



PROVIDER CLINICAL DOCUMENTATION TIPS

"Specificity and detail in the medical record is needed to accurately capture the complexity of the patient you are treating in order to justify and properly identify the resources needed to care for your patient. Your documentation affects the accuracy of publicly reported data including risk adjusted quality measures and outcomes data. "

Always document:

- the reason for admission. Include possible, probable or suspected diagnoses.
- the disposition of each diagnosis, whether confirmed, ruled out, remains possible, etc.
- the clinical diagnoses of significant labs, radiology reports and pathology findings.

D/C Summary: Summary of all Med/Surg, Mental Health conditions managed during IP stay (Acute & Chronic)

"History of" means a condition existed in the past and has completely resolved. Consider "chronic" or drop "history of" for monitored conditions.

Medical Linkage = "Due to" or "Secondary to"

When two conditions are related. UTI "due to" Foley catheter, Acute Blood Loss Anemia "secondary to" GI bleed.

Always carry through to the discharge summary any diagnoses that have not been ruled out.

Always document:

Present on Admission status (POA):

- *Decubitus Ulcers: Type, site and stage
- *Sepsis: If identified after study and not documented on admission (ETC or H&P notes)
- *Catheter associated UTI
- *Infection due to Indwelling Device: Dialysis Cath, PICC, PD catheter, Joint Prosthesis, Hickman, Infusion Pump
- *Surgical Site Infection - include depth

Acute Blood Loss Anemia (ABLA):

- Drop in HGB of 2 gm or more due to acute blood loss
- Does not require a certain amount of blood loss.
- Does not require transfusion.
- May or may not be symptomatic.
- Monitored with additional Hgb labs.
- Not a post procedural complication unless specified as a complication by provider

Sepsis: Suspected or Confirmed:

Two or more of the following **PLUS** a source of infection:

- WBC >12,000 or <4,000 or >10% bands
- Lactate >1.0
- Temp >101 or <96.8
- ↑ Procalcitonin
- Pulse >90 bpm
- ↑ CRP
- Resp >20/min
- Altered Mental State
- Hypotension
- Hyperglycemia >140 (non-Diabetic)

Severe Sepsis:

Sepsis with Organ Damage:

- Lactic acidosis, AKI, Encephalopathy, resp failure, hypotension

Shock:

- Systolic BP <90, MAP <70
- Or Decreased Baseline SBP of 40 mmHg or more.
- PLUS, end organ damage (lactic acidosis, AKI)
- Lactic level >4 mmol/L

Specify Type: Cardiogenic, Hypovolemic, Toxic, Neurogenic, Anaphylactic, Postprocedural, Post-Traumatic, Septic,

Specify Treatment: IVF, blood transfusion **AND/OR** vasopressors
For Septic shock:

Hypotension AFTER fluid resuscitation of 30 mL/kg crystalloid

Acute Respiratory Failure:

- Requires some S/S of resp distress that need to be documented:
- Document: RR >20, Increased work breathing, Tripoding, Anxious, Unable to speak complete sentences, Altered mental status, Accessory muscles, Shallow breathing, Tachypnea, Nasal flaring
- ABG's are NOT required

Specify Type: Hypoxic and/or Hypercapnic

Specify Acuity: Acute, Chronic or Acute on Chronic

Acute Hypoxic Respiratory Failure:

- ABG: arterial pO2 on room air < 60mmHg
- SpO2<91% by pulse ox in a pt. w/o chronic resp failure
- P/F ratio (pO2/FIO2) <300 not applicable for A/C Resp Failure

Acute Hypercapnic Respiratory Failure:

- pCO2 >50mm Hg with pH of <7.35 or If baseline PCO2 is known, a 10-15 mmHg increase in baseline pCO2

Chronic Respiratory Failure:

Indicators: Hypoxic, elevated pCO2, elevated bicarb, normal pH (7.35 to 7.45) **AND** Chronic use of continuous home O2 = 24 hrs a day. Is NOT Intermittent, exertional, or nocturnal use of O2.

Acute on Chronic Respiratory Failure:

Indicators:

- pCO2 >50 mmHg + pH of <7.35
- Increase in baseline pCO2 (if known) by 10mmHG or more
- pO2 <60 mmHg or SpO2 <91% with ≥ usual home O2 rate
- worsening dyspnea requiring an increase in chronic supplemental oxygen

Acute Kidney Injury: **Not** Renal Insufficiency

-Increase in Cr level ≥ 1.5x baseline known/presumed within prior **7 days** or

-Increase in Cr level ≥ 0.3mg/dl in prior **48 hrs** or

-UOP: **< 0.5 ml/kg in 6 hrs**

Specify Cause: Dehydration, Hypotension, Diuresis, Contrast

Specify Type:

Consider ATN: Meets criteria for AKI but expected to take >72 hrs to resolve.

Specify Causes of ATN:

IV contrast, Sepsis, Shock, Drugs, Major Surgery, Rhabdomyolysis, Prolonged Hypotension

Pneumonia:

"Healthcare Acquired or Community Acquired indicates where pneumonia was acquired and is not a codable diagnosis. Instead document according to type or organism".

Specify Type:

Aspiration, Interstitial, Viral, With Influenza, Bacterial

Specify Causative Organism: Including Probable, Possible, or Suspect Gram -, Gram +, Staphylococcal, Pneumococcal,

Klebsiella, etc. Document "possible gram-neg pneumonia when treating for suspected or gram-neg pneumonia".

Does not require culture confirmation to support a suspected/possible/probable diagnosis.

Acute Encephalopathy:

-A medical condition that may cause S/S of delirium.

-Not the same as delirium (a mental disorder or symptom)

Specify Type: Metabolic, Toxic, Hepatic, Septic, Anoxic, Hypertensive, Alcoholic

-Toxic Encephalopathy refers to condition due to a toxin/drug which could be iatrogenic or illicit substance

CVA:

Specify Type: Ischemic, Hemorrhagic, Embolic, Thrombosis,

Specify Site:

Precerebral: Vertebral, Basilar, Carotid

Cerebral: Middle, Anterior, Posterior

Cerebellar

Specify Laterality: Left, right, dominant, nondominant

Intracranial Bleed:

Specify Cause: Traumatic, Non-traumatic

Specify Type: Acute, Subacute, Chronic

Specify Site:

Subarachnoid, Epidural, Subdural, Hemisphere, Cortical

Cerebral Edema/Brain Compression:

-Not Codable: Mass effect, Midline shift and Effacement

Chronic Kidney

Disease:

Document: CKD Stage		
Stage	G Stage	GFR
1	G1	≥90
2	G2	60-89
3	G3a	45-59
3	G3b	30-44
4	G4	15-29
5 or ESRD or on dialysis	G5	<15

Congestive Heart Failure:

Specify Type:

Diastolic: EF >55% (HFpEF)

Systolic: EF <45% (HFrEF)

Specify Acuity: Acute, Chronic or Acute on Chronic

Specify Cause:

Due to hypertensive/ valvular/ ischemic heart disease
Right heart failure (acute/chronic) with pulmonary hypertension, is **not** due to essential hypertension

MI:

Specify Type: (UDMI= Univ Definition of MI)

Type 1 MI: -STEMI, Q-Wave, And NSTEMI (UDMI: Type 1 MI)

-Trop >99th % (0.04 ng/ml) with acute infarction

-Due to CAD/plaque rupture

-Immediate reperfusion treatment

(PCI or anti-thrombotic, anticoagulant + anti-platelet therapy)

Type 2 MI: (UDMI as a Type 2 MI)

Myocardial supply/demand mismatch without plaque rupture

Trop > 99th % (0.04 ng/ml) with evidence of acute infarction

- **Due to condition other than CAD**

- Documentation: include causative condition

Note: Demand ischemia indicates EKG changes/symptoms/neg. trops

Fluid Overload:

Specify Type:

Fluid Overload Non-Cardiac Renal Origin:

-Fluid Overload/ Acute Pulmonary Edema due to or associated with renal failure. No evidence of cardiac decompensation.

-Volume overload/ acute pulmonary edema due to noncompliance with dialysis and/or diet.

-No evidence of cardiac decompensation.

Atrial Fibrillation:

Specify Type:

-**Chronic**-general term, **specify the sub-type:** paroxysmal, persistent, long-standing persistent or permanent a-fib.

Encourage use of the term chronic as it offers a CC to support the complexity of care needed; **subtypes alone do not.**

-**Paroxysmal:** Self-terminating or intermittent. Terminates spontaneously or w/intervention w/I 7 days of onset. May recur w/various frequency.

-**Persistent:** Fails to resolve or self-terminate w/I 7 days. Have repeated efforts at rhythm control.

Permanent: Longstanding persistent atrial fib. that is being managed by rate but not rhythm control.

Atrial Flutter:

Specify Type:

Type1: Atypical atrial flutter, atrial rate of 240 to 340

Type 2: Atypical atrial flutter, atrial rates of 340 to 440

Hypertensive Urgency:

Typically: SBP>180 or DBP>110

With symptoms: HA, dyspnea, CP

Without end organ involvement.

Treatment: Prompt reduction of BP over hours or days with oral antihypertensives.

Hypertensive Emergency:

Typically: SBP>180 or DBP>120

With end organ involvement:

CVA, unstable angina, MI, AKI seizure, HF, encephalopathy,

Treatment: Urgent reduction of BP using IV antihypertensives.

Document Nicotine Dependence Withdrawal:

-Nicotine dependence when patch is ordered.

- **Document Symptoms:** Intense craving, sweating, anxiety, tingling hands/ feet, headache, irritability, depression

The Term “Postoperative”: Indicates a complication!

-Postoperative does **NOT** indicate a time frame.

-Use this term **only if condition is an unexpected condition or complication** of procedure, anesthesia, previous care, failure of device, or late effect of medical treatment.

-**If condition (ileus, puncture, laceration, resp failure (w/hx of COPD, ILD), etc.) is NOT a complication, document:** Occurring after surgery, unrelated to surgery, expected, unavoidable, or inherent to procedure

Postprocedural Respiratory Failure

Document only when patient has significant unexpected resp prob **due to procedure or vent weaning is beyond normal expectation.**

Coexisting Conditions:

Always Document: Acute blood loss anemia, Atelectasis, Ileus, AMI, Shock, Sepsis, AKI, CVA, Hyponatremia, etc

OP Notes: Codes come from procedure narratives.

Always Document:

- All procedures
- Implanted devices
- Laterality: Left, right
- Pathology found
- Condition inherent to procedure
- Intraoperative complications
- Lysis + what body parts were released
- Tissue and parts removed
- Unexpected findings

PVD Surgery:

Always Document: Reason or cause for procedure
Progression of arteriosclerosis, disease,
Failure/complication of previous procedure-bypass graft, stent.

Hypercoagulable State:

-Unprovoked DVT/PE may be due to inherited/acquired thrombophilia.

-If provocation is identified i.e. malignancy, Factor V Leiden estrogen, oral contraceptives, document ‘secondary hypercoagulable state’.

Debridement

Always Document: Each of the following:

- 1.Excisional (cut away/remove) or Non-excisional NOT “Sharp debridement” (Versa jet, irrigate, brush, clean)
2. Instruments used (scalpel, scissors, forceps, saw, etc)
3. Deepest level of debridement (skin, fascia, bone)
(debridement is the dot phrase template)

Muscle Flap Closure:

Transfer flap for Stage IV Pressure Ulcers and other wounds.

Specify: Deepest layer in the flap.

Specify: Muscle or body part transferred.

Pancytopenia

Specify Cause: Chemo, radiation, malignancy, splenomegaly

Pressure Ulcers/Wounds:

Refer to WOC Nurse Note for Assistance:

Provider must document site and POA of a pressure ulcer.

Specify Type: Pressure, Traumatic, Chronic Non-pressure, Nonhealing Surgical

Specify Stage: I-IV, Deep tissue pressure injury, Unstageable

Specify Present on admission status: POA or Hospital Acquired

Morbid (Severe) Obesity:

-BMI ≥40

-**OR** BMI 35-39.9 with a comorbid condition (DM, CAD, CHF, OSA, HTN, or ANY chronic condition impacted by habitus).

Malnutrition:

Order and follow up on RD note to determine severe, moderate, mild or unspecified protein-calorie malnutrition.

Electrolytes: Use diagnosis terms i.e. hyponatremia, not low sodium. Indicate treatment or lab monitoring.

Major Depression:

Specify Episode: Single, Recurrent, or Remission

Specify Severity: Mild, Moderate, or Severe

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