Documentation Tips – Internal Medicine / Hospitalists

Principal Diagnoses (PDx):
- PDx is the condition(s) after careful study, present on admission (POA), requiring admission and treatment. Need to confirm even after resolved (i.e., “Acute Respiratory Failure POA, resolved”)
- Explain underlying etiology where possible (i.e., “Acute respiratory failure due to presumed gram negative pneumonia and longstanding chronic respiratory failure”)

Secondary Diagnoses (CCs/MCCs):
- Include all diagnoses which are treated and/or monitored
- Identify as “present on admission” if appropriate
- Utilize subspecialty/surgical consults when needed to improve specificity of all diagnoses
- Consider documenting a diagnosis any time you do something to a patient (“CVC placement due to septic shock”)

Pearls for Hospitalist Documentation:
- Describe “Clinical Impression” (e.g. thought process)
  - Diagnoses are commonly not “certain”
  - Use words like probable, likely, suspect, etc.
- **Heart Failure** (“CHF” no longer adds to severity)
  - Chronic systolic, diastolic (or combined) failure adds severity as a comorbidity (CC)
  - Acute systolic, diastolic (or combined) failure adds severity as a major comorbidity (MCC)
- **Sepsis** = SIRS + infection (as the cause) – an MCC
  - Positive blood cultures not necessary
  - *Not* synonymous with “bacteremia”
  - “Urosepsis” = UTI (to a hospital coder)
- **Acute Renal Failure/Acute Kidney Injury** (AKI) – a CC
  - AKIN criteria - ↑ in Cr by 0.3-0.5 above normal baseline = St 1 AKI
  - Acute Renal Insufficiency, pre-renal azotemia, dehydration, etc = low severity

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- Acute Renal Failure with ATN (acute tubular necrosis) remains an MCC
- **Chronic Kidney Disease (CKD)** – *must* identify stage
  - Stage 4 (GFR<30) and stage 5 (GFR<15) = CC
  - Chronic Renal Insufficiency (CRI) = *low severity*
- **Acute Respiratory Failure** – an MCC
  - Clinical diagnosis, no need for ETT/mechanical ventilation
  - Respiratory distress = *little credit*
  - Pulmonary insufficiency (except post-op) = *low severity*
- **Encephalopathy** – an MCC
  - “Delirium” is not a CC unless specified as a certain type. Altered MS is a symptom
- **Chest pain** – need cause, even if “probable”
  - GERD, chest wall pain, angina, psychogenic angina, etc.
- **Pneumonia – Simple vs. Complex**
  - VAP, HCAP, HAP, NH-acquired, nosocomial, etc. = *simple Pna*
  - *Suspect* gram neg, MRSA, aspiration, etc. = *complex Pna*
- **Decubitus Ulcers** – Stage 3,4 are MCCs
  - Document as “POA,” even if lesser stage on admission
- **Acute Coronary Syndrome (ACS)**
  - Documentation of ACS = unstable angina to coders
  - Document AMI (STEMI vs. NSTEMI) if indicated
- **Severe Malnutrition (MCC)**
  - Malnutrition or cachexia = CC
- **Acute blood loss anemia (CC)** – assoc w/GI diagnoses or post op
  - Don’t need transfusion or active bleeding for dx
- **Symbols**
  - ↓ Na⁺ ≠ hyponatremia (to a coder)