditions

Please establish the ‘cause and effect' relationship between Diabetes and its manifestations using terms like ‘due to’ and plan of care for both

Terms like ‘controlled’ can be part of code description. Please avoid using these ‘disease management’ terms

Clinical Documentation Improvement (CDI) Principles for Acute and Sub-Acute Conditions

Understanding Acute and Sub-Acute Conditions in Outpatient Care

Acute conditions such as Acute Kidney Injury (AKI), fractures, and Deep Vein Thrombosis (DVTs) do not simply resolve at the point of discharge. It is understandable that providers document these acute conditions during follow-up outpatient visits. However, documenting and coding acute conditions in outpatient records can become a target for RADV and OIG audits.

Quick Wins

To ensure accurate coding and compliance, providers should document supporting evidence for managing these conditions

- Use terms such as 'subsequent visit for fractures' and 'mechanical complications in post-operative periods' when applicable to assist coders in assigning the correct codes
- Avoid using ICD-10 descriptions in documentation. Instead, clearly describe the clinical status and the actions taken. Coders will then assign the appropriate code based on the documentation

Examples of Proper Documentation

AKI: Even after discharge, AKI may still be present. Document ongoing tests and treatments to support continued management

Fractures: If the fracture is non-traumatic, acute care can extend into outpatient settings for prolonged periods. Specify the nature of the injury whenever possible

Thrombosis and Clots: These conditions can persist and require long-term management. If appropriate, document them as chronic rather than acute

KEY TAKEAWAYS

- When unspecified, injuries are often considered traumatic - clear documentation is essential
- Providers are only questioned when documentation is lacking. They are not questioned about their clinical decisions if the documentation clearly supports them

CDI for Kidney Conditions

CDI experts dislike unspecified conditions, and kidney disease is no exception. The kidneys are vulnerable to end-organ damage due to conditions like diabetes and hypertension, and kidney diseases themselves can lead to manifestations such as anemia and bone disorders.

Since kidney disease progresses slowly, a key pitfall in encounter documentation is the presence of multiple stages in the same encounter, as historical data is often carried forward. It is common to see microalbuminuria, nephropathy, and various stages of CKD spread across the encounter.

Quick Wins

- Document the latest stage of kidney disease in the assessment and remove older stages from other headers if possible
- Avoid linking CKD to just one disease when multiple conditions contribute
  - ICD guidelines allow linking CKD to both diabetes and hypertension
  - Example: Instead of ***"Diabetic CKD with hypertension,"*** document **"CKD stage 3a due to long-standing diabetes and hypertension"**
    - The first phrasing forces the coder to link CKD only with diabetes, whereas the second provides a more accurate clinical picture

Rare Pitfall

Not Updating CKD Stage After Transplant

A kidney transplant does not reverse CKD, but coders may struggle to code ESRD after transplantation as the kidney function should improve after transplantation. Also, AV fistulas in examination are not enough to assume Dialysis status

Quick Wins

- Document chronologically to reflect ongoing kidney disease status post-transplant and clarify that CKD persists
- Document the status of Dialysis more clearly

CDI for Respiratory Conditions

Documenting respiratory conditions can be tricky, as ICD guidelines frequently change and often overcomplicate classification

For instance, providers may not treat COPD *exacerbated by an episode of bronchitis* any differently than " COPD with acute bronchitis," or they may not see a significant difference between "moderate extrinsic asthma" and "moderate persistent asthma"

However, ICD guidelines do distinguish these conditions, and incorrect documentation can lead to coding errors

Pitfalls

Providers may be unaware of frequently changing ICD coding guidelines for respiratory conditions

COPD often coexists with other chronic respiratory conditions, such as asthma, and ICD guidelines dictate how these conditions are bundled or unbundled based on their type and severity

Acute exacerbations of chronic respiratory conditions require more documentation support than just continuing inhaled medications

Quick Wins

Specify the type of respiratory condition for accurate coding

Example: Instead of ***"asthma,"*** use descriptive terms like document **'Mild, Moderate, Persistent and Intermittent'** (if applicable)

Document acute infections as complicating existing conditions rather than listing them separately

Example: Instead of just ***"acute bronchitis,"*** document **"acute bronchitis complicating COPD"** even though it's obvious!

Medication list maintenance:

Remove short-term medications like antibiotics from medication lists if they are no longer active

Ensure exacerbations and acute conditions are supported by treatment changes rather than just a continuation of existing inhalers

The Pain of Documenting Neoplasms

Documenting neoplasms can be as tricky as managing them. This area is filled with pitfalls, but surprisingly, the quick wins are simple

Coders get cold sweats when they approach cancer charts because determining the active presence of cancer is extremely challenging without clear documentation. Neoplasms can be:

- Treated
- Followed up
- In remission
- Carefully watched
- Undergoing prophylactic or palliative treatment
- Managed with planned therapies

Without precise documentation, coders cannot assume whether a cancer diagnosis is active, in remission, or history of cancer—leading to incorrect coding

Examples of Vague Documentation and Why They Are Problematic

"Right breast cancer on Tamoxifen s/p mastectomy"

Issue: It is unclear whether Tamoxifen is being used for prophylaxis or ongoing cancer treatment, which impacts code selection

Improved: *"History of right breast cancer, s/p mastectomy, currently on Tamoxifen for prophylaxis to prevent recurrence"*

"Metastatic lung cancer managed by Dr. Smith."

Issue: Coders may misinterpret the primary and metastatic sites, potentially coding primary lung cancer with unspecified metastasis or incorrectly assuming metastasis from another site

Improved: *"Metastatic lung cancer (primary site: lung) under active treatment by Dr. Smith"*
(If metastasis is from another organ, specify the primary site, e.g., "Metastatic lung cancer secondary to breast cancer")

"Breast cancer – patient had undergone bilateral mastectomy a month ago, now being followed up by Dr. Smith for options of hormonal chemo"

Issue: It is unclear whether the cancer is still active, in remission, or a history of cancer

Improved: *"History of breast cancer S/P bilateral mastectomy (completed one month ago); currently evaluating prophylactic hormonal therapy options with Dr. Smith"*

Quick CDI Points for Accurate Documentation

- Congestive heart failure (CHF) is an unspecified term—always document specificity, such as preserved or reduced ejection fraction (HFpEF or HFrEF).
- Cardiovascular drugs are used for multiple conditions—align medications like beta-blockers with the specific conditions they manage, such as hypertension, prior infarcts, or arrhythmias.
- Do not use disease names interchangeably, as this creates confusion for coders (e.g., SVT and atrial fibrillation/flutter are distinct conditions).
- Understand and apply ICD specificity guidelines—for example, if a patient has hyperlipidemia, hypertriglyceridemia, and hypercholesterolemia, document only the most specific diagnosis that covers all.
- Avoid documenting comprehensive panels for multiple diseases—instead, specify which test is being used for a particular disease.
- Lab values and clinical findings should not contradict disease status—ensure documentation is consistent with clinical interpretation.
- Do not list diseases as indications alongside drugs in the medication list—coders may mistakenly pick up these indications as active diagnoses.

- Abnormal BMI values should be supported with weight-related diagnoses and a documented plan of care, and vice versa.
- Certain conditions documented in the physical exam may be sufficient for support, but they should also be carried into the assessment and plan of care.
- Diagnoses that contradict surgical history should be clarified—e.g., if senile cataract is documented in HPI but the history notes prior cataract removal, specify if it pertains to the other eye or has recurred. Similarly, thyroid or parathyroid removal does not automatically indicate deficiency; provide supporting clinical evidence.
- Cancers are metastatic in nature, but do not document cancers as "metastatic" unless metastases are present—e.g., "metastatic renal cancer" should not be used unless there is clear evidence of metastases.
- Avoid uncertain terms like "appears to be" or "most likely"—if a diagnosis is tentative, document it as a differential diagnosis in the medical decision-making (MDM) section.
- Be cautious when documenting new diagnoses or sub-acute exacerbations during telehealth visits—these carry a high risk of denials. Ensure telehealth encounters have clear evidence of a video consultation.
- All encounters should be signed with credentials and the date of signature—credentials should be included directly with the electronic signature, not taken from cover sheets.
- Avoid addendums whenever possible, but if necessary, ensure they are properly signed and dated with the reason for the addendum clearly stated.

Communicating Effectively with Your CDI Team

CDI and provider education efforts can fall short if not tailored to your needs. If your CDI team's suggestions:

- Seem disjointed and inconsistent
- Increase your workload unnecessarily
- Come across as instructional or questioning your care quality

Speak Up!

Your CDI team is there to support you in achieving documentation excellence. Don't hesitate to share your concerns and provide feedback

- CDI teams are adaptable and responsive to feedback
- Open communication helps tailor suggestions to your needs

CDI ensures accurate documentation, but true success requires a holistic approach. At Annova Solutions, we provide a full suite of services to help health plans and providers optimize performance and achieve superior outcomes

Our Services

- **Risk Adjustment Coding** – Accurate, compliant coding via retrospective, prospective, and concurrent reviews across Medicare, ACA, and Medicaid
- **Chart Retrieval** – High-efficiency medical record retrieval with an 80%+ first-pass success rate
- **Clinical Documentation Improvement (CDI) and Provider Education** – Enhancing documentation accuracy to support risk adjustment and compliance
- **HEDIS & Quality Reporting** – Supporting data collection and abstraction to improve Star Ratings and quality measures
- **Member Engagement** – Targeted outreach to improve care gap closure and patient outcomes
- **Revenue Cycle Management (RCM)** – End-to-end billing, coding, and claims optimization for financial integrity

Reach out to us for expert-driven solutions

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Annova

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