CentraCare™

PROVIDER CLINICAL DOCUMENTATION TIPS

OB/GYN

"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 disposition 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.

Diagnoses with Trimester designation (Problem List):
Clarify if condition is resolved, ruled out, or still present at time of admission

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):
*Sepsis: If identified after study and not documented on admission
*Infection due to Indwelling Device: Dialysis Cath, urinary catheter, PICC, Portacath, Infusion Pump
*Surgical Site Infection - include depth

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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)

Maternal Sepsis:
Two or more of the following perinatal SIRS criteria PLUS a source of infection
- WBC:> 20,000 or < 4,000
-Temp > 101° F - Heart Rate (HR) > 110 - Resp (RR) > 24
-New Mental Status Change
-Blood Glucose > 140 mg/dl in absence of diabetes and has not received betamethasone

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: Hemorrhagic, Hypovolemic, Toxic, Septic, Anaphylactic, Cardiogenic, Neurogenic, Postprocedural, Post-Traumatic
Specify Treatment: IVF, blood transfusion **AND/OR** vasopressors
For Septic shock:
Hypotension AFTER fluid resuscitation of 30 mL/kg crystalloid

Intraamniotic Infection (IAI)/Chorioamnionitis

Isolated Maternal Fever	Suspected Chorioamnionitis (IAI)
Oral temp between 38.0/100.4 °F & 38.9° C/102.2°F or w/o persistent temp elevation -No risk factors present. -In the absence of another cause of fever, likely treated as *"Suspected"* Chorioamnionitis (IAI)	Temperature of ≥39.0 ° C /102.2 °F) OR Oral temp between 38.0/100.4 °F & 38.9° C/102.2°F with one or more of the following: -Maternal leukocytosis (>15,000) -Fetal tachycardia (>160 for ≥ 10 min) Excluding accels/decels/marked variability -Purulent cervical drainage -Uterine/abdominal tenderness

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

Thrombocytopenia:
Platelets < 150,000
Specify cause

Anemia:
Hgb <12gm/dl women; HGB <11gm/gl pregnancy
Pregnancy: Specify if pre-existing or gestational

Acute Blood Loss Anemia (ABLA):
Specify: symptoms, monitoring, or treatment
-Drop in HGB of 1-2 gm or more due to acute blood loss
-Monitored w/additional Hgb labs beyond the standard POD 1 or EBL/QBL measurements beyond standard recorded with delivery or treatment, such as Fe Supplement
-Does not require a certain amount of blood loss or transfusion
-Not a post procedural complication unless specified as a complication by provider

Postpartum Hemorrhage:
QBL/EBL > 1000 mL related to Vaginal or CS delivery
QBL/EBL > 500 mL in vaginal delivery is considered abnormal and warrants additional monitoring and investigation.
Treatment: IV/IM Meds, tamponade/Bakri, IVF, PRBC

Obstruction of Labor:
Specify as "obstructed/obstruction"
Specify cause: persistent OP, OT, or asynclitic position, deep transverse arrest, CPD, Shoulder Dystocia

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, pregnancy document 'secondary hypercoagulable state'.

Encephalopathy:
-Any diffuse disease of the brain that alters brain function or structure (may cause s/s of delirium)
-Not the same as delirium (a mental disorder or symptom)
Specify Type: Metabolic, Toxic, Septic, Hypertensive, Hepatic, Alcoholic, Anoxic
-Toxic Encephalopathy refers to condition due to a toxin/drug which could be iatrogenic or illicit substance
I.E. Mag Toxicity, Acute Alcohol/Drug intoxication

Obesity:
-BMI≥30 Pre-Pregnancy

Morbid (Severe) Obesity:
-BMI ≥40 Pre-pregnancy
-OR BMI 35-39.9 with a comorbid condition (DM, Asthma, OSA, HTN, GERD 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.

Chronic/preexisting hypertension - PENDING APPROVAL:
"Essential (Primary) HTN", specify if known cause (secondary) –HTN that precedes pregnancy OR is present on at least two occasions before the 20th week of gestation OR persists longer than 12 weeks postpartum.

Gestational hypertension- - PENDING APPROVAL:
-develops after 20 weeks of gestation
-hypertension (systolic ≥140 and <160 mmHg, and/or diastolic ≥90 and <110 mmHg) without proteinuria or other symptoms of preeclampsia-related end-organ dysfunction
-Development of proteinuria moves diagnosis to preeclampsia.

Preeclampsia - - PENDING APPROVAL:
After 20 weeks of gestation in a previously normotensive woman or postpartum
Specify: Mild/Moderate or Severe
-new onset of hypertension and proteinuria OR
-hypertension and significant end-organ dysfunction with or without proteinuria
-Severe HTN or signs/symptoms of significant end-organ dysfx.
Severe Pre-eclampsia criteria:
-SBP ≥ 160 and/or DBP ≥110 mm/hg or higher on 2 occasions at least 4 hours apart (unless antihypertensive therapy is initiated before this time)
-Platelets <100K
-Impaired liver function &/or Persistent RUQ/epigastric pain
-Renal insufficiency (serum creatinine concentration more than 1.1 mg/dL or a doubling of the serum creatinine concentration in the absence of other renal disease)
-Pulmonary edema
-New onset headache, cerebral or visual disturbances
Preeclampsia superimposed on chronic/preexisting hypertension - new onset of proteinuria, significant end-organ dysfunction, or both after 20 wks. gestation in a woman with chronic/preexisting HTN. If chronic/preexisting HTN w/proteinuria prior to pg or in early pregnancy, superimposed preeclampsia is defined by worsening or resistant HTN (especially acutely) in the last half of pregnancy or development of signs/symptoms of the severe end of the disease spectrum.

Eclampsia:
Convulsive manifestation of hypertensive disorder of pregnancy in the absence of other causes.

HELLP syndrome - - PENDING APPROVAL:
Predominant features:
-**H**emolysis
-**E**levated **l**iver enzymes (LDH ≥600 IU/L, AST and ALT elevated more than twice the upper limit of normal)
-**l**ow **p**latelets (<100,000)

Acute Pulmonary Edema:
- dyspnea, tachypnea, tachycardia, hypoxemia, poss. HTN, and diffuse crackles, +CXR findings of bilateral air space disease
-May be attributed to iatrogenic volume overload, Mag sulfate, other tocolytic meds, preeclampsia/eclampsia, cardiac dx.
-noncardiogenic otherwise best described as acute or acute on chronic CHF
-Tx: IV diuresis, ECHO, oxygen, tx of underlying conditions

Cardiomyopathy:
Definition: Abnormality of myocardium that impairs function; if CHF has ever had clinical manifestations requiring management it is then best described as chronic congestive heart failure
Specify: pre-existing (identify cause if known) or pregnancy/peripartum related

Congestive Heart Failure:
Specify Type:
Diastolic: EF >55% (HFpEF)
Systolic: EF <45% (HFrEF)
Specify Acuity: Acute, Chronic or Acute on Chronic; has impact even if chronic/compensated

Acute Respiratory Failure:
-Requires some S/S of resp distress 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

Document Nicotine Dependence Withdrawal:
-Nicotine dependence when patch is ordered.
- **Document Symptoms**: Intense craving, sweating, anxiety, tingling hands/ feet, headache, irritability, depression

Major Depression:
Specify Episode: Single, Recurrent, or Remission
Specify Severity: Mild, Moderate, or Severe

Chemical Use:
Specify: to what substance
Specify: Abuse, Use Disorder - Specify Severity: Mild, Moderate (=Dependence), Severe (=Dependence)), Remission
Specify: Intoxication, Withdrawal, Delirium, Substance-Induced Disorder

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

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

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 etc.) is NOT a complication of procedure, document as: 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.* **Specify if due to underlying condition** (severe COPD, Asthma, CHF, aspiration pneumonia, pneumothorax)

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