

Commonly Asked Physician Clinical Documentation Questions

Q: What portions of the patient record are most important regarding the documentation I provide?

A: Everywhere that you, your APRN, PA or any residents under your supervision document is important. Best practice is all about consistency, including the documentation you provide in Progress Notes, History and Physical Notes, Discharge Summary, Operative Notes, Consult Notes and ED Notes.

Q: Are the diagnostic test results contained in the chart sufficient for coding?

A: No. A common misperception about coding sources is that coders can use test results as a basis for coding. A coder *cannot* use documentation found in lab, radiology, pathology or other test results. A physician or clinical practitioner (i.e., APRN, PA) must review, interpret and document the clinical significance of the results in the Progress Notes. By law, the coder must rely only on what the treating clinicians enter into the patient record. Additionally, coders *cannot* code documentation from nursing and nutritionists - except for BMI and stages of pressure ulcers.

Example: If nursing documents patient has pressure ulcer, the physician must document the diagnosis of the pressure ulcer and the site. For the nutritionist documentation, the physician must acknowledge the diagnosis of morbid obesity or malnutrition, etc. in the H&P, progress notes, and/or discharge summary.

Q: Should I restate the consulting provider's diagnosis again as an attending provider?

A: Yes – the attending must restate that they have read, and agree with, diagnoses made by a consultant. However, information can be leveraged from consult notes and used for coding.

Example: A nephrologist documents that the patient has acute renal failure. If the attending agrees, the attending physician should also acknowledge the acute renal failure in the notes.

Q: If I have a patient with many different diagnoses, do I need to document all of them?

A: Yes. Providers must document all diagnoses present during the current visit. All diagnoses, treatments, procedures and evaluations monitored during admission will be treated as secondary diagnoses and can be used in the coding process. These secondary diagnoses provide information needed to calculate important data, such as the complexity of the case, mortality risk and the like. A one-time documentation in the H&P is sufficient regarding chronic conditions that do not affect the treatment provided during the present admission.

Including all secondary diagnoses not only paints the most accurate clinical picture for the healthcare team, but also the presence of those secondary diagnoses more accurately reflects the complexity and severity of the patient's illness for coding and data reporting.

Q: When should "suspected," "possible" or "probable" be used?

A: These words can only be used in the *inpatient* setting. If a diagnosis is documented as "possible" or "probable" at the time of admission or during the patient's stay, and is treated, the confirmed diagnosis must be noted in the Discharge Notes to be coded.

If a "possible" or "probable" diagnosis is not confirmed, the CDI Nurse will query for clarification and final determination. However, if a diagnosis is ultimately ruled out, all related services cannot be coded. For clarity, document that a condition or diagnosis is "ruled out" in the Progress Notes.

Q: How should I document a diagnosis that I have ruled out?

A: If the diagnosis has been ruled out, you must clearly state that the "probable" or "possible" diagnosis is in fact **not present**, and it will not be coded.

Q: How should the problem list be most effectively utilized?

A: ***From a coding perspective***, the problem list is not a list of diagnoses that pertain to the care being provided on this admission. Therefore the patient's active conditions (diagnoses) must be documented in the ED notes, Progress Notes, H&P, Procedure Notes or Discharge Summary. Diagnoses can be coded, problems, *per se*, cannot.

However, you should add to the problem list as necessary to accurately a total picture of the patient's medical conditions.

Q: What if I disagree with a diagnosis from a consult?

A: If there is discrepancy in the record, a query will be issued to the attending physician. In order to avoid a query for conflicting diagnoses, the attending should document the diagnosis that he/she judges to be correct, and justification for that conclusion. If the attending states that a specific diagnosis is ruled out or disagrees with the consultant's diagnosis, coding guidelines state that the coder should defer to the attending physician.

Q: If a consultant's diagnosis needs clarification, does the consultant receive the query or the attending physician?

A: In most cases, the consultant will receive the query. However any treating physician, consultant, resident, APRN or PA can answer the query, though diagnoses must be confirmed by a physician. If there is conflicting documentation in the chart, the attending may be queried.

Q: What do I do if I was not the attending physician in the time period that the query refers to?

A: Any provider who treated the patient can answer the query. If the information in the medical record enables you to answer, doing so will streamline the process. Moreover, if you are the attending at the time of discharge, you will be expected to answer the query. If needed, you can ask or confirm with appropriate providers before responding to the query.

Q: Why can't another group of people complete notes for us?

A: The law does not allow it. The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) only permit coders to obtain documentation for coding purposes from physicians' documentation. This includes physician-validated notes entered by residents, PAs and APRNs.

Q: I thought you cannot do debridement without excising?

A: Due to documentation and coding standards, "excisional" or "non-excisional" debridement needs to be explicitly stated in the documentation. Coders are not allowed to assume, infer or diagnose based on clinical terminology in the patient's record (as opposed to diagnostic).

The operative note must indicate 1) the type of instrument used, 2) whether it was used to “cut away” tissue, and 3) the type of tissue removed (excisional debridement); **or** whether the instrument was used to scrap, brush or wash the tissue (non-excisional debridement).

Q: How do clinical documentation and coding impact my billing, reimbursement and RVUs?

A: The skills and principles you learn in documentation coaching and via interaction with the CDIP Nurses impact the accuracy and completeness of clinical documentation in all settings. While the activities of the CDIP Nurses directly impact coding and billing by the hospital, consistency of coding and billing between hospital and professional will become ever more crucial as payers coordinate their adjudication of facility (e.g., hospital) billing with claims submitted by professionals for the same episode of care.

Inconsistency between the two types of claims (Professional and Hospital) may result in decreased or denied reimbursement to one or both parties.

Q: How will the coders and CDIP nurses know that doctors have improved their clinical documentation?

A: The coders will assign codes to the highest degree of specificity based on the documentation within the medical record. Increased accuracy and specificity of documentation will result in a decrease in retrospective queries and an increase in Case Mix Index (CMI). These and other metrics will reflect increased documentation specificity.

Q: How do I receive feedback on the accuracy, completeness and specificity of my clinical documentation?

A: This is a work in progress. Medical Staff leadership, especially the newly created Network Clinical Care Councils (NC3's), will determine the most accurate and meaningful ways to measure and report physician performance, including documentation performance.

Q: What do I do if current T-sheets do not have enough room to allow me to accurately reflect the documentation required?

A: There is a progress note/faculty note addendum document that can be used by providers when the T-sheet is not sufficient for documentation. The coders review this document in the Medical Record to capture additional clinical relevant information. Check with your site specific clinical manager to find where yours is located.

Q: How do I document complications or untoward events that occur in surgery?

A: It is crucial to document whether the occurrence was anticipated versus unintended or accidental. For example, bowel perforations in a patient with multiple adhesions or other predisposing conditions are expected and should be documented as such. In contrast, unintended transection of a ureter during bowel surgery is not intended and should be documented as a true complication.

Q: What tools does Seton have that can help me document more accurately and completely?

A: Additional tools are in development and will be shared when available. Current resources include:

- Concurrent queries initiated by the CDIP Nurse during the inpatient stay or retro queries after discharge

- The Documentation Blitz Training
- CDI program nurses for presentations
- Individual questions/education
- Seton's Documentation Prompter pocket cards

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