Points to Consider:

- "SIRS due to an infection." Clarify if patient has sepsis (systemic infection) or a localized infection.
- Positive blood cultures are not required to document diagnosis of sepsis or suspected sepsis.
- Document any conditions that occur intraoperatively or postoperatively. Additionally, document a cause-and-effect relationship (or lack thereof) between the procedure and the condition and that the condition is a complication or an expected outcome.
- Clarify whether gastroenteritis is infectious (bacterial or viral) or non-infectious and indicate associated organism if known.
- Document associated dehydration or hypotension with gastroenteritis.
- Provide causes (probable/suspected) of presenting symptoms (e.g., chest pain, syncope, abdominal pain, back pain) while awaiting confirmative workup and response to treatment.
- Clarify if fever is suspected to be bacterial, viral or other (e.g., leukemia) in origin.
- Document HIV status as symptomatic (AIDS) or asymptomatic (HIV positive only without seroconversion).

Medical Record Completion Requirements

- **H&P**: Must be completed within 24 hours following admission, but prior to surgery. Needs to include the chief reason for admission and all pertinent diagnoses and conditions that are present on admission. Include all signs and symptoms the patient is experiencing.
- **Operative report**: Must be completed within 24 hours of procedure and include a full description of procedure and any intra-operative or postoperative complications, if known.
- **Discharge summary**: Needs to include the final principal diagnosis, all secondary diagnoses which were clinically significant for the current hospitalization including all conditions that were resolved and each procedure performed. Also include indication if plan for readmission.

Definitions Important for Complete Documentation

- **Principal diagnosis** is that condition established *after study* to be *chiefly responsible* for occasioning the admission of the patient to the hospital for care.
- **CC:** Comorbidity/Complication
- **Comorbidity:** A pre-existing condition present at the time of admission which may cause an increase in the length of stay
- **Complication:** a condition that arises during the hospital stay that may prolong the length of stay
- **MCC:** Major Comorbidity/Complication
- **POA**: Present on Admission
- **HAC**: Hospital Acquired Condition
- **ROM:** Risk of Mortality
- **SOI:** Severity of Illness

Common Severity/Mortality Drivers

- Acute renal failure (indicate underlying cause)
- Arrhythmia (atrial fibrillation/flutter, ventricular fibrillation/flutter, ventricular tachycardia)
- COPD (document if with exacerbation or decompensated)
- Electrolyte imbalances (hypo/hypernatremia, hypo/hyperkalemia, hypo/hypermagnesemia, hypo/hypercalcemia)
- Encephalopathy (specify type, acuity and cause)
- Gastrointestinal hemorrhage (document acuity and link to site of bleed)
- Heart failure (specify acuity and type)
- Hemiparesis (specify cause and laterality)
- Hypotension (specify cause)
- Ileus
- Malnutrition (specify severity)
- Pressure ulcer (include anatomic location, laterality and stage)
- Respiratory failure (specify acuity)
- UTI (specify site of infection such as bladder, kidney, or urethra)

GENERAL & INTERNAL MEDICINE

DOCUMENTATION IMPACTING MS-DRG & APR-DRG ASSIGNMENT AND SEVERITY/MORTALITY PROFILES

Dear Doctor, Please note that the Clinical Terms and Diagnostic Statements referenced are examples only, and in no way intended to lead the physician to any particular diagnosis. Your independent clinical judgment and documentation is the ultimate source of reference in the medical record.

A patient's Severity of Illness (SOI) and Risk of Mortality (ROM) is determined by the diagnostic terminology expressed in the medical record. Documentation must be accurate, complete and specific.

Basic Physician Documentation Requirements

- Document the reason(s) for the inpatient admission and the complex medical judgment factors to be considered including the severity of the signs and symptoms and the medical predictability of something adverse happening to the patient whenever possible to provide appropriate substantiation for severity of illness and risk of mortality.
- For all medications, treatments, and diagnostic studies, document the corresponding medical diagnoses indicating the clinical significance of the diagnosis. A code may not be assigned based on abnormal laboratory results or diagnostic report findings alone.
- Document all conditions including probable, suspected, or questionable based on your independent professional judgment and the clinical evidence and treatment provided. Clearly document if a condition was ruled out or was still considered probable at the time of discharge. Documentation should include the medical decision making process and supportive clinical information.
- Document all conditions still present, though possibly compensated or controlled, if they are currently being monitored, evaluated, treated, or causing increased nursing care or length of stay. These diagnoses should be listed as current medical conditions.
- Remove diagnoses from the problem list that are not clinically significant or have been ruled out.

3M

Clinical Terms (Needs clarification)	*Diagnostic Statement (Accurate code may be assigned)*
Continue home medications such as furosemide, HCTZ, ACE inhibitor	Document specific diagnosis such as chronic systolic/diastolic heart failure, CAD, atrial fibrillation, angina, HTN
History of CHF, will continue home meds	Specify acuity (chronic, acute, acute on chronic); specify type (systolic, diastolic, combined systolic and diastolic)
Cardiac enzymes elevated, elevated troponin, EKG positive	**Acute myocardial infarction** (specify type such as STEMI or NSTEMI; document specific artery involved such as LAD, left circumflex; exact date of any recent AMI)
Acute coronary syndrome (ACS)	Document intended diagnosis such as **intermediate/insufficiency syndrome, unstable angina, coronary slow flow syndrome, myocardial infarction**
Cardiac history	Document specific diagnoses such as **CAD, angina, old MI** (document date when MI occurred)
Atrial fibrillation	Specify type such as paroxysmal, permanent, persistent, chronic
Atrial flutter	Specify type such as typical (type I) or atypical (type II)
BP 70/40, ordered norepinephrine or dopamine for support	**Shock** (specify type such as cardiogenic septic, hypovolemic)
↓BP, IV fluid bolus started	**Hypotension** (specify type such as chronic, drug-induced, iatrogenic, idiopathic, intra-dialytic, orthostatic, postoperative)
LUL infiltrate	**Pneumonia** (specify type and organism, if known or suspected, such as Klebsiella pneumonia; document cause such as aspiration pneumonia)
Asthma	Document severity and type (mild intermittent, mild persistent, moderate persistent, severe persistent), document status (uncomplicated, with acute exacerbation, or with status asthmaticus)

Clinical Terms (Needs clarification)	*Diagnostic Statement (Accurate code may be assigned)*
Pleuritic chest pain, SOB, O_2 sat 65%	**Pulmonary embolism** (specify type, if known or suspected, such as saddle, septic; specify acuity such as acute or chronic; specify source such as DVT; healed/old; document presence of cor pulmonale if applicable)
SOB, $paCO_2$ 60 mmHg, pH 7.32, O_2 sat 88%, BiPAP	**Respiratory failure** (specify acuity, if known or suspected: acute, chronic or acute on chronic; document hypoxia, hypercapnia, if present)
CT scan/MRI of brain indicative of infarction	**CVA/stroke/cerebral infarction** (specify if due to embolism, thrombosis, occlusion, stenosis – document the clinical significance from the diagnostic findings to the current condition; document artery involved such as carotid, middle cerebral, vertebral; document laterality such as left or right; document any associated cerebral edema)
Diabetes, blood sugar ↑360, will start insulin drip, history of PVD	Specify type (type 1, type 2, drug or chemical induced, other underlying condition), document any associated complications (diabetic autonomic neuropathy, diabetic foot ulcer, PVD due to diabetes – must document a cause and effect link), document insulin control status as controlled, out of control, with hyperglycemia
Altered mental status, confusion, impaired memory, continue Exelon	**Dementia** (document underlying cause if known or suspected such as Alzheimer's, Parkinson's, drug-induced; specify presence of aggressive, combative or violent behavior associated with dementia)
Encephalopathy	Specify type, if known or suspected, such as alcoholic encephalopathy, hepatic encephalopathy, hypertensive encephalopathy, metabolic encephalopathy, toxic encephalopathy
Hepatic failure/hepatic encephalopathy	Specify acuity (acute, subacute, chronic), document presence of hepatic coma, document etiology (alcohol, drugs, hepatitis C, cirrhosis)
Dry mucus membranes, poor skin turgor, will rehydrate	**Dehydration**

Clinical Terms (Needs clarification)	*Diagnostic Statement (Accurate code may be assigned)*
Abdominal pain, increased lipase and amylase	**Pancreatitis** (specify acuity such as acute or chronic; specify etiology such as idiopathic acute pancreatitis or alcohol induced acute pancreatitis)
Coffee ground emesis	**GI hemorrhage** (specify acuity, site and lesion type, if known or suspected, such as acute gastric ulcer with hemorrhage, diverticulitis with hemorrhage)
Chronic kidney disease (CKD)	Document stage (stage 1-5, ESRD) and etiology such as due to diabetes or polycystic kidney disease
Acute kidney failure	Document etiology, if known or suspected (acute tubular, cortical or medullary necrosis; postprocedural; post-traumatic or drug-induced)
Renal insufficiency	Document intended diagnosis such as **kidney failure, kidney injury**; document acuity such as acute or chronic; document underlying cause
Hgb 6.2, Hct 27.5, will transfuse	**Anemia** (specify type, if known or suspected, such as acute or chronic blood loss anemia, anemia of chronic disease, hemolytic anemia, iron deficiency anemia, pernicious anemia)
Emaciated, ↓ albumin, weight loss, BMI 16.5, nonhealing wounds, nutritional consult, ordered supplements	**Malnutrition** (specify type such as protein calorie, protein energy; and severity such as mild, moderate or severe or first, second or third degree)
Unable to void, straight cath with 600 ml	**Urinary retention** (specify underlying cause if known or suspected)
Dysuria, abnormal urinalysis, urine culture >100,000	**UTI** (specify site of UTI such as bladder, urethra, kidney; specify if UTI is related to device such as Foley catheter; document causative organism such as E. Coli)
Urosepsis	Be clear on intended diagnosis such as **UTI, sepsis or severe sepsis.** Document any organ dysfunction and presence of shock. (Urosepsis is not a codeable diagnosis in ICD-10-CM)