



**NEUROSCIENCES  
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 adjustment quality measures and outcomes data."

**Always document:**

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

**"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

**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

**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.

**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

**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'.

**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

-May or may not be symptomatic

-Does not require transfusion

-Not a post procedural complication unless specified as a complication by provider

-Monitored with additional Hgb labs

**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 ≥ 0.3mg/dl or

-Increase in Cr level ≥ 1.5x baseline within prior 7 days

-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

**Electrolytes:** Record imbalances "particularly" given that hyponatremia is a CC with labs and monitoring.

Use diagnosis terms i.e. hyponatremia, not low sodium.

**Smart phrases:**

**Found by typing DOT-C-D-I (.CDI)**

**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	

### 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**

### 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

### Document Nicotine Dependence Withdrawal:

-Nicotine dependence when patch is ordered.

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

### Morbid 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.

### Major Depression:

**Specify Episode:** Single, Recurrent, or Remission

**Specify Severity:** Mild, Moderate, or Severe

## SURGICAL CONSIDERATIONS:

### **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 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.**

**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

### 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.

### 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

### Pathology of malignancy post discharge

Likely to change DRG/SOI/ROM

Need addendum to discharge summary to associate the malignancy with the acute hospitalization itself

## Definitions/Abbreviations:

DRG: Diagnosis Related Group; main “bucket” for acute encounter, driven by procedure if present

CC/MCC: Have major impact on designation

Anything that requires:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Extended length of hospital stay
- Increased nursing care and/or monitoring

CC: Comorbid condition

MCC: Major comorbid condition

SOI: Severity of illness

ROM: Risk of mortality

### Common considerations that may impact SOI/ROM \*Italics indicates CC; Bold italics indicates MCC

*Pressure ulcer, stage III/IV, Coma/Comatose, Nicotine dependence with acute withdrawal, Hyponatremia or hypernatremia, Hypercoagulable state, Acidosis, Ileus, Hemiplegia or Hemiparesis, late effect of prior CVA, UTI, Left sided neglect, Obstructive hydrocephalus, Seizures, Dysphagia, Aphasia, Dementia with behavioral, disturbances Sundowning, Functional quadriplegia, Aspiration Pneumonia, Apnea, AV block/bundle branch block, History of cardiac arrest, CKD any stage, Atelectasis, Depression w specificity, Dehydration, Urinary retention, Oliguria, Thrombocytopenia, Obesity, Hypokalemia, Hypocalcemia, Hypoxia*

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