Documentation Tips – Emergency Department

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 probable gram negative pneumonia and longstanding chronic respiratory failure"*)
  - ARF = Clinical diagnosis, no need for ETT/mechanical ventilation
  - Respiratory distress = *little* credit (codes like simple cough)
  - Pulmonary insufficiency = *low severity*

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 Emergency Physician Documentation:

- Describe your "Clinical Impression" (e.g. thought process)
  - Diagnoses are commonly not "certain"
  - Medicare wants to know your "clinical impression"
  - *probable, likely, suspect*, etc. – codes to definitive diagnosis
- **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) – dx justified by clinical findings such as rales, SOB, etc.
- **Sepsis** = SIRS + infection (as the cause) – an MCC
  - Positive blood cultures not necessary
  - "bacteremia" is not a diagnosis
  - "Urosepsis" = UTI (to a hospital coder)
- **Acute Renal Failure/Acute Kidney Injury** (AKI) – a CC

2012 Copyright© J.A. Thomas & Associates, Proprietary & Confidential

- AKIN criteria - ↑ in Cr by 0.3-0.5 above normal baseline = *Stage 1 AKI*
- Acute Renal *Insufficiency*, pre-renal azotemia, dehydration, etc = *low severity*
- ARnF(AKI) 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*
- **Encephalopathy** – an MCC
  - "Delirium" is not a CC without specificity. Altered MS is a *symptom* – not even a CC
- **Chest pain** – need cause [clinical impression], 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** – 3 or 4 are MCCs and considered HACs unless POA
  - Document as "POA," even if lesser stage
- **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
  - Don't need transfusion or active bleeding for dx
- **Symbols**
  - coders can't make diagnoses
  - ↓ Na^+ ≠ hyponatremia (to a coder)

2012 Copyright© J.A. Thomas & Associates, Proprietary & Confidential