Clinical Documentation Improvement (CDI) Alert Completion Tips

How to Complete the CDI Alert

1 Which response should be marked on the alert?

- *Yes* should be marked on the CDI Alert if the diagnosis or suggested diagnosis CDI opportunity is **being addressed with the patient during the current face-to-face or audio and visual telehealth visit**.
- *No* should be marked if the diagnosis or suggested diagnosis in a CDI opportunity **does not exist** (for example, diagnosis is 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 the current visit** for any reason (for example, patient is in for an acute illness, not enough time to get through the entire alert).

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 or audio and visual telehealth 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 documentation is expected with each response?

- 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 (for example, labs, X-rays, CT scan or echocardiograms)
  - Evaluating as part of the physical exam (for example, monofilament exam for diabetic neuropathy or checking dorsalis pedis pulses for peripheral vascular disease)
  - Assessing the stability or progression of a disease (for example, documenting the condition is stable or improving)
  - Treating the condition (for example, 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 (for example, 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 Centers for Medicare & Medicaid Services and ICD-10-CM Official Coding Guidelines for Coding and 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 the condition was addressed during the 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 information.
- A provider that receives a query **is expected to amend his or her 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 patient visit**. Providers won't be asked to make any changes to his or her documentation outside of the 30-day time frame.
- The CDI Alert is not part of the permanent medical record. **All documentation relative to the patient's diagnosis, assessment, management and referrals should be done in the office visit note.** Providers are only expected to mark their responses on the alert, and sign and date it. Providers won't be asked to make any changes to his or her documentation outside of the 30-day time frame.

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